Health Survey of the Arab, Muslim, and Chaldean American Communities in Michigan

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Purpose

With approximately 300,000 Arab Americans, Michigan is home to the largest Arab American population in North America. Arab Americans are the third largest and fastest growing minority group in the state of Michigan; 84% of this population resides in metropolitan Detroit. Arabs in Michigan come from every country in the Arab World, with the majority emigrating from Lebanon, Palestine, Yemen, and Iraq. The Arab and Chaldean community of Metro Detroit and in Michigan is a diverse grouping of Middle Eastern immigrants, Muslim and Christian; first, second, and third generation Americans.

Despite the size of the Arab and Chaldean communities in Michigan, information about their health status remains lacking. This is partly due to the fact the federal statistics consider Arabs, even with the darkest of skin, under the grouping White. Recognition of a separate ethnic grouping for people of Middle Eastern descent has been accomplished by state and local health entities in Michigan, but large statistical efforts to quantify the needs and health conditions of the population have not been widely undertaken.

The current survey was designed by the Michigan Department of Community Health and completed in conjunction with the Arab Community Center for Economic and Social Services (ACCESS).

Hypothesis

Statistics from the Office of the State Registrar indicate that about 20% of Arab family income is below the federal poverty line. This low-income level makes health services unaffordable for a large percentage of Arab Americans. Moreover, because

persons with a lower income cannot afford to use medical care regularly, they often rely on crisis care. Health problems in the lower income group are often more serious because problems are ignored until they reach crisis proportions. Thus chronic diseases tend to be neglected longer among the poor, with resultant longer hospitalization and greater morbidities. Similarly, higher levels of smoking, and poorer dietary practices may be expected.

The current survey is undertaken with two main hypotheses posited.

1) That the Arab and Chaldean population of Michigan is, on the whole, less healthy than the general population as evidenced by self-reported health risk factors,
2) And that the increased relative risk of morbidity and mortality in the Arab and Chaldean communities compared to the general population is related to higher levels of unhealthy health behavior practices, reduced access to health care and inadequate exposure to primary prevention
3) That with respect to certain cultural/social practices, some cultural tendencies are protective with respect to health outcomes

Background

The term Arab is a classification based largely on common language (Arabic) and a shared sense of geographic, historical and cultural identity. The term Arab is not a racial classification, but includes peoples with widely varied physical features. The Arab people live in an expansive geographic region extending from the Atlantic coast of Northern Africa to the Persian Gulf. The total population the Arab world is approximately XXX million in 22 nations. There are 9 Arab countries in Africa

(Morocco, Mauritania, Algeria, Tunisia, Libya, Sudan, Somalia, Djibouti and Egypt) and 12 countries in Asia, including (Iraq, Jordan, Lebanon, Syria, Kuwait, Bahrain, Qatar, Oman, United Arab Emirates, Saudi Arabia, Yemen, and the people of Palestine who are presently either living under Israeli rule, partial Palestinian Authority autonomy, or dispersed throughout the world. Despite the national boundaries drawn between the Arabs in the post-colonial period, the Arabs on the popular level view themselves as a unified entity.

Arabs are not homogenous with respect to religious belief, but include Christians, Jews and Muslims. The large majority of Arabs are Muslim, but in total the Arabs comprise only about 17% of the Islamic population worldwide. The religion of Islam, however, is closely associated with Arab identity because of the origins of Islam in the Arabian Peninsula and the fact that the language of Arabic is the sacred language of the Holy Qur'an.

What is a Muslim?

The Arabic word 'Islam' simply means 'submission', and derives from a word meaning 'peace'. In a religious context it means complete submission to the will of God. Muslims are adherents to the religion of Islam, as defined by the revealed holy book (the Qur'an), and the teaching and example of the Prophet Muhammad. One billion people from a vast range of races, nationalities and cultures across the globe - from the southern Philippines to Nigeria - are united by their common Islamic faith. About 18% live in the Arab world; the world's largest Muslim community is in Indonesia; substantial parts of Asia and most of Africa are Muslim, while significant minorities are to be found in the Soviet Union, China, North and South America, and Europe. The Muslim population of

the world is around one billion. 30% of Muslims live in the Indian subcontinent, 20% in Sub-Saharan Africa, 17% in Southeast Asia, 18% in the Arab World, and 10% in the Soviet Union and China. Turkey, Iran and Afghanistan comprise 10% of the non-Arab Middle East. Although there are Muslim minorities in almost every area, including Latin America and Australia, they are most numerous in the Soviet Union, India, and central Africa. There are 5 million Muslims in the United States. The practice of Islam stipulates five central pillars: declarations of belief in One God and the prophecy of the Prophet Muhammad, prayer five times daily, fasting in the month of Ramadan, paying of charity alms, and pilgrimage to Mecca.

Salat is the name for the obligatory prayers that are performed five times a day, and are a direct link between the worshipper and God. There is no hierarchical authority in Islam, and no priests, so a learned person who knows the Quran, chosen by the congregation, leads the prayers. Prayers are said at dawn, noon, mid-afternoon, sunset and nightfall, and thus determine the rhythm of the entire day. Although it is preferable to worship together in a mosque, a Muslim may pray almost anywhere, such as in fields, offices, factories and universities.

Every year in the month of Ramadan, all Muslims fast from first light until sundown, abstaining from food, drink, and sexual relations. Those who are sick, elderly, or on a journey, and women who are pregnant or nursing are permitted to break the fast and make up an equal number of days later in the year. If they are physically unable to do this, they must feed a needy person for every day missed. Children begin to fast (and to observe the prayer) from puberty, although many start earlier.

Among the stipulations of Islamic law that pertain to health, the prohibition of intoxicants is perhaps the most significant. Islam also prohibits out of wedlock sexual relations, which translates into widespread social censure for dating, and encourages separation between males and females outside of the family unit.

What is a Copt?

The name Copt is derived from the word Aigyptos, which meant "Egypt" in Greek, which was transformed by Arabic speakers after the Arabic conquest of Egypt in 652 A.D. to "Gypt" or "Kipt". The Copts reside mainly within the boundaries of modern Egypt today, and speak a language that is the linguistic descendant of the ancient Pharonic Egyptian, but adopted the Greek alphabet for writing, after adding seven letters to adapt to some Egyptian pronunciations that were not found in the Greek alphabet. With the increasing influence of the Arabic language in Egypt from 650 onwards, the Coptic language gradually diminished.

The modern designation of Copt refers mainly to the minority community of Egyptians that remained Christian and preserved the Coptic language in church liturgies and prayers. The designation Copt refers today to those members of the still standing Orthodox Church of Alexandria. When Christianity became the official religion of the Byzantine Empire, the Coptic Church doctrine differed from of what evolved after the Council of Nicea as ‘official’ Christianity. Subsequently, the Alexandrine Orthodox suffered a period of oppression under Byzantine rule because of these beliefs, lasting until the Arab conquest of 641 when the Copts sought protection under Muslim rule from ongoing Byzantine persecution. Subsequently, many of the Coptic Christians were assimilated into the Muslim community until Arabic speaking Muslims comprised the

majority of the Egyptian population. Culturally, there is little variance between the Copts and other Egyptians with respect to social structures and health perception, save those particular injunctions found in Islamic law that are not stipulated by the Christian Church (i.e. strict prohibition of alcohol consumption, prohibition of pork, etc.)

Chaldeans

The Chaldeans and Assyrians of Beth Nahrain (Mesopotamia which is current days Iraq, east Syria, and south east Turkey) are the largest communities of the Aramaic-speaking people remaining in the Middle East. The Chaldeans and Assyrians represent mosaic communities that are a live continuation of the indigenous people of Mesopotamia --Sumerians, Akkadians, Amorites, Babylonians, Assyrians, Chaldeans, and Syriacs (Suryoyo). Though they are citizens of modern Arabic states, and speak the dominant Arabic language, their primary language is a collection of modern variants of Aramaic descended from the languages of ancient Mesopotamian civilizations.

Like the Coptic population of Egypt, the Chaldeans and Assyrians of modern Iraq are mainly the minority people of ancient Mesopotamian descent who remained part of a Christian church rather than assimilating into the Muslim majority in Iraq. The name Chaldean historically came to imply those Aramaic peoples that were members of the Catholic Church, while Assyrians were predominately members of the Eastern Church. Unlike the Copts, the Chaldean and Assyrian languages survived independent of church liturgy and remains a spoken language among these populations in particular areas of Iraq.

There are approximately 150,000 Chaldeans in the US, and an additional 100,000 who classified themselves as Assyrians. Metropolitan Detroit is the largest population

cluster of these two populations nationally, with smaller populations in Chicago and San Diego.

Methods

The current survey is an attempt to reach a broad cross section of the Middle Eastern peoples described above. The initial survey tool was designed by the Michigan Department of Community Health and then translated into an equivalent Arabic language version.

Survey participants were recruited through convenience sampling of the above stated communities statewide. Surveys were administered widely through local community based organizations. This method provides the advantage of reaching a wide scope of Middle Eastern communities via 34 different community centers across the state of Michigan. Surveys were circulated in large quantity to each of these organizations, and they were distributed among the centers' constituency. This method provided access to a wide range of Chaldean, Coptic, Muslim Shiite and Sunni populations across, though not necessarily in reflection of the state's numeric composition of these respective communities.

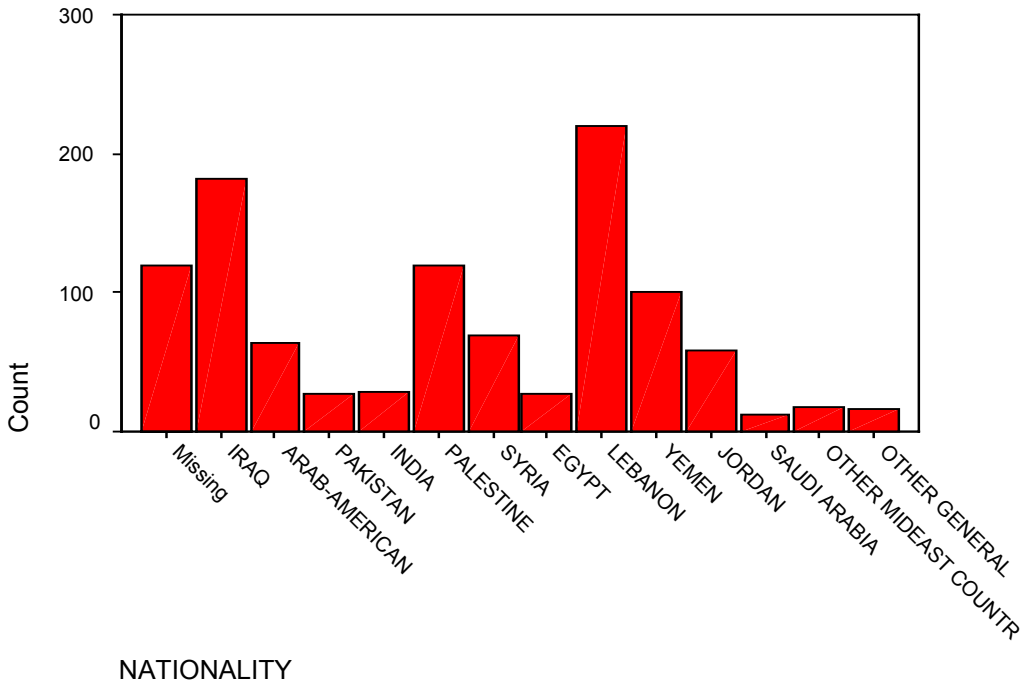
Survey questionnaires were collected from those respondents willing to participate. Data was compiled into frequencies and then analyzed in relation to key demographic factors like age.

Findings

Demographic Background of Survey Respondents

57.6% of the survey respondents were female, and 42.6% were male. 72.0% were currently married, with 3.5% divorced, 2.8% widowed, and 21.7% never married. 40.9% had completed education less than 12th grade. 39.8% had completed 2-4 years of college, and 14.7% had graduate level educations. 50.4% reported family incomes less than $30,000 (25.3% less than $20,000 and 25.1% between 20-30,000). 18.2% earned $30,000-$40,000 and 31.4% earned more than $50,000. 54.7% of respondents were employed.

Ethnic and religious background was collected as part of the demographic profile. The following table represents the ethnic composition of survey respondents:



The current survey was administered in both English and Arabic. 56.4% of respondents answered the survey tool in English, while 43.6% responded to the Arabic survey tool. No measures were provided for oral administration of the survey to those individuals who are illiterate, and they were likely excluded from the survey.

When asked about the number of people in their family, 34.6% responded less than 3, 52.4% had 4 to 6 members, 10.8% had 7 to 9, and 2.3% had more the 10 family members.

Perception of Health

Several questions were devoted to assessing the self-perception of survey respondents' health in comparison to other communities. 48.1% of respondents believed that their health was equivalent to other communities, while 29.3% thought their community was healthier and 22.6% thought their health to be poorer.

48.8% of the respondents described their health as excellent, very good or good as compared to others their same age. Conversely, 20.7% considered their health fair or poor in comparison with others their age. 30.2% of respondents reported being currently on medication.

Health Insurance and Issues of Access

Among survey respondents, 79.5% reported some form of insurance coverage, while 20.5% reported themselves and family uninsured. 63.8% of respondents were not aware of free and available health services for women and children at a local health department or community center. The insured individuals consisted of 27.1% with Blue Cross, 19.4% with private HMO coverage, 18.8% with Medicare coverage, and 17.6% with Medicaid coverage. 56.2% had obtained their health insurance through

employment, 12.9% had purchased their plan independently, and 30.9% were insured through a government plan.

52.8% of respondents reported themselves as the primary insured person, while the remaining insured were mainly covered by their husband (33.3%) or wife (13.9%). Among the insured respondents, 72.8% were satisfied with their insurance coverage.

A large majority of the survey respondents were satisfied with their health insurance plan. 72.8% reported satisfaction with their health insurance, while 22.9% were dissatisfied. 46.9% of respondents had seen a doctor in the past three months, and 68.7% had had a doctor visit within 6 months of the survey. Over 89% had seen a physician within the past two years.

Cardiovascular Disease Risk

44% of survey respondents were hypertensive as told to them by their doctor. When separated by age, 51.7% of those ages 40 and above had been told they were hypertensive by a doctor. Additionally, 46.8% had been told they had hypercholesterolemia. 19.3% of respondents reported having diabetes. 7.6% of respondents reported having heart disease, though this was unspecified as to congestive heart failure, prior myocardial infarction, valvular disease or other conditions.

Cancer Prevalence and Screening

11.4% of respondents stated they had some form of cancer. Only 26.6% were aware of having been tested for a cancer in their lifetime.

Women's neoplasms in particular were an area where the Arab American respondents were less likely than the general population to have been screened for cancer. 31.1% of female respondents stated they had never had a mammogram in their lifetime

(age >35). Similarly, 44.8% of all female respondents report never having had a pap smear in their lifetime.

Colon cancer screening was the least likely screening to have been obtained according to the respondents, though only 20% of the total respondents answered this question. Among female respondents, 91.6% reported no prior colon cancer screening in their lifetime. Among men older than age 40, 57.6% reported never having had a rectal exam, and 32.6% had never had a PSA blood test. 77.8% of men reported never having had a colon cancer screening. Among those men who had been screened for any form of cancer, 73.8% had had their screening in the past year.

Exercise

Data was not obtained as to the nature of self-reported exercise and the frequency per week. 60.9% of respondents stated that they exercise. Of the respondents that exercise, 55.3% reported exercise for 20 minutes, 25.3% for 40 minutes, and 19.4% for at least one hour.

Diet

19.4% of respondents were on a diet to control an illness. 80.0% of respondents described their diet as healthy and balanced. 41.5% reported eating junk food daily, while 27.5% stated they consumed no junk food in an average week.

Alcohol, Tobacco and other Drugs

15.0% of respondents in this survey admitted smoking. Among smokers, 22.9% smoking five or less cigarettes per day, while 63.6% smoked greater than a half a pack per day.

6.7% of respondents stated they drank alcohol, while 93.3% did not drink. Among those that drank, 48.2% drank two or less drinks per week, 80.4% less than four, while 10.7% reported consuming more than six drinks weekly. 40.4% of those that drank alcohol reported a desire to quit drinking.

Child Safety and Injury Prevention

30.8% of respondents described their neighborhood as very safe, 59.4% described it as safe, and 9.7% described it as unsafe.

86.4% reported driving within the speed limit, and 65.8% reported always driving within posted limits, while 29.9% stated "sometimes" and 4.3% reported "seldom" or "never" keeping posted speeds. 92% reported using a seat belt, of whom 77.4% stated they always used belts, 19.4% sometimes used them, and 3.3% seldom or never used belts. 90.5% reported using seat belts for their children, and 77.6% reported always using these child belts.

Pregnancy and Family Planning

10.1% of female respondents were currently pregnant. 5.9% of women stated that they had children who died during the first year of life.

30.9% stated that they used birth control. Of the users of birth control, 34.0% used pills, 22.0% used IUD, 3.1% had had an implant, 9.9% had had tubal ligation, and 24.6% used a natural method. Only 14.6% of female respondents stated that their husband used birth control.

Discussion

Limitations

The primary problem with convenience sampling in the Arab community is the problem of selection bias based upon willingness to respond. In general, there is a mistrust of government and information gathering that is stronger among newly arrived immigrants than, for example, a third generation Arab American. At the same time, those same individuals more reluctant to respond to a health survey questionnaire are likely the individuals most likely to suffer from lack of health care access and poorer levels of health education.

To understand the general suspicion of surveys and other forms of information gathering among the Arab Americans, one must understand something of their historical background. The Arab peoples in the 20th century have encountered widespread strife in the postcolonial period. The extensive upheavals seen in the Middle East in the last century are partly due to the instability of post-colonial political and social structures and the residual problems of colonial period disruptions, and in part because of Western and Soviet involvement in control of the Middle East's strategic location, being a crossroad between Africa and Asia and possessor of tremendous fossil fuels resources.

Out of the atmosphere of oppression under which many of the Arab peoples have suffered before immigration, and the discrimination against them that is widespread throughout the American press and popular culture, many Arab Americans are extremely reluctant to participate in surveys seeking personal information. Of the nearly 5,000 survey questionnaires distributed in this current effort, only about 20% of the questionnaires were returned for inclusion in the current study.

Are We Masking Communities of Greater Risk?

In a number of surveys that have attempted to survey Arab health statewide, health statistics invariably reflect the combination of two distinct subsets of the total community. One segment of the Arab and Chaldean American community is well established in the United States, either have immigrated >20 years ago or being second and third generation Americans by birth. These individuals have had relatively great success in educational achievement, economic stability and general adaptation to the American lifestyle.

On the other hand, our community is composed increasingly of new immigrants arriving to join already immigrated families or arriving newly to the area because of the Arabic language resources in Metro Detroit. This population tends to be composed of individuals who have fled from situations of war and social upheaval in their countries of origin. Consequently, they also tend to be individuals who have had less exposure to the types of services that positively impact the health of population. In particular, this newly arrived population lacks access to health care and screening, and levels of education that allow one to understand health risk behavior, the importance of exercise, etc.

The current survey represents responses from Arabic and other Muslim, Coptic and Chaldean populations across the state. This is not necessarily reflective of the actual population distribution of these aforementioned groups. The statewide population of these Middle Eastern peoples in estimated variably around 300,000. A great majority of this population is clustered in Wayne County. As a whole, the populations of Chaldeans clustered in the 7 Mile/Woodward district of Detroit and Arab in the Hamtramck and Southwest Detroit/Dearborn areas are the poorer members of the overall community.

These same community members also represent the large majority of the total Middle Eastern population statewide. In this survey, the communities of the wealthier Oakland County suburbs or other communities like Kalamazoo are represented in greater proportion than their statewide numbers, while the poorer communities like Dearborn's South End and Hamtramck are represented in less than their actual proportions.

Second limitation is the survey's reliance on self-reporting of health problems and levels of screening. Some of the respondents may have had prior medical work-ups for cancers and other conditions, but were unaware of reason for such medical tests.

In previous surveys conducted through the Arab Community Center for Economic and Social Services, the level of illiteracy was found to be high among respondents. This barrier was alleviated by the hiring of bilingual personnel to administer the survey tools one-on-one to participants. A limitation of the current survey is the ability to read in either English or Arabic. Because of the immigration patterns among the local community, many members of the community have migrated from rural regions where written Arabic is a language very unlike the local spoken colloquial. The variation in written and spoken Arabic is not well comprehended by Westerners, where the written and spoken languages are essentially the same, with smaller regional and slang variation. An example to the distinction between the two forms in Arabic might be the distinction between Shakespearean English and common American usage. Therefore, the problem of selection bias must again be considered in that those who were able to self administer the survey tool in either written English or Arabic were likely not representative of the poorest elements of our local community.

Lack of Screening in the Arabic Population

Despite the growing public health perception that screening is a humane and necessary means of secondary morbidity prevention, the high rates of uninsured essentially exclude many community members from such needed primary care services.

As in previous assessments of surveys, the levels of mammography and other cancer screening appear to be lower in the Arab American population as compared with the general population. The community-based organizations in the Arab community have filled the role of addressing this unmet need, but not sufficiently. One straightforward recommendation from that stems from these findings is a call for intensified public health advocacy and outreach in the low income Arab and Chaldean communities of Michigan.

Perceptions of Health

Health behavioral studies must be understood within the context of the culture that is to be studied. Within Arabic culture, disease in general is hidden from people outside of the family. There are a number of reasons for this, but the foremost is the idea of shame. Illness like cancer, which is viewed a familial by the Arab people, is considered an imperfection that reflects on the whole family. The disease is rarely named, or referred to only as “that terrible condition”.

Because of this cultural environment, it is difficult to both assess cancer burden and to outreach for cancer screening. Despite these factors, 11.4% of the current survey participants responded anonymously that they had some form of cancer. Unfortunately, these cancer rates were not quantified in a way that allows comparison with other populations or with local epidemiological data on particular cancer prevalences.

Need to Improve Insurance Access

Among the public health needs of the Arab American population, perhaps the most salient issue that recurs in community-based surveys in the high rate of medically uninsured individuals. The 1997 Wayne County Behavior Risk Factor Survey found a rate of uninsured as high as 37% in Wayne County. The current survey additionally supports this finding, though to a lesser extent. Rates of insurance likely relate directly to types of employment opportunities for Arabs, and this varies greatly across the heterogeneous Arab American population. Those individuals in higher income brackets tend to obtain health insurance coverage through employers. The poorest naturalized elements of the population are eligible for Medicaid coverage. In between are unskilled laborers and small shop workers, who are in an income bracket prohibitive of high health insurance costs, and who are ineligible for government insurance assistance either by income or citizenship qualification. This situation is most applicable in the Wayne County urban Arab American population.

Disproportionate Cardiovascular Disease Burden

In comparison to the general population, Arab Americans are apparently less healthy than the majority in terms of cardiovascular disease and its risk factors. This survey confirmed similar finding in the Arab Primary Care Survey (Hammad and Kysia, 1998) and Wayne County Behavioral Risk Factor Survey (Gold, et. al, 1997). All three efforts found disproportionately high self reported levels of hypertension, diabetes, and hypercholesterolemia. Similarly, the Arab Cardiovascular Risk Reduction Project of 1997 (Kysia and Hammad) measured blood pressure and cholesterol directly, finding

Arabs had more hypertensive and hypercholesterolemic than the general population in all categories except age 65 and older. This current study suggests similar risk, with greater than 46% reporting having been told they had high cholesterol and

Family Planning

With respect to natality, it appears that average household size is greater than that of the general population. Natural family planning methods were high in among survey respondents, and these methods are the most unreliable contraceptive methods. The Arab and Chaldean cultures view family planning in a wide variety of ways. There is little consensus opinion about the use or prohibition of these methods from a cultural or social point of view. Religious belief is likely a significant factor in reduced use of contraceptive method, though this is not universal. Among Muslims, consensus concerning birth control is split. Chaldean Catholics perhaps view family planning less favorably from a religious standpoint.

Among all populations, though, there appears to be a greater pro-natality than is present in the majority population. Based on this finding, family planning should be considered as a significant area of public health need. This is not to argue that Arab Americans need to reduce natality, but the finding of this survey indicate that when contraception is desired, the majority of contraception users are choosing inaccurate and unreliable methods. Perhaps better access to public health education related to understanding fertility and natality would benefit the reproductive health of the community.

Smoking and Drug Abuse

One surprising finding from the current study was the low rates of smoking. In comparison with three large surveys conducted exclusively within Wayne County, this survey found significantly lower rates of Arab American tobacco use. A series of studies in Southeastern Wayne County, smoking rates have ranged from 35-45%, while this current survey found only 15% of respondents were smokers. This might reflect the greater proportion of individuals in higher socioeconomic brackets in the current survey, or may be related to the fact that survey respondents were recruited from religious centers where more devote practitioners of the respective faiths we surveyed were less likely than the general population to smoke. With respect to drugs and alcohol use, the current survey found the Arab and Chaldean populations to be less likely than the general population to drink or use illicit drugs.

Conclusion

In general, this study upholds the hypothesis that Arab American health is poorer than that of the general population. This is true in terms of health insurance coverage and health care access. It is similarly true for cardiovascular and neoplastic disease risk. With respect to alcohol and drug abuse, the Arab and Chaldean communities appear at significantly reduced risk for cardiopulmonary, hepatic and other substance-related pathologies. Similarly, child and motor vehicle safety appeared to be a less significant risk among survey respondents. Results of the current survey suggest a continued need for outreach in the Arab and Chaldean communities for education related to cancer, heart disease and the importance of screening for secondary prevention of disease morbidity.

TABLE 1 – Distribution of Respondents by Sex

	Frequency	Percent
Male	392	42.4
Female	532	57.5
TOTAL	924	100.0

TABLE 2 – Distribution of Respondents by Marital Status

	Frequency	Percent
Never Married	201	21.7
Married	666	72.0
Divorced	32	3.5
Widowed	26	2.8
TOTAL	925	100.0

TABLE 3 – Distribution of Respondents by Education Level Completed

	Frequency	Percent
Grades 0-6	74	7.9
Grades 7-12	308	33.0
2 Yrs. College	195	20.9
4 Yrs. College	185	19.8
Graduate School	137	14.7
Other	34	3.6
TOTAL	933	100.0

TABLE 4 – Distribution of Respondents by Family Income

	Frequency	Percent
$10,000 – 20,000	213	25.3
$20,000 – 30,000	211	25.1
$40,000 – 50,000	153	18.2
> $50,000	254	31.4
TOTAL	841	100.0

TABLE 5 – Distribution of Respondents By Employment

	Frequency	Percent
Yes, employed	495	54.7
Not employed	410	45.3
TOTAL	905	100.0

TABLE 6 – Distribution of Respondents By Number of Family Members

	Frequency	Percent
< 3 people	293	34.6
4 – 6 people	443	52.4
7 – 9 people	91	10.8
10 – 15 people	19	2.3
TOTAL	846	100.0

TABLE 7 – Distribution of Respondents By Age Categories

	Frequency	Percent
Youths (0-18)	66	7.3
19-29 years old	276	30.6
30-39 years old	217	24.0
40-89 years old	344	38.1
TOTAL	903	100.0

TABLE 8 – Distribution of Respondents By Weight Categories

	Frequency	Percent
50 – 100 lbs.	33	3.7
101 – 110 lbs.	79	8.9
120 – 139 lbs.	183	20.6
140 – 159 lbs.	196	22.0
160 – 179 lbs.	187	21.0
180 – 199 lbs.	130	14.6
200 – 239 lbs.	60	6.7
240 – 280 lbs.	21	2.4
TOTAL	889	100.0

TABLE 9 – Distribution of Respondents by Nationality

	Frequency	Percent
Iraq	182	19.3
Arab-American	64	6.8
Palestine	120	12.7
Syria	69	7.3
Egypt	27	2.9
Lebanon	220	23.4
Yemen	101	10.7
Jordan	58	6.2
Saudi Arabia	12	1.3
Other Mideast Muslim	17	1.8
Countries	72	7.7
TOTAL	942	100.0

TABLE 10 – Distribution of Respondents by Language of Response

	Frequency	Percent
English	598	56.443.
Arabic	463	6
TOTAL	1061	100.0

TABLE 11 – Distribution of Respondents by Perception of Health Compared to Other Communities

	Frequency	Percent
Healthier	281	29.3
Sicker	217	22.6
No Change	461	48.1
TOTAL	959	100.0

TABLE 12 – Distribution of Respondents by Individual Health Compared to Other Same Age

	Frequency	Percent
Excellent	182	18.7
Very Good	293	30.1
Good	297	30.5
Fair	166	17.0
Poor	36	3.7
TOTAL	974	100.0

TABLE 13 – Distribution of Respondents by Last Personal Doctor Visit

	Frequency	Percent
3 Months	440	46.9
6 Months	205	21.8
12 Months	147	15.7
2 Years	51	5.4
> 2 Years	96	10.2
TOTAL	939	100.0

TABLE 14 – Distribution of Respondents by Personal Physical Problem Restricting Physical Activity

	Frequency	Percent
Yes	128	13.8
No	797	86.2
TOTAL	925	100.0

TABLE 15– Distribution of Respondents by Mental Health Problems Restricting Daily Activity

	Frequency	Percent
Yes	162	18.0
No	740	82.0
TOTAL	909	100.0

TABLE 16– Distribution of Respondents by Health Insurance Coverage for Self and Family

	Frequency	Percent
Yes	743	79.5
No	192	20.5
TOTAL	935	100.0

TABLE 17 – Distribution of Respondents by Type of Health Insurance

	Frequency	Percent
Blue Cross	215	27.1
Private HMO	154	19.4
Medicare	149	18.8
Medicaid	140	17.6
Other	136	17.1
TOTAL	794	100.0

TABLE 18 – Distribution of Respondents by Primary Insured Person

	Frequency	Percent
Self	391	52.8
Husband	247	33.3
Wife	103	13.9
TOTAL	741	100.0

TABLE 19 – Distribution of Respondents by How Health Insurance Was Obtained

	Frequency	Percent
Employer	438	56.2
Purchased	101	12.9
Government	241	30.9
TOTAL	780	100.0

TABLE 20– Distribution of Respondents by Satisfaction with Health Insurance

	Frequency	Percent
Yes	605	72.8
No	190	22.9
Other	36	4.3
TOTAL	831	100.0

TABLE 21 – Distribution of Respondents by High Blood Pressure According to Doctor

	Frequency	Percent
No	189	55.6
Yes	151	44.4
TOTAL	340	100.0

TABLE 22 – Distribution of Respondents by High Cholesterol

	Frequency	Percent
No	182	53.2
Yes	160	46.8
TOTAL	342	100.0

TABLE 23 – Distribution of Respondents by Diabetes

	Frequency	Percent
No	276	80.7
Yes	66	19.3
TOTAL	342	100.0

TABLE 24 – Distribution of Respondents by Cancer

	Frequency	Percent
No	303	88.6
Yes	39	11.4
TOTAL	342	100.0

TABLE 25– Distribution of Respondents by Heart Disease

	Frequency	Percent
No	316	92.4
Yes	26	7.6
TOTAL	342	100.0

TABLE 26– Distribution of Respondents by Other Health Problems

	Frequency	Percent
No	306	89.7
Yes	35	10.3
TOTAL	341	100.0

TABLE 27– Distribution of Respondents Tested for Cancer

	Frequency	Percent
Yes	221	26.5
No	614	73.5
TOTAL	835	100.0

TABLE 28– Distribution of Respondents by Women Having Cancer Screening for Mammography

	Frequency	Percent
No	81	30.9
Yes	181	69.1
TOTAL	262	100.0

TABLE 29– Distribution of Respondents by Women having Cancer Screening Pap Smear

	Frequency	Percent
No	117	44.8
Yes	144	55.2
TOTAL	261	100.0

TABLE 30– Distribution of Respondents by Woman having Cancer Testing Colon Screening

	Frequency	Percent
No	239	91.6
Yes	22	8.4
TOTAL	261	100.0

TABLE 31– Distribution of Respondents by Women having other Cancer Testing

	Frequency	Percent
No	249	95.4
Yes	12	4.6
TOTAL	261	100.0

TABLE 32– Distribution of Respondents by Women Having Last Cancer Testing Exam

	Frequency	Percent
< 1 year Ago	253	58.3
1 Year Ago	83	19.1
2 Years Ago	53	12.2
3 or More Years	45	10.4
TOTAL	434	100.0

TABLE 33– Distribution of Respondents by Men Having Cancer Testing Rectal Exam

	Frequency	Percent
No	95	60.1
Yes	63	39.9
TOTAL	158	100.0

TABLE 34– Distribution of Respondents by Men having Cancer Testing PSA Blood Test

	Frequency	Percent
No	72	45.6
Yes	86	54.4
TOTAL	158	100.0

TABLE 35– Distribution of Respondents by Men having Cancer Testing Colon Screening

	Frequency	Percent
No	123	77.8
Yes	35	22.2
TOTAL	158	100.0

TABLE 36– Distribution of Respondents by Men having other Cancer Testing

	Frequency	Percent
No	128	81.0
Yes	30	19.0
TOTAL	158	100.0

TABLE 37– Distribution of Respondents by Men Having Last Cancer Testing Exam

	Frequency	Percent
< 1 year Ago	125	52.1
1 Year Ago	52	21.7
2 Years Ago	35	14.6
3 or More Years	28	11.7
TOTAL	240	100.0

TABLE 38– Distribution of Respondents Currently on Medication

	Frequency	Percent
Yes	235	30.2
No	543	69.8
TOTAL	778	100.0

TABLE 39– Distribution of Respondents on Diet to Control Illness

	Frequency	Percent
Yes	168	19.4
No	691	80.6
TOTAL	857	100.0

TABLE 40– Distribution of Respondents Regarding Neighborhood Safety

	Frequency	Percent
Very Safe	291	30.8
Safe	561	59.4
Not Safe	92	9.7
TOTAL	944	100.0

TABLE 41– Distribution of Respondents Who Drive W/N the Speed Limit

	Frequency	Percent
Yes	771	86.4
No	121	13.6
TOTAL	892	100.0

TABLE 42– Distribution of Respondents and How Often They Drive W/n the Speed Limit

	Frequency	Percent
Always	534	65.8
Sometimes	243	29.9
Seldom	16	2.0
Never	19	2.3
TOTAL	812	100.0

TABLE 43– Distribution of Respondents And How Often Car Seat Belt Is Used

	Frequency	Percent
Yes	826	92.0
No	72	8.0
TOTAL	898	100.0

TABLE 44– Distribution of Respondents and How Often Seat Belts Are Used

	Frequency	Percent
Always	671	77.4
Sometimes	168	19.4
Seldom	18	2.1
Never	10	1.2
TOTAL	867	100.0

TABLE 45– Distribution of Respondents Whose Children Use Seat Belts

	Frequency	Percent
Yes	684	90.5
No	72	9.5
TOTAL	756	100.0

TABLE 46– Distribution of Respondents And How Often Their Children Wear Seat Belts

	Frequency	Percent
Always	565	77.6
Sometimes	138	19.0
Seldom	11	1.5
Never	14	1.9
TOTAL	728	100.0

TABLE 47– Distribution of Respondents Who Exercise

	Frequency	Percent
Yes	547	60.0
No	365	40.0
TOTAL	912	100.0

TABLE 48– Distribution of Respondents And How Long They Exercise

	Frequency	Percent
20 minutes	326	55.3
40 minutes	149	25.3
60 minutes	114	19.4
TOTAL	589	100.0

TABLE 49– Distribution of Respondents Whose Children Wear Helmets When Riding Bike

	Frequency	Percent
Always	125	22.4
Sometimes	141	25.2
Seldom	87	15.6
Never	206	36.9
TOTAL	559	100.0

TABLE 50– Distribution of Respondents Who Smoke

	Frequency	Percent
Yes	137	15.0
No	774	85.0
TOTAL	911	100.0

TABLE 51– Distribution of Respondents and Use of Tobacco Products

	Frequency		Percent
Yes	55	341	13.9
No		396	86.1
TOTAL			100.0

TABLE 52– Distribution of Respondents and Number of Times Use Of any Tobacco Product

	Frequency	Percent
Snuff	1	2.0
Chewing	7	13.7
Argileh	33	64.7
Cigar	10	19.6
TOTAL	51	100.0

TABLE 53– Distribution of Respondents Who Smoke in Same Room/Vehicle W/ Pregnant Woman

	Frequency		Percent
Yes	70	294	19.2
No		364	80.8
TOTAL			100.0

TABLE 54– Distribution of Respondents Who Smoke In Same Room/Vehicle W/Children

	Frequency	Percent
Yes	88	25.3
No	260	74.7
TOTAL	348	100.0

TABLE 55– Distribution of Respondents and Anyone Else
In Family that Smokes at Home In Addition to Them

	Frequency	Percent
Yes	111	27.3
No	296	72.7
TOTAL	407	100.0

TABLE 56– Distribution of Respondents Who Want to Quit Smoking

	Frequency	Percent
Yes	132	12.4
No	81	7.6
TOTAL	848	100.0

TABLE 57– Distribution of Respondents Who Drink Alcohol

	Frequency	Percent
Yes	60	6.7
No	834	93.3
TOTAL	894	100.0

TABLE 58– Distribution of Respondents and How Many Drinks Per Week

	Frequency	Percent
2 Drinks	27	48.2
4 Drinks	18	32.1
6 Drinks	5	8.9
> than 6 Drinks	6	10.7
TOTAL	56	100.0

TABLE 59– Distribution of Respondents Who Want To Stop Drinking Alcohol

	Frequency	Percent
Yes	42	40.4
No	62	59.6
TOTAL	104	100.0

TABLE 60– Distribution of Respondents Who Eat a Healthy Balanced Diet

	Frequency	Percent
Yes	689	80.0
No	172	20.0
TOTAL	861	100.0

TABLE 61– Distribution of Respondents and Frequency of Eating Junk Food

	Frequency	Percent
Every Day	145	41.5
1-3 Times/Week	108	30.9
None	96	27.5
TOTAL	349	100.0

TABLE 62– Distribution of Respondents and Their Opinion on Access To Health Care

	Frequency	Percent
Yes	462	50.4
No	454	49.6
TOTAL	916	100.0

TABLE 63– Distribution of Respondents and Opinion that Their Community Has Access to Health Care as Much as Other Groups

	Frequency	Percent
Yes	487 423	53.5
No	910	46.5
TOTAL		100.0

TABLE 64– Distribution of Respondents Who are Pregnant

	Frequency	Percent
Yes	56	10.1
No	497	89.9
TOTAL	553	100.0

TABLE 65– Distribution of Respondents Who Use Birth Control

	Frequency	Percent
Yes	150	30.9
No	336	69.1
TOTAL	486	100.0

TABLE 66– Distribution of Respondents and Type of Birth Control Used

	Frequency	Percent
Pills	65	34.0
IUD	42	22.0
Implant	6	3.1
Tubal Ligation	19	9.9
Hysterectomy	12	6.3
Natural Method	47	24.6
TOTAL	191	100.0

TABLE 67– Distribution of Respondents Whose Husbands' Use Birth Control Methods

	Frequency	Percent
Yes	64	14.6
No	374	85.4
TOTAL	438	100.0

TABLE 68– Distribution of Respondents Who Had Children Who Died During the Fist Year of Life

	Frequency	Percent
Yes	26	5.2
No	475	94.8
TOTAL	501	100.0

TABLE 69– Distribution of Respondents Who Have Knowledge of Free Available Services for Women and Children in the Near Health Department

	Frequency	Percent
Yes	263	36.2
No	464	63.8
TOTAL	727	100.0

Table 70 - Male Cancer Testing/Colon Screening
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	6	35	71	112
% Within Age Category	85.7%	81.4%	77.2%	78.9%
% of Total	4.2%	24.6%	50.0%	78.9%
# of Individuals, Yes Testing	1	8	21	30
% Within Age Category	14.3%	18.6	22.8%	21.1%
% of Total	.7%	5.6%	14.8%	21.1%
# of Total Individuals Tested	7	43	92	142
% of Total	4.9%	30.3%	64.8%	100.0%

Table 71 - Male Cancer Testing/PSA Blood Test
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	5	30	30	65
% Within Age Category	71.4%	69.8%	32.6%	45.8%
% of Total	3.5%	21.1%	21.1%	45.8%
# of Individuals, Yes Testing	2	13	62	77
% Within Age Category	28.6%	30.2%	67.4%	54.2%
% of Total	1.4%	9.2%	43.7%	54.2%
# of Total Individuals Tested	7	43	92	142
% of Total	4.9%	30.3%	64.8%	100.0%

Table 72 - Male Cancer Testing/Rectal Exam
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	4	28	53	85
% Within Age Category	57.1%	65.1%	57.6%	59.9%
% of Total	2.8%	19.7%	37.3%	59.9%
# of Individuals, Yes Testing	3	15	39	57
% Within Age Category	42.9%	34.9%	42.4%	40.1%
% of Total	2.1%	10.6%	27.5%	40.1%
# of Total Individuals Tested	7	43	92	142
% of Total	4.9%	30.3%	64.8%	100.0%

Table 73 - Women Cancer Testing/Colon Screening
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	10	99	106	215
% Within Age Category	83.3%	93.4%	91.4%	91.9%
% of Total	4.3%	42.3%	45.3%	91.9%
# of Individuals, Yes Testing	2	7	10	19
% Within Age Category	16.7%	6.6%	8.6%	8.1%
% of Total	.9%	3.0%	4.3%	8.1%
# of Total Individuals Tested	12	106	116	234
% of Total	5.1%	45.3%	49.6%	100.0%

Table 74 - Women Cancer Testing/Pap Smear
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	9	39	59	107
% Within Age Category	75.0%	36.8%	50.9%	45.7%
% of Total	3.8%	16.7%	25.2%	45.7%
# of Individuals, Yes Testing	3	67	57	127
% Within Age Category	25.0%	63.2%	49.1%	54.3%
% of Total	1.3%	28.6%	24.4%	54.3%
# of Total Individuals Tested	12	106	116	234
% of Total	5.1%	45.3%	49.6%	100.0%

Table 75 - Women Cancer Testing/Mammography
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No Testing	7	43	18	68
% Within Age Category	58.3%	40.6%	15.4%	28.9%
% of Total	3.0%	18.3%	7.7%	28.9%
# of Individuals, Yes Testing	5	63	99	167
% Within Age Category	41.7%	59.4%	84.6%	71.1%
% of Total	2.1%	26.8%	42.1%	71.1%
# of Total Individuals Tested	12	106	117	235
% of Total	5.1%	45.3%	49.6%	100.0%

Table 76 - Diabetes By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No	21	96	137	254
% Within Age Category	84.0%	85.0%	77.9%	80.9%
% of Total	6.7%	30.6%	43.6%	80.9%
# of Individuals, Yes	4	17	39	60
% Within Age Category	16.0%	15.0%	22.2%	19.1%
% of Total	1.3%	5.4%	12.4%	19.1%
# of Total Individuals Tested	25	113	176	314
% of Total	8.0%	36.0%	56.1%	100.0%

Table 77 - High Cholesterol By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No	21	53	91	165
% Within Age Category	84.0%	46.9%	51.7%	52.5%
% of Total	6.7%	16.9%	29.0%	52.5%
# of Individuals, Yes	4	60	82	146
% Within Age Category	16.0%	53.1%	46.6%	46.5%
% of Total	1.3%	19.1%	26.1%	46.5%
# of Total Individuals Tested	25	113	176	314
% of Total	8.0%	36.0%	56.1%	100.0%

Table 78 - High Blood Pressure According to Doctor
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, No	15	73	85	173
% Within Age Category	60.0%	65.8%	48.3%	55.4%
% of Total	4.8%	23.4%	27.2%	55.4%
# of Individuals, Yes	10	38	91	127
% Within Age Category	40.0%	34.2%	51.7%	44.6%
% of Total	3.2%	12.2%	29.2%	44.6%
# of Total Individuals Tested	25	111	176	312
% of Total	8.0%	35.6%	56.4%	100.0%

Table 79 - Are You Employed?
By Age Category Cross Tabulation

	Age Category			TOTAL
	< / = 20	21 – 39	> / = 40	
# of Individuals, Yes	27	262	177	466
% Within Age Category	28.7%	59.8%	54.3%	54.3%
% of Total	3.1%	30.5%	20.6%	54.3%
# of Individuals, No	67	176	149	392
% Within Age Category	71.3%	40.2%	45.7%	45.7%
% of Total	7.8%	20.5%	17.4%	45.7%
# of Total Individuals Tested	94	438	326	858
% of Total	11.0%	51.0%	38.0%	100.0%

Table 80 - Are You Employed? By Sex Cross Tabulation

	Sex		
	Male	Female	TOTAL
# of Individuals, Yes	269	207	476
% of Total	30.8%	23.7%	54.5%
# of Individuals, No	103	294	397
% of Total	11.8%	33.7%	45.5%
# of Total Individuals	372	501	873
% of Total	42.6%	57.4%	100.0%

Table 81 - Do You Smoke? By Sex Cross Tabulation

	Sex		
	Male	Female	TOTAL
# of Individuals, Yes	70	52	122
% of Total	8.1%	6.0%	14.2%
# of Individuals, No	293	447	740
% of Total	34.0%	51.9%	85.8%
# of Total Individuals	363	499	862
% of Total	42.1%	57.9%	100.0%

Table 82 - Do You Have Health Insurance Coverage?
Self and Family? By Sex Cross Tabulation

	Sex		
	Male	Female	TOTAL
# of Individuals, Yes	298	406	704
% of Total	33.7%	46.0%	79.7%
# of Individuals, No	78	101	179
% of Total	8.8%	11.4%	20.3%
# of Total Individuals	376	507	883
% of Total	42.6%	57.4%	100.0%