The Influence of Cultural Beliefs and Social Norms on Arab-American Women's Healthcare Experiences: A Qualitative Study

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ABSTRACT

This descriptive qualitative study was conducted by interviewing 10 Arab-American women to describe their experiences being Arab-American and the influence it has on their healthcare choices within the United States healthcare system. This paper aims to explore how cultural beliefs and social norms may influence Arab-American women's experiences with healthcare. This research is important due to the lack of current literature covering this topic and serves to fill in current gaps in knowledge. Additionally, although it is essential to examine healthcare inequalities for women in all cultures, the lack of disclosure for Arab-American women makes it a particularly crucial topic to explore. This paper concludes that Arab-American women with a higher level of assimilation identified more stigmas and social norms that impact their healthcare experiences, specifically on sexual and women's health, and mental health.

Keywords: Arab-American, Cultural Influence, Arab-American Women, Women's Health, Mental Health, Healthcare Attitudes, Health Practices

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INTRODUCTION

Arab Migration & Diaspora

Modern scholars refer to "the Arab World" as the countries that speak Arabic dialect: Algeria, Bahrain, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, occupied Palestine territories, Qatar, Saudi Arabia, Syria, Tunisia, Turkey, United Arab Emirates, and Yemen.[1] The Arab World has a population of over 464.5 million people[2] with about 3.7 million Arab-Americans living in the United States.[3] Western media has often depicted the Middle East as a war-ridden, desert landscape, with men with guns and camels, leading donkeys and sheep from coast to coast.[4] The historically war-dominated area has forced men, women, and children to flee to the United States and other countries in North and South America, as well as Europe. Alas, the immigration of Arab people is not only due to war, and it is not a recent phenomenon, but rather has a history and wide-ranging impacts.

Originally, the term 'diaspora" was derived from the Greek verb *speiro*, meaning 'to sow' and its preposition *dia*, meaning 'over.'[5] [6] The earliest diasporas in West Asia are those of

[1] "Geography of the Modern Middle East and North Africa," Middle East Teaching Tools Geography of the Modern Middle East and North Africa Comments, accessed November 9, 2021. http://www.middleeastpdx.org/resources/original/geography-of-the-modern-middle-east-and-north-africa/.
[2] "Population, Total - Middle East & North Africa," Data, accessed November 9, 2021, https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZQ.
[3] Brown, Heather, Guskin, Emily, and Mitchell, Amy. "Arab-American Population Growth," Pew Research Center's Journalism Project (Pew Research Center, December 31, 2019), https://www.pewresearch.org/journalism/2012/11/28/arabamerican-population-growth/.
[4] Arab American Institute Foundation *Underreported, Under Threat: Hate Crime in the United States and the Targeting of Arab Americans 1991-2016* (2018). Available online at: https://www.aaiusa.org/library/under-reported-under-threat (Accessed January 10th, 2022)
[5] Noman, Abdalwahid Abbas. "Diaspora and Multiculturalism in Reconstructing the Cultural Identity of Arabs in America." *Cross-Cultural Communication* 15, no. 1 (March 26, 2019): 57. https://doi.org/10.3968/10969.
[6] Shuval, Judith T. (2000), Diaspora Migration: Definitional Ambiguities and a Theoretical Paradigm. International Migration, 38: 41-56. https://doi.org/10.1111/1468-2435.00127

Yemeni and Omani persons around the early spread of Islam, leading to trade and labor diasporas. Islam spread to Spain and the Moors became a prominent population that remained in Spain until the forced conversions to Christianity after the Christian conquest of Granada in 1492.[7] The first historically noted wave of Arab migration to the United States was that of the Lebanese, Syrian, and Palestinians around the 1870s and the 1920s due to trade influences, lessened immigration restrictions, French and British colonial expansion, and the fall of the Ottoman empire.[8] They had gone to many locations, including France, Brazil, Canada, Australia, and the United States. The second recorded wave of Middle Eastern migration in the United States focuses on the Lebanese, Palestinians, Yemenis, and Iraqi movements, beginning after World War II, between the 1940s and 1960s. Specifically for the Palestinian people, three-quarters of their population left their homes in what was called the *Nakba*, a process of ethnic cleansing caused by the Arab-Israeli war that forced a large, unarmed population, estimated to be about 711,000 to leave their homes in 1948.[9] [10]

Then, while the political instability of those nations continued to rise, another wave of immigrants occurred in the 1970s and the 1980s.[11] [12] After World War II, Arab emigrants moved

[7] "Arabs in the Americas; Interdisciplinary Essays on the Arab Diaspora. - Free Online Library." Accessed April 25, 2022.
[8] Ibid., 26
[9] *Nakba: Palestine, 1948, and the Claims of Memory*. Columbia University Press, 2007. https://www.jstor.org/stable/10.7312/sadi13578.
[10] Batalova, Jeanne, and Laura Harjanto. "Middle Eastern and North African Immigrants in the United States." migrationpolicy.org, January 12, 2022. https://www.migrationpolicy.org/article/middle-eastern-and-north-african-immigrants-united-states.
[11] "Arabs in the Americas; Interdisciplinary Essays on the Arab Diaspora. - Free Online Library." 8
[12] Lucas, Christopher J., and Stefano Manfredi. *Arabic and Contact-Induced Change*. Zenodo, 2020. 303

to Europe and the United States to fill gaps in the labor shortage that the war caused.[13] Scholars label this a third wave of immigration from the Middle East to the United States starting from the 1970s to the present, beginning with the 1965 Immigration and Nationality Act. This act repealed the restrictive quota that had been in place since 1924 and allowed for the naturalization of immigrants from Asia.[14] This resulted in an estimated 757,000 Arabs immigrating to the United States between the 1970s and 2000.[15] Major influences of migration today are caused by economic or social instability, including geographic proximity to instability, war, concerns for safety, historical economic tensions, state and government policies, political and economic conditions, natural disasters, family reunification and social networks, availability of visas, labor recruitment, and human trafficking.[16] Because of the contemporary destabilization of the entire Middle East, immigration to the United States continues despite refugee intake restrictions.[17] All three waves are shaped by multiple influences, and the phenomenon of Arab migration is extremely complex.

Migration and diaspora may be understood through both quantitative and qualitative lenses. Quantitatively, the literal definition of "migration" refers to the number of people who move away from their habitual residence and the statistical examination of the populations.[18] Diaspora differs from other types of migration in that it is based on the claim that migrants have

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[13] Sensenig-Dabbous, Eugene. "Arab Diaspora Women." *Al-Raida Journal*, 2007, 2-3. https://doi.org/10.32380/alrj.v0i0.200

[14] Foad, Hisham S., "Waves of Immigration from the Middle East to the United States" 2013. http://doi.org/10.2139/ssrn.2383505, pp. 8

[15] Orfalea, Gregory. *Arab Americans: A History*. Interlink Publishing Group, 2006.

[16] Cainkar, Louise, *Global Arab World Migrations and Diasporas* 2013. 70.

[17] Lucas, Christopher J., and Stefano Manfredi. *Arabic and Contact-Induced Change*, 304

[18] "Migration," United Nations (United Nations), accessed November 9, 2021, https://www.un.org/en/global-issues/migration.

a “natural right” to return to their homeland based on religious, ethnic, or cultural ties, despite the circumstances that forced them to leave in the first place.[19] From a qualitative lens, the notion of migration includes the experience of migrants, including social and cultural ties to the homeland through conscious thought and action, as well as social structures.[20] The experiences of being an immigrant are not universal and are complex due to social and emotional associations with migration. Thus, qualitative examination of migration spans across different paradigms, limiting the formation of a cohesive overview of migration.[21]

Upon the discussion of migrants, vocabulary such as “alien” and “illegal” is oftentimes alluded to as synonyms, erasing all aspects of humanity and dignity from a migrant. It labels them as a “visitor” or a “stranger” rather than an individual taking new roots. Regarding diasporas, the action of migrating can itself be understood as an act of dignity as moving from a state that one is dissatisfied with to another requires courage, commitment, and self-respect. Cainkar (2013) encourages readers to expand this idea and link migration and Arab revolutions together as acts fueled by the pursuit of human dignity. In Cainkar’s view, both migration and revolution stem from a lack of satisfaction with the current state and the discomfort that emerges from it, and thus both take action to find another state in which to reside, whether physically or politically. Thus, both migration and revolution reflect the search for human dignity and self-sufficiency.[22]

[19] Shuval, Judith Diaspora Migration: Definitional Ambiguities and a Theoretical Paradigm. 46
[20] Cainkar, Louise, “Global Arab World Migrations and Diasporas.” 152-153
[21] Ibid., 128-129
[22] Ibid., 131-132

There are two perspectives that stand out in research on migration. The first is a sociological perspective that explores networks and linkages, "transnational social fields," meaning that there is a focus on the connections between origin and destination.[23] [24] Sociologists define origin and destination in a social rather than the geographic manner, allowing for an understanding of transnationality on a social level.[25] The second perspective focuses more on the differences separating generations of immigrants, and the relationship between identity and culture between generations.[26] This perspective distinguishes between the experience of an individual who underwent immigration as an adult versus as a child and argues that their encounters with the diaspora are notably different from one another. Due to these varied experiences, the definition of a diaspora could have many different meanings to different people. Despite differing views, one recurring thread connecting these perspectives is the concept of human dignity.

Arab-American Identity & Tension

A common theme described in both perspectives is the hybridization of identities between the two social identities (that of their home country and that of their new residence) that a migrant may have to navigate.[27] Historically, it was expected that immigrant groups would fully assimilate into the norms of their new location. The Western world views its culture as

[23] Cainkar, Louise, "Global Arab World Migrations and Diasporas." 129-130
[24] Lubbers, Miranda Jessica, Ashton M. Verdery, and José Luis Molina. 2020. *Social Networks and Transnational Social Fields: A Review of Quantitative and Mixed-Methods Approaches.* International Migration Review 54, no. 1 (March 2020): 177–204. https://doi.org/10.1177/0197918318812343.
[25] Ibid.
[26] Ibid.
[27] Abu-Shomar, Ayman. 2020. "Critical Spaces of Diaspora and the Shifting of Paradigm: Negotiating Intercultural Narratives in Arab Anglophone Literatures. 22nd Istanbul International Conference on "Literature, Humanities, and Social Sciences" March 2-4, 2020

superior and any differing as "other," so it had become the expectation that any Arab culture would be assimilated into Western culture.[28] [29] Navigating two socio-cultural contexts can cause substantial challenges and stress. Given the substantial differences in cultural norms between the Middle East and the United States, one migrating to the United States may have a difficult time balancing this multiculturalism. Different generations may have different levels of assimilation to a new culture, which may also cause challenges as differing opinions on social behavior and cultural expectations emerge between generations. Research has suggested, however, that an individual can accept both identities without the eradication of one; embracing multiple identities.[30]

For women, this conflicting multiculturalism may be felt strongly due to the sizable differences in expectations for women in Arab versus Western cultures. In Arab culture, the family takes utmost importance in societal structures. Families reside in proximity to each other, and a nuclear unit consists of a father, mother, and their children. Extended family units include the *Aila:* father, mother, unwed children, wed children, and their own families, as well as the *Ashirah:* all family members from the same paternal ancestor. Women in the family are held in high regard; they are expected to maintain all domestic functions, such as childbirth, house management, and raising children.[31] In terms of sexuality, women are expected to abstain from

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[28] Shuval, Judith, Diaspora Migration: Definitional Ambiguities and a Theoretical Paradigm., 44
[29] Hattar-Pollara, Marianne, and Afaf I. Meleis. "The Stress of Immigration and the Daily Lived Experiences of Jordanian Immigrant Women in the United States." Western Journal of Nursing Research 17, no. 5 (October 1995): 522. https://doi.org/10.1177/019394599501700505.
[30] Shuval, Judith, Diaspora Migration: Definitional Ambiguities and a Theoretical Paradigm., 45
[31] Hattar-Pollara, Marianne, and Afaf I. Meleis. "The Stress of Immigration and the Daily Lived Experiences of Jordanian Immigrant Women in the United States." 523

sex before marriage, and any stray from that may cost her and her family their reputation and material assets. In some Arab areas, there could be lawful and community punishment for such an act.[32] In Western culture, women's bodies are still controlled, but it is more socially acceptable—due to the albeit limited success of feminist ideologies and movements—to engage in the workforce and balance work obligations with the duties of motherhood, as well as to engage in pre-marital sex.[33]

The cultural dissonance between expectations of Arab women from the Arab culture versus the Western culture result from efforts at the hybridization of identities. The pressure to assimilate to the prominent Western norms when one has a strong foundation in the Arab identity may be a struggle for some Arab American women. Previous research on female Jordanian immigrants has shown that it was common for the women to experience loneliness, emotional distress, anxiety and social isolation due to assimilation stressors, such as societal prejudice, financial worries, household management, maintenance of ethnic identity, and upbringing of children while limiting their perceived unacceptable Western behaviors.[34] Some norms that may be acceptable in the United States, such as some aspects of healthcare (gynecological health) and opposite-sex relations, may not be the same in Arab culture. This nature of the identity struggle differs among different generations of immigrants, but a sense of conflict between the Arab and Western identities is common.

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[32] Noman, Abbas. A. "Diaspora and Multiculturalism: Reconstructing the Cultural Identity of Arabs in America. Cross-Cultural Communication,"
[33] Caplan, Pat. *Cultural Construction of Sexuality*. Routledge, 2016.
[34] Amer, M.M., Hovey, J.D. Socio-demographic Differences in Acculturation and Mental Health for a Sample of 2nd Generation/Early Immigrant Arab Americans. *J Immigrant Minority Health* 9, 335 (2007). https://doi.org/10.1007/s10903-007-9045-y

Culture and societal beliefs play a large role in community behaviors and actions in various ways, both positive and negative. This paper aims to explore how cultural beliefs and social norms may influence Arab American women's experiences with healthcare. This exploration will employ a qualitative approach to describing how and why women's health may be affected by societal norms and expectations for Arab-American women.

BACKGROUND

Access to healthcare can be affected by a variety of factors. From a social viewpoint, literature has identified key social determinants of health that have the most impact on healthcare access, such as social status, economic impact, age, and gender.[35] [36] [37] However, gender is recognized as one of the most profound social determinants of health, and an exploration of the relationship between gender and healthcare exposes inequalities within the American healthcare system that are harmful to public health. [38] Gender inequality is prevalent among different social and cultural groups and is the basis for these inequities in healthcare. These inequalities within the American healthcare system increase the chance that women will be exposed to vulnerabilities and risk factors in terms of their health, as seen in previous studies that have noted that women have an increased risk of having unmet healthcare needs compared to men.[39] [40] Ethnicity is also recognized as another profound social determinant of health.[41] Arab Americans

[35] Braveman, Paula, and Laura Gottlieb. "The Social Determinants of Health: It's Time to Consider the Causes of the Causes." *Public Health Reports* 129, no. 1_suppl2 (2014): 21. https://doi.org/10.1177/00333549141291S206.
[36] Heymann, Jody, Jessica K. Levy, Bijetri Bose, Vanessa Ríos-Salas, Yehualashet Mekonen, Hema Swaminathan, Negar Omidakhsh, et al. "Improving Health with Programmatic, Legal, and Policy Approaches to Reduce Gender Inequality and Change Restrictive Gender Norms." *Lancet (London, England)* 393, no. 10190 (June 22, 2019): 2522–34. https://doi.org/10.1016/S0140-6736(19)30656-7.
[37] Manuel, Jennifer I. "Racial/Ethnic and Gender Disparities in Health Care Use and Access." *Health Services Research* 53, no. 3 (June 2018): 1407–29. https://doi.org/10.1111/1475-6773.12705.
[38] Aldosari, Hala. "The Effect of Gender Norms on Women's Health in Saudi Arabia." Policy Paper. Arab Gulf States Institute in Washington, 2017. https://books.google.com/books?id=tyxhuwEACAAJ.
[39] Ibid.
[40] Manuel, Jennifer I. "Racial/Ethnic and Gender Disparities in Health Care Use and Access."
[41] Ibid.

are classified within the United States' racial schema as 'white,' and this classification makes them invisible as a minority group.[42]

Arab-American women are tied to these two risk factors that influence their ability to access healthcare resources within the United States. Despite the large population of Arab-Americans in the United States, few studies have been completed and published on Arab-American health behaviors and beliefs, and even fewer for Arab-American women. Previous studies published in regards to Arab-American immigrant experiences with healthcare access and barriers have shown that levels of assimilation, language barriers, societal stigmas against Arabs, concerns about confidentiality, and lack of public health-related knowledge are all barriers against healthcare access and utilization.[43] [44] Additionally, it is suggested that culture plays a large role in attitudes towards health, illness, and health behaviors.[45]

Studies show that attitudes toward mental health are largely impacted by cultural norms in Arab communities. One study found that culture largely impacted whether treatment for mental or emotional distress was sought after.[46] Additionally, social norms may promote negative associations with mental illness. Individuals may avoid speaking about their mental health needs or concerns for fear that they will be shamed or judged.[47] Additionally, Arab culture emphasizes

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[42] Abuelezam, Nadia N., Abdulrahman M. El-Sayed, and Sandro Galea. "The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review." *Frontiers in Public Health* 6 (September 11, 2018): 262. https://doi.org/10.3389/fpubh.2018.00262.

[43] Abuelezam, Nadia N., Abdulrahman M. El-Sayed, and Sandro Galea. "The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review."

[44] Shah, Susan M et al. "Arab American immigrants in New York: health care and cancer knowledge, attitudes, and beliefs." *Journal of immigrant and minority health* vol. 10,5 (2008): 429-36. doi:10.1007/s10903-007-9106-2

[45] Azaiza, Faisal, and Miri Cohen. "Between traditional and modern perceptions of breast and cervical cancer screenings: a qualitative study of Arab women in Israel." *Psycho-oncology* vol. 17,1 (2008): 34-41. doi:10.1002/pon.1180

[46] Amer, M.M., Hovey, J.D. Socio-demographic Differences in Acculturation and Mental Health for a Sample of 2nd Generation/Early Immigrant Arab Americans.

[47] Erickson, C. D., and N. R. al-Timimi. "Providing Mental Health Services to Arab Americans: Recommendations and Considerations." *Cultural Diversity & Ethnic Minority Psychology* 7, no. 4 (November 2001): 308–27. https://doi.org/10.1037/1099-9809.7.4.308.

the importance of family units, prioritizing the collective group rather than the individual.[48] If an individual were to seek help, it would be done within the family support system. If it was done through a professional, there is a risk that this action would bring shame or disloyalty to the family unit.[49] Despite the studies done examining mental health attitudes in Arab and Arab-American populations, more studies need to be done focusing on Arab-American women specifically.

In terms of sexual and women's health, similar, but limited, findings can be found. Studies have shown that Arab American women may have limited total control over their reproductive health, with a strong emphasis to produce male heirs and as many children as possible.[50] Additionally, women are to refrain from engaging in behaviors that are associated with sexual conduct, including visits to an OBGYN or participating in relationships.[51] For women who do not follow these norms, there is a risk of judgment and shame for them and their families.[52]

To combat the negative effects of limiting social norms, culturally competent healthcare providers need to be abundant in areas with large populations of Arab-Americans. Cultural competence is the awareness of cultural factors that affect the relationship between medical professionals and clients.[53] Studies have shown that, at least for mental health care, culturally

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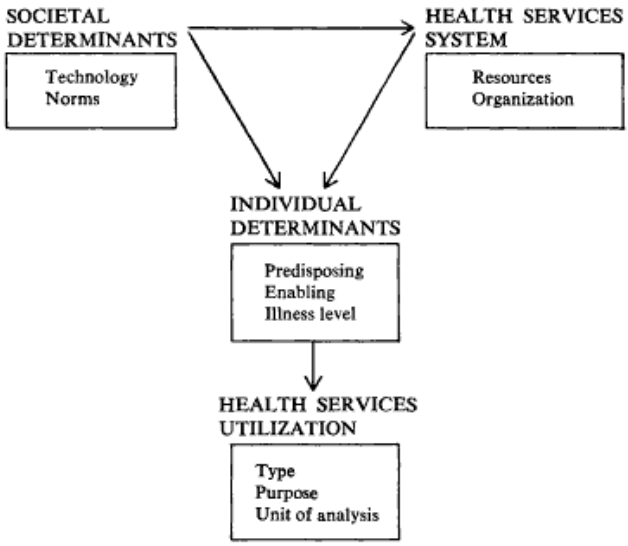
[48] Kakoti, Sally A. "Arab American Women, Mental Health, and Feminism." Affilia 27, no. 1 (February 2012): 60–70. https://doi.org/10.1177/0886109912437572.
[49] Ibid.
[50] Meleis, A. I., and L. Sorrell. "Bridging Cultures. Arab American Women and Their Birth Experiences." *MCN. The American Journal of Maternal Child Nursing* 6, no. 3 (June 1981): 171–76. https://doi.org/10.1097/00005721-198105000-00009.
[51] Ahmed, Sawssan R., Maryam Kia-Keating, and Katherine H. Tsai. "A Structural Model of Racial Discrimination, Acculturative Stress, and Cultural Resources among Arab American Adolescents." *American Journal of Community Psychology* 48, no. 3–4 (December 2011): 181–92. https://doi.org/10.1007/s10464-011-9424-3.
[52] Holmes, Hannah, "Arab American Women's Health Study: Correlational And Experimental Examination Of A Sexual Health Interview" (2019). Wayne State University Dissertations. 2221. https://digitalcommons.wayne.edu/oa_dissertations/2221
[53] Kakoti, Sally A. "Arab American Women, Mental Health, and Feminism."

competent practice and practitioners are more likely to provide services that participants will utilize and continue to utilize.[54] This can extend to other healthcare services as well and could be a key factor in healthcare outcomes for Arab-American women in the United States. However, this requires further research and evaluation of Arab-American women.

THEORETICAL FRAMEWORKS

The Andersen healthcare utilization model is a conceptual framework that is helpful in demonstrating and understanding factors that influence healthcare service usage. This model has been adapted over time, with the original model formed in the 1960s by Andersen and Newman (1973). The first model focuses on the importance of (1) characteristics of the health services delivery system, (2) changes in medical terminology and social norms around defining and treating illness, and (3) individual determinants of utilization.[55] Andersen aimed to take into account both the societal and individual determinants that impact healthcare utilization, however it was criticized for lacking in examining the cultural and social interactions to healthcare usage.



[54] Kakoti, Sally A. "Arab

[55] Andersen, Ronald, and John F. Newman. "Societal and Individual Determinants of Medical Care Utilization in the United States." *The Milbank Memorial Fund Quarterly. Health and Society* 51, no. 1 (1973): 95. https://doi.org/10.2307/3349613.

Figure 1. Depiction of the first Andersen-Newman Model of Healthcare Services Utilization. Taken from Andersen, Ronald, and John F. Newman. "Societal and Individual Determinants of Medical Care Utilization in the United States." (1973)

The model has gone through phases over time, adapting to policies and collaborations. The second phase included the influence of the 'health care system,' specifically focusing on national health policy, resources, and healthcare system organization as important determinants of the population's use of services. Additionally, it clarifies the measures of health services' use and adds explicit outcomes of health services and consumer satisfaction.[56]

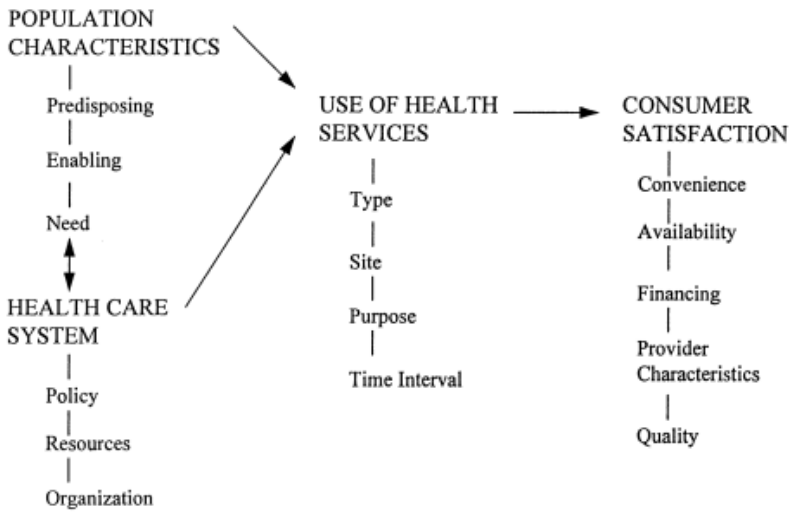


Figure 2. Depiction of the second Andersen-Newman Model of Healthcare Services Utilization. Taken from Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" (1995)

The third phase was brought forth in the 1980s and 1990s and aims to recognize that healthcare should focus on improving and maintaining the populations' health, making it a useful tool in health policy and reform movements. It does so by highlighting external environmental

[56] Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" *Journal of Health and Social Behavior.* 36, no. 1 (1995) https://doi.org/10.2307/2137284. 6.

inputs (political and economic components) as well as personal health practices (diet and exercise) and their influences on population health.[57]

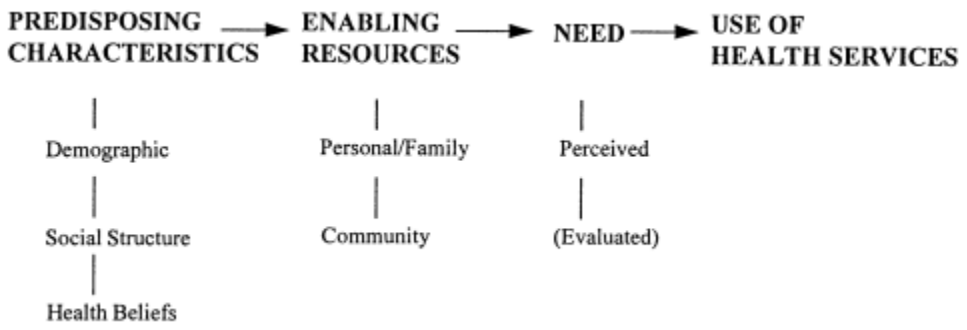


Figure 2. Depiction of the third Andersen-Newman Model of Healthcare Services Utilization. Taken from Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" (1995)

Another model was later proposed that expanded on the previous model's use of psychosocial factors that goes deeper into the factors that influence decision making on planned behaviors. Additionally, this model acknowledges the interrelationship between psychosocial, enabling, and need factors. Lastly, it proposes that race and ethnicity are factors of psychosocial determinants, which was not acknowledged previously.[58]

[57] Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" 7.
[58] Bradley, Elizabeth H., Sarah A. McGraw, Leslie Curry, Alison Buckser, Kinda L. King, Stanislav V. Kasl, and Ronald Andersen. "Expanding the Andersen Model: The Role of Psychosocial Factors in Long-Term Care Use." *Health Services Research* 37, no. 5 (October 2002): 1221–42. https://doi.org/10.1111/1475-6773.01053.

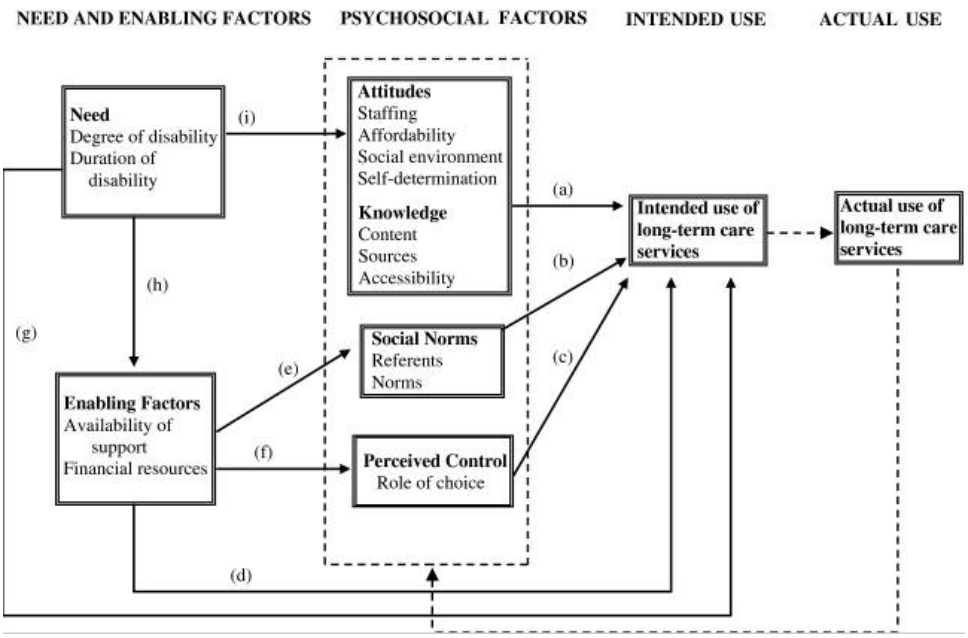


Figure 2. Depiction of the Andersen-Newman Model of Healthcare Services Utilization. Taken from Bradley, E. H., McGraw, S. A., Curry, L., Buckser, A., King, K. L., Kasl, S. V., & Andersen, R. Expanding the Andersen model: the role of psychosocial factors in long-term care use. (2002)

One aspect that all these models have in common is the lack of focus and application to Arab-American women's experiences. The first variations of models did not adequately address the cultural and social determinants, leaving space for an empirical gap on data for this specific population. Even though this specific gap has not been addressed in the contemporary models, they do begin to address the cultural and social determinants in other populations.[59] This paper will examine the data obtained from the interviews and apply it to the Andersen model. By doing so, the goal is to determine whether this model adequately assesses the determinants of healthcare utilization for Arab-American women.

[59] Andersen, Ronald, and John F. Newman. "Societal and Individual Determinants of Medical Care Utilization in the United States." *The Milbank Quarterly* 83, no. 4 (2005): Online-only-Online-only. https://doi.org/10.1111/j.1468-0009.2005.00428.x.

METHODS

Study Design & Sample

The study presented is a qualitative study focusing on interviews that collected data aimed at understanding health beliefs and experiences with varying perceptions and realities. The main source of inquiry was a total of 10 interviews with Arab-American women of varying ages and backgrounds. The interviewees provided background on nationality and age as well as answered questions inquiring about their experiences as Arab-American women and the influence of Arab culture and related beliefs on their healthcare choices.

Table 1. Participant Characteristics

Participant #	Age	Ethnicity	Generational Status
Participant 1	35	Jordanian	First-generation
Participant 2	76	Jordanian	Immigrant
Participant 3	75	Jordanian	Immigrant
Participant 4	21	Jordanian & Puerto Rican	First-generation
Participant 5	67	Lebanese	First-generation
Participant 6	39	Egyptian	First-generation
Participant 7	38	Lebanese	First-generation
Participant 8	47	Jordanian	First-generation
Participant 9	39	Jordanian	Immigrant
Participant 10	36	Jordanian	Immigrant

The study was approved by the Science, Technology, & Society Department at Vassar College and was exempt from IRB review according to federal regulation §46.104 (d)(2)(i). To ensure the confidentiality of the participants, personal identifiers were not collected in audio

recordings and were removed from written and typed documents upon the completion of interviews. Audiotapes of interviews were destroyed once they were transcribed. All transcripts were transcribed and coded by the author.

Table 2. Interview Guide

1. What is your family history with coming to America? Are you first-generation? Did you personally immigrate?
    a. What is it like having this experience? Do you feel well assimilated into American society or do you feel others?
2. Do you have a primary care physician that you attend regularly?
    a. Would you agree to this statement: I feel comfortable addressing health concerns with my PCP?
3. How did you choose your PCP?
4. Has there been an experience where you felt a cultural influence or pressure on your healthcare choices? Could you speak about that experience?
    a. Where did this pressure come from (i.e. family, religion, etc)
    b. How did this impact your health?
    c. If there is no experience to share, have you seen a family member experience this? Could you elaborate on this experience?
5. Has there been a time when you had to choose between healthcare choices and culturally influenced, personal beliefs? Could you elaborate on this?
6. Is there anything else you want to add to elaborate on any previously mentioned subject or touch on anything we have not mentioned that you feel would be helpful?

RESULTS

Participant Characteristics

The total number of study participants was ten Arab American Women aged 21 to 76 years (*M = 47.3)*. Six of the participants were born in the United States and identified as first-generation (*n = 6*), four were born in Jordan and identified as immigrants (*n = 4)*.

Themes

The results of the interviews revealed three major thematic categories: Relationship with Primary Care Physicians, Sexual & Women's Health, and Mental Health.

Table 3. Major thematic categories & Subthemes
Relationship with Primary Care Physicians Stigma Trust Sexual & Women's Health Stigma Control Over Reproduction Mental Health Stigma Shame

Relationship with Primary Care Physician

All participants were asked whether they had a primary care physician (PCP) and all but one stated that they regularly attend one. Participants with a primary care physician stated that they chose their PCP through Recommendation (5), Referrals (1), and Personal Research (3). Five participants had a non-Arab PCP, one purposefully, and four said they had an Arab PCP, one stating that she is looking to switch to another PCP soon, preferably a non-Arab PCP.

Trust

As a follow-up, the participants were asked whether they felt comfortable addressing healthcare concerns with their primary care physician, and from the sample who regularly attended one, all stated that they were comfortable doing so. One participant stated that although they are comfortable sharing their healthcare concerns, they are actively searching for a new PCP, preferably non-Arab. The topic of privacy and confidentiality was also discussed.

Comments ranged from choosing primary care providers that were not Arab American to keeping healthcare choices and needs private from family members.

Additionally, trust in Western medicine was influenced by culture in a few of the participants. Values that involved questioning modern medicine and embracing traditional medicine had been instilled in a handful of the participants from family members while growing up in America. One participant stated that she does not love the American medical system and referenced her mother's teachings and lack of trust in Western Medicine. She was told to "go to the doctor as little as possible" and use traditional remedies, such as tea and herbs. Another participant noted that culturally influenced remedies are positively impactful on her health, but she still trusts her doctor and their medical influence.

Another participant referenced a healthcare choice that was swayed by her relationship with her female, Arab obstetrician after having twin children. After delivering, she was diagnosed with high blood pressure and was personally concerned about the potential of blood clots and expressed this to her obstetrician. The obstetrician dismissed her concerns and did not address them further. Due to the shared ethnicity, she felt that there was a cultural pressure to listen to the obstetrician and "go along with what she was saying" when she assured her that she was fine.

> "*I stuck to my gut feelings and knew that something was not right, but I felt that I had to go with what she was saying because she was Arab and we had this shared connection. I'm glad I did not listen to her."*

Stigma

The participant who did not regularly attend a PCP voiced concern about comfort around medical professionals as an Arab woman.

> *"Internally, I felt that there was a stigma around what I wanted to say, and I felt the need to rehearse it before the appointment … I felt uncomfortable, but would say it anyway … Everything will come back to your family somehow."*

There was fear that her answers would propose negative stigmas on her and her family. Her childhood pediatrician was a family friend and an Egyptian male, and the participant feared that her health concerns would be exposed to her family in some way.

A different participant stated that she purposefully chooses to not have an Arab doctor for privacy reasons. Similarly, she prefers to not worry about her private medical information being spread among the Arab community she resides in, similar to the concerns brought up by a different participant.

Sexual & Women's Health

Five participants mentioned aspects of sexual health in their interviews and eight acknowledged stigmas and taboos surrounding general feminine health and practices.

Stigma

One participant summarized the stigma attached by her culture to seeing an OBGYN as a young unmarried woman.

> *"There was the assumption that I was sexually active despite not being married, and this assumption is negative, even though it being an actual health necessity to go to the gynecologist."*

Another participant reiterated the beliefs brought up by the first, adding that she sometimes keeps specific healthcare choices private from her family to avoid judgment or backlash. She believes that this is compounded by family, religion, and cultural influences. Similarly, another

also discussed choosing to disclose selected information about her feminine health and healthcare choices for similar reasons,

> *"there is a pressure to keep certain information private, and to not create opportunities for people to gossip."*

She identified societal pressure as the main reasoning behind her choice to keep her healthcare choices private.

On a similar note, one participant shared that her family's medical history was kept secret from her, and this caused a near-death experience that could have been avoided having known this information. She attributed this to the

> *"ideological tropes of obtaining perfection. People strive to be perfect or else health issues are seen as a weakness"*

The desire to keep information private was attributed to preventing shame and stigma for themselves and their families.

Another participant stated that there were expectations that she deems culturally motivated, not religiously, such as: abstaining from sexual encounters before marriage, not using a tampon, maintaining one's virginity, and not going to the OBGYN until marriage. These expectations made it difficult for her to start seeing a gynecologist when she needed to as a young adult, which negatively impacted her personal health.

A different participant also agreed that she was told not to go to the gynecologist until she was married and attributed this to cultural and familial beliefs. A different participant states that

it was normal to not go to the gynecologist until one was married during her time in Jordan and there was no stigma around it.

> "*When I was growing up in Jordan, you don't go [to the OBGYN] unless you either really need to go or until you are married. In the Middle East, it is not as much of a norm to go before you are married.*"

She moved to America after marrying her husband and becoming pregnant, so she felt no stigma against her decision to not see an OBGYN previously.

Control Over Reproduction

Two participants stated that during their pregnancies they noticed that there was a cultural preference for having a boy rather than a girl.

> "*There's the attitude that you have to have a boy, or I'm not whole, or I'm incomplete as a mother.*"

There was pressure from families to try to have a boy, which would lead to specific diets that they were urged to try, and shame and judgment if you were unable to have one.

A different participant spoke about an experience that occurred after having her fourth child, where her OBGYN recommended her for a tubal ligation at her six-week postpartum appointment.

> "*I went in for my appointment and the doctor recommended that I think about getting my tubes tied. I said that I did not want that and the doctor said "Oh, so you want to have more babies?" and I said, "No, I don't want to have more babies, but that doesn't mean I want my tubes tied."*

Fertility concerns were also brought up by another participant, who underwent medical treatment as a child, which had the risk of impacting her ability to have children. Her mother would send her for tests to see whether the chemotherapy treatments she underwent impacted her ability to have children in the future.

> "*My mother would regularly test me to make sure I was still fertile because that was a priority for my family: to make sure we could have future generations. I felt hurt. I felt that my personal health was more important than my future ability to have children, but I was too young to form an opinion for myself. This deeply impacted me though."*

The participant felt that her value lay in her ability to have children rather than her health and overall wellbeing. She attributed this to cultural, religious, and familial norms.

Mental Health

Stigma

As documented before, one participant chose to disclose selected information about her healthcare choices with her family and healthcare professionals, due to a fear of stigma around her and her family. Additionally, she was not informed of a family history surrounding mental health needs because there is a familial belief that "mental health is not real healthcare" and a strong stigma against needing support for mental health needs. She stated that her father's side refuses to acknowledge mental health as a valid health care necessity.

> *"It's either that I talk about it and be socially ostracized but get help, or not talk about it and not feel ostracized, but not get the help I need."*

She feels ostracized whenever she mentions mental health or seeks help, and keeps that side of her life private from her family to avoid that feeling.

Shame

One participant spoke specifically about having a child with autism, and how she felt pressure from her family to keep his condition and needs private from extended family.

> *"My husband and I were afraid that we would be looked down upon for having a child that is handicapped. We did not take him to large family functions because we felt embarrassed and afraid that there would be gossip, or that they would make fun of him. It was a hard time for me as an Arab woman and a mother, I felt shameful about my capabilities as a woman for finally having a son, but a son that was Autistic."*

She stated that intention of hiding her son from her family was to prevent shameful backlash. She did not want to be seen as an unfit wife and mother for having a son with autism, who was seen as "imperfect" by her extended family.

Effect of Assimilation

All participants were asked about their relationship with American society and their perceived levels of assimilation, and they reported a range of responses. Two of the elderly participants felt well assimilated into American society after immigrating. One specified that she felt so much more before the pandemic but feels more isolated since then. Both found it easy to settle down and establish themselves in their communities upon moving to the United States. Three participants also stated that they felt well assimilated. Two of them acknowledged that the transition from life in Jordan to life in America was difficult but felt welcomed into the community and assimilated well.

> "*It was tough in the beginning, there was a big change between languages, environments, people, finding a job, leaving my friends, family, and previous life behind. I learned British English in Jordan and had to get used to American English."*

Another participant felt similarly, attributing it to the tight-knit community and household that she was raised in.

> *"People were very welcoming, and we were treated like everyone else… we spent a lot of time in organized activities, which helped a lot. My parents had an open mind about interacting with other people, they ran a tight ship but weren't anti-assimilation. They were not worried about losing our culture, we had strong cultural connections and customs."*

The impact of community was mentioned by one participant who grew up in Brooklyn, New York.

> *"The street that I grew up in was very diverse, there were families that were Irish, German, Italian Jewish, and Black, it was a melting pot… I never identified as "American," just as Lebanese within the community."*

This feeling changed once she joined the working world. There was a sense of identity loss and she felt that she was just seen as American, not as Lebanese American anymore. Similarly, another participant stated that she felt assimilated, since she grew up in America and went through American public school and is connected to her community, but the racism that she has experienced during her adulthood has made her feel not fully welcomed into American society.

Two other participants felt differently. One participant acknowledged that she had different experiences than her white classmates, due to the fact that her family wanted her to assimilate into American society, "but not too much." There is a negative association with being too assimilated, with fear of losing their cultural identity or specifically losing their daughter to American ideals. The other states:

"I do not feel fully assimilated due to cultural and social restrictions, which make me less able to feel assimilated with the American people. This, also with less exposure to American culture, makes me feel this way too."

All participants coded responses were organized based on whether they felt assimilated or not. Participants who felt assimilated brought up experiences related to the themes of sexual & women's health, relationships with primary care physicians, and stigmas/shame. None of the participants mentioned mental health in their responses. Participants who did not feel assimilated brought up the themes mentioned previously as well as mental health.

Table 4. Participant Perceived Level of Assimilation & Interview Themes

Assimilated	Not Assimilated
Participant 2	*Participant 1*
Relationship with PCP	Sexual & Women's Health Stigmas/Shame
Participant 3	*Participant 4*
Stigmas/Shame	Sexual & Women's Health Relationship with PCP Stigmas/Shame Mental Health
Participant 6	*Participant 5*
Sexual & Women's Health Relationship with PCP Stigmas/Shame	Sexual & Women's Health Relationship with PCP Stigmas/Shame
Participant 7	*Participant 8*
Sexual & Women's Health Relationship with PCP	Sexual & Women's Health Stigmas/Shame Mental Health
Participant 9	
Sexual & Women's Health	
Participant 10	
Sexual & Women's Health	

Out of participants who felt assimilated, all but two mentioned aspects of sexual & women's health in their responses. Half of the participants brought up their relationship with their primary care physician. Two of the six participants mentioned experiences impacted by shame and stigmas in their interviews. Out of the participants who did not feel assimilated, all of them mentioned experiences around sexual & women's health as well as shame and stigmas. Half of the participants mentioned their relationship with their primary care physicians and mental health.

These results show that there are differences in healthcare experiences between Arab-American women with different levels of perceived assimilation. One main difference is that Arab-American women who do not feel assimilated are more likely to have and share experiences around mental health and stigmas than Arab-American women who do. Additionally, all of the participants who did not feel assimilated mentioned sexual & feminine health in their interviews, while four of the six who did feel assimilated mentioned it. These results also show that there are no differences in some aspects of healthcare experiences between Arab-American women of different levels of perceived assimilation, such as relationships with their primary care physicians.

DISCUSSION

The results of this qualitative study revealed several important findings in regards to healthcare access for Arab-American women. It is evident that cultural barriers exist for this population, which affects whether they seek specific healthcare services. In summary, these findings support the importance of communicating about this taboo subject in hopes of creating further dialogue and awareness among the general Arab-American population.

Nine out of the ten participants had a primary care physician that they attended regularly, and all stated that they felt comfortable addressing their concerns with them. The one participant without a primary care physician expressed previous fear in regards to their private health information being revealed and negative stigmas becoming a result. These findings support the statement that cultural beliefs and stigmas do have an impact on an Arab-American woman's relationship with her primary care physician.

Sexual and women's health were widely mentioned throughout the interviews and resulted in key findings for this study. Specifically, it was mentioned that there is a stigma associated with young, unmarried women going to see an OBGYN. This stigma was identified by participants as either culturally, familial, or religiously motivated. These stigmas encourage women to either keep their healthcare choices private from family and friends or not seek out medical services and risk negative health consequences. One interesting connection with these data is the difference in perceived need to attend the OBGYN within the American and Middle Eastern cultures. In the United States, it is recommended and encouraged by primary care physicians that a young women's first pap smear occurs between the ages of 18 and 21 years, with a recommended first gynecological visit occurring between 13 and 15 years.[60] This information may be conflicting for a first-generation Arab-American woman whose mother was advised to go after marriage in fear of negative assumptions. This could explain the difference in attitudes around feminine health/OBGYN visits between participants who immigrated to the United States and those who identified as first-generation.

[60] Bryan, Ava Ferguson, and Julie Chor. "Factors Influencing Young Women's Preparedness for Their First Pelvic Examination." *Obstetrics and gynecology* vol. 132,2 (2018): 479-486. doi:10.1097/AOG.0000000000002749

Attitudes toward mental health were another theme that was identified as a key result. Participants shared experiences where they felt shamed and stigmatized for either needing mental health services or having a son with autism. They stated that they purposefully kept information related to these experiences private from extended family to avoid feeling shameful. These results support the hypothesis that there are stigmas and social norms associated with mental health and mental health care needs.

These results parallel the last Andersen healthcare utilization model that this paper brings forth. The needs for many of these women are dependent upon the healthcare need in question However, the enabling factors are highly influential of psychosocial factors, such as social norms and perceived control, as shown in the model. For many Arab-American women, they may not have support available to reach out to the healthcare services they may need. Focusing on the psychosocial factors, it is shown that attitudes, social norms, and perceived control have the most impact on whether they would utilize a healthcare service. This study shows that enabling factors heavily influence social environment and social norms, which has prevented some participants from accessing and utilizing systems, such as OBGYNs or mental health services. Additionally, it is shown that for some aspects of their health, they have minimal control. This was prevalent in certain areas of women's health, where some participants told experiences where they did not have total control over their reproductive capabilities. Future studies need to be completed to confirm and support this implication of the model. Additionally, future models should be created with the intention of filling the empirical gap of Arab-American women's experiences in healthcare utilization.

These results show that there are aspects of social norms and stigmas that prevent Arab-American women from obtaining equal and unprejudiced access to healthcare services.

Key findings show that there are stigmas associated with sexual and women's health as well as mental health and that these stigmas can cause tension between Arab and American identities and cultures for Arab-American women in the United States.

Limitations of this study include the sensitivity of the topic and language barriers. This study included 10 participants from one geographical area and snowball sampling methods were used, limiting diversity in the result saturation. Due to the lack of conversations around this topic currently and the taboo on the subject, this study assumes that all participants gave truthful and accurate responses to the interview questions, but acknowledges that this may not be the case. To refute this, all participants were promised anonymity as well as the option to have their interviews recorded. All data were self-reported by the participants and no confirmation was obtained from other sources. As a result, the thoroughness of this study cannot be guaranteed due to these factors and results may have differed with additional data sources or larger sample size. This could lead to further thematic saturation. Additionally, with some participants' first language being Arabic, translations were required throughout the process. A translator was present when needed and translations from Arabic to English and vice versa were done as accurately as possible. Despite these caveats, this study provides useful data on the impact that cultural and societal beliefs have on Arab-American women's perceived access to healthcare.

CONCLUSION

Being an Arab-American woman in the United States can be challenging, especially navigating two socio-cultural contexts. It is noted that the strong difference in cultural norms between the Middle East and the United States can impact one's healthcare choices and perspectives. Different generations have different levels of assimilation to a new culture, which can cause challenges as differing opinions on social behavior and cultural expectations emerge

between generations. It is known, however, that an individual can accept both identities without the eradication of one; embracing multiple identities.

For women, this conflicting multiculturalism may be felt particularly strongly due to the sizable differences in expectations for women in Arab versus Western cultures. In Arab culture, the family takes utmost importance in societal structures, while in Western culture, women's bodies are still controlled, but it is more socially acceptable to—due to the albeit limited success of feminist ideologies and movements—pursue deep individualism and autonomy. The cultural dissonance between expectations of Arab women from the Arab culture versus the Western culture result from efforts at the hybridization of identities. The pressure to assimilate to the prominent Western norms when one has a strong foundation in the Arab identity may be a struggle for some Arab American women. This nature of the identity struggle differs among different generations of immigrants, but a sense of conflict between the two identities is common.

This qualitative paper revealed that there are some aspects of cultural beliefs and social norms that prevent Arab-American women from obtaining equal and unprejudiced access to healthcare. There are stigmas associated with sexual and women's health and these stigmas can cause tension between Arab and American identities and cultures for Arab-American women in the United States. Attitudes toward privacy are related to these findings, and as a result, have negative implications for Arab-American women's access to healthcare services. This paper explored how cultural beliefs and predispositions have a negative influence on Arab-American women's access to healthcare. This exploration employed a qualitative approach to describing

how and why women's health is impacted by societal norms and expectations, and if there is a common theme or reasoning as to why this phenomenon occurs. These common themes were expanded on to suggest how social norms and expectations influence women's health and developed hypotheses concerning why such norms and expectations have the influence they do. This paper concludes that Arab-American women with a higher level of assimilation identified more stigmas and social norms that impact their healthcare experiences, specifically on sexual and women's health, and mental health.

Future research in this field calls for further exploration of Arab-American women's experiences within the United States and its healthcare system. Through further interviews, focus groups, and fieldwork, more stories can be brought forth and shared, and conversations around this topic can continue to be had. The completion of more focus groups and interviews would examine a broader population of Arab-Americans and their attitudes and beliefs regarding healthcare access for Arab-American women. This would diminish the sensitivity that this topic has within the Arab community. Ultimately, this research can lead to more equal healthcare access and autonomy for Arab-American women.

CONFLICTS OF INTEREST

The author has no conflict of interest to disclose.

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REFERENCES

Abuelezam, Nadia N., Abdulrahman M. El-Sayed, and Sandro Galea. "The Health of Arab Americans in the United States: An Updated Comprehensive Literature Review." *Frontiers in Public Health* 6 (September 11, 2018): 262. https://doi.org/10.3389/fpubh.2018.00262.

Abu-Shomar, Ayman. 2020. "Critical Spaces of Diaspora and the Shifting of Paradigm: Negotiating Intercultural Narratives in Arab Anglophone Literatures. 22nd Istanbul International Conference on "Literature, Humanities, and Social Sciences" March 2-4, 2020

Ahmed, Sawssan R., Maryam Kia-Keating, and Katherine H. Tsai. "A Structural Model of Racial Discrimination, Acculturative Stress, and Cultural Resources among Arab American Adolescents." *American Journal of Community Psychology* 48, no. 3–4 (December 2011): 181–92. https://doi.org/10.1007/s10464-011-9424-3.

Aldosari, Hala. "The Effect of Gender Norms on Women's Health in Saudi Arabia." Policy Paper. Arab Gulf States Institute in Washington, 2017. https://books.google.com/books?id=tyxhuwEACAAJ.

Amer, M.M., Hovey, J.D. Socio-demographic Differences in Acculturation and Mental Health for a Sample of 2nd Generation/Early Immigrant Arab Americans. *J Immigrant Minority Health* 9, 335 (2007). https://doi.org/10.1007/s10903-007-9045-y

Andersen, Ronald M. "Revisiting the Behavioral Model and Access to Medical Care: Does It Matter?" *Journal of Health and Social Behavior* 36, no. 1 (1995): 1–10. https://doi.org/10.2307/2137284.

Andersen, Ronald, and John F. Newman. "Societal and Individual Determinants of Medical Care Utilization in the United States." *The Milbank Memorial Fund Quarterly. Health and Society* 51, no. 1 (1973): 95. https://doi.org/10.2307/3349613

Andersen, Ronald, and John F. Newman. "Societal and Individual Determinants of Medical Care Utilization in the United States." *The Milbank Quarterly* 83, no. 4 (2005): Online-only-Online-only. https://doi.org/10.1111/j.1468-0009.2005.00428.x.

Arab American Institute. "Underreported Under Threat: Hate Crime in the United States and the Targeting of Arab Americans." Accessed April 25, 2022. https://www.aaiusa.org/library/under-reported-under-threat.

"Arabs in the Americas; Interdisciplinary Essays on the Arab Diaspora. - Free Online Library." Accessed April 25, 2022. https://www.thefreelibrary.com/Arabs+in+the+Americas%3B+interdisciplinary+essays+on+the+Arab+diaspora.-a0159048186.

Azaiza, Faisal, and Miri Cohen. "Between traditional and modern perceptions of breast and cervical cancer screenings: a qualitative study of Arab women in Israel." *Psycho-oncology* vol. 17,1 (2008): 34-41. doi:10.1002/pon.1180

Batalova, Jeanne and Harjanto, Laura. "Middle Eastern and North African Immigrants in the United States." migrationpolicy.org, January 12, 2022. https://www.migrationpolicy.org/article/middle-eastern-and-north-african-immigrants-united-states.

Bradley, Elizabeth H., Sarah A. McGraw, Leslie Curry, Alison Buckser, Kinda L. King, Stanislav V. Kasl, and Ronald Andersen. "Expanding the Andersen Model: The Role of Psychosocial Factors in Long-Term Care Use." *Health Services Research* 37, no. 5 (October 2002): 1221–42. https://doi.org/10.1111/1475-6773.01053.

Braveman, Paula, and Laura Gottlieb. "The Social Determinants of Health: It's Time to Consider the Causes of the Causes." *Public Health Reports* 129, no. Suppl 2 (2014): 19–31.

Brown, Heather, Guskin, Emily, and Mitchell, Amy. "Arab-American Population Growth," Pew Research Center's Journalism Project (Pew Research Center, December 31, 2019), https://www.pewresearch.org/journalism/2012/11/28/arabamerican-population-growth/.

Bryan, Ava Ferguson, and Julie Chor. "Factors Influencing Young Women's Preparedness for Their First Pelvic Examination." *Obstetrics and gynecology* vol. 132,2 (2018): 479-486. doi:10.1097/AOG.0000000000002749

Cainkar, Louise. "Global Arab World Migrations and Diasporas,"

Erickson, C. D., and N. R. al-Timimi. "Providing Mental Health Services to Arab Americans: Recommendations and Considerations." *Cultural Diversity & Ethnic Minority Psychology* 7, no. 4 (November 2001): 308–27. https://doi.org/10.1037/1099-9809.7.4.308.

Foad, Hisham S. "Waves of Immigration from the Middle East to the United States," 2013. https://doi.org/10.2139/ssrn.2383505.

"Geography of the Modern Middle East and North Africa | Middle East Teaching Tools." Accessed April 25, 2022. http://www.middleeastpdx.org/resources/original/geography-of-the-modern-middle-east-and-north-africa/.

Hattar-Pollara, Marianne, and Afaf I. Meleis. "The Stress of Immigration and the Daily Lived Experiences of Jordanian Immigrant Women in the United States." Western Journal of Nursing Research 17, no. 5 (October 1995): 521–39. https://doi.org/10.1177/019394599501700505.

Heymann, Jody, Jessica K. Levy, Bijetri Bose, Vanessa Ríos-Salas, Yehualashet Mekonen, Hema Swaminathan, Negar Omidakhsh, et al. "Improving Health with Programmatic, Legal, and Policy Approaches to Reduce Gender Inequality and Change Restrictive Gender Norms." *Lancet (London, England)* 393, no. 10190 (June 22, 2019): 2522–34. https://doi.org/10.1016/S0140-6736(19)30656-7.

Holmes, Hannah, "Arab American Women's Health Study: Correlational And Experimental Examination Of A Sexual Health Interview" (2019). Wayne State University Dissertations. 2221. https://digitalcommons.wayne.edu/oa_dissertations/2221

Kakoti, Sally A. "Arab American Women, Mental Health, and Feminism." Affilia 27, no. 1 (February 2012): 60–70. https://doi.org/10.1177/0886109912437572.

Lubbers, Miranda Jessica, Ashton M. Verdery, and José Luis Molina. "Social Networks and Transnational Social Fields: A Review of Quantitative and Mixed-Methods Approaches." International Migration Review 54, no. 1 (March 2020): 177–204. https://doi.org/10.1177/0197918318812343.

Lucas, Christopher, and Manfredi, Stefano. *Arabic and Contact-Induced Change*. Zenodo, 2020. https://doi.org/10.5281/ZENODO.3744565.

Manuel, Jennifer I. "Racial/Ethnic and Gender Disparities in Health Care Use and Access." *Health Services Research* 53, no. 3 (June 2018): 1407–29. https://doi.org/10.1111/1475-6773.12705.

Meleis, A. I., and L. Sorrell. "Bridging Cultures. Arab American Women and Their Birth Experiences." *MCN. The American Journal of Maternal Child Nursing* 6, no. 3 (June 1981): 171–76. https://doi.org/10.1097/00005721-198105000-00009.

"Migration | United Nations." Accessed April 25, 2022. https://www.un.org/en/global-issues/migration.

Nakba: Palestine, 1948, and the Claims of Memory. Columbia University Press, 2007. https://www.jstor.org/stable/10.7312/sadi13578.

Noman, Abdalwahid Abbas. "Diaspora and Multiculturalism in Reconstructing the Cultural Identity of Arabs in America." *Cross-Cultural Communication* 15, no. 1 (March 26, 2019): 56–64. https://doi.org/10.3968/10969.

Orfalea, Gregory. *Arab Americans: A History*. Interlink Publishing Group, 2006.

"Population, Total - Middle East & North Africa | Data." November 9th, 2021. https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZQ.

Sensenig-Dabbous, Eugene. "Arab Diaspora Women." *Al-Raida Journal*, 2007, 2–3. https://doi.org/10.32380/alrj.v0i0.200.

Shah, Susan M et al. "Arab American immigrants in New York: health care and cancer knowledge, attitudes, and beliefs." *Journal of immigrant and minority health* vol. 10,5 (2008): 429-36. doi:10.1007/s10903-007-9106-2

Shuval, Judith T. (2000), Diaspora Migration: Definitional Ambiguities and a Theoretical Paradigm. International Migration, 38: 41-56. https://doi.org/10.1111/1468-2435.00127