New Horizons of Muslim Diaspora in North America and Europe

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CHAPTER 11

MULTICULTURALISM IN MUSLIM AMERICA? THE CASE OF HEALTH DISPARITIES AND DISCRIMINATION IN "ARAB DETROIT," MICHIGAN

Marcia C. Inhorn

Introduction

The United States is considered to be both "multicultural" and "democratic"—features of the nation-state that are extolled as political virtues. Yet, not all American citizens enjoy the full benefits of a multicultural democracy. This chapter examines the experiences of recent Arab Muslim migrants to the United States, and the intersecting forms of oppression facing this particular Muslim community. The focus of this chapter, furthermore, is on "health disparities," defined as differences in health status, health environment, and access to quality health care, which lead certain populations to have poorer health outcomes than others (Braveman 2006). In the United States, research on health disparities has focused heavily on African Americans and, to a lesser extent, Latinos. However, health disparities are a problem for other ethnic minority populations in the United States, including new immigrant and refugee populations from the Muslim world.

This chapter provides an ethnographic foray into the health disparities faced by one of America's most rapidly growing immigrant populations—namely, Arab Muslims, many of whom are resettled refugees from Middle Eastern war zones. Four major areas of health disparity face this growing Muslim immigrant population: namely, the lingering health effects of war and torture; postwar reproductive health impairments, including both male and female infertility; lives of poverty in resettlement communities; and the lack of access to basic health care services in the United States (Inhorn and Fakih 2005; Inhorn and Serour 2011). To date, relatively few studies have examined the health status or reproductive difficulties faced by new Muslim immigrant populations in the United States (El-Sayed and Galea 2009; Read et al. 2005). However, the few available studies suggest that Arab Muslim immigrants to the United States tend to be of lower

socioeconomic status, uneducated, monolingual in Arabic, and, depending upon the home country, to suffer from psychological and physical trauma inflicted in situations of political violence (Hedges and Al-Arian 2008).

Arab Muslim Refugees and Discrimination in the United States

Nearly 80,000 Iraqis, mostly Shia Muslims, were resettled in the United States following the First Gulf War (1991–1992) (Walbridge and Aziz 2000). Since the 2003 US-led war in Iraq, the US Refugee Admissions Program (USRAP) has been on a humanitarian mission to resettle vulnerable Iraqi nationals, including those who have served with US forces in Iraq. Since the inception of the USRAP in 2007, more than 200,000 Iraqi nationals have been referred for resettlement. More than 140,000 of them have been interviewed, and more than 120,000 have been approved for resettlement. Yet, only about 85,000 of these Iraqi refugees had actually arrived in the United States as of April 2013 (US Department of Homeland Security 2013).

A disproportionate number of these Iraqi and other Arab Muslim refugees have been resettled in so-called Arab Detroit (Abraham and Shryock 2000; Hassoun 2005; Detroit Arab American Study Team 2009; Abraham et al. 2011). Since the First Gulf War, metropolitan Detroit, Michigan, has been the major receiving site for resettled Iraqis, as well as for Lebanese war refugees. According to 2010 estimates, more than 220,000 Arabs now live in the metropolitan Detroit area, which represents nearly 16 percent of the entire US Arab population of 1.46 million (Schopmeyer 2011). Most of these Arab immigrants live in Dearborn, Michigan, a southwestern suburb of Detroit, which has been dubbed the "capital of Arab America" and which is home to a major Ford automobile manufacturing plant. However, with Michigan's failing automobile-based economy, Iraqi resettlement to Michigan has been officially stopped by the USRAP. As of March 2011, unemployment rates for Iraqis in Michigan were nearly three times the national average of 9 percent, and it is estimated that nearly 2,000 Iragi refugees have left the United States for other countries (Sheppard 2011).

Indeed, the events of the past decade have generally reversed the assimilating efforts of Arab Muslims to move from "margin to mainstream" (Abraham and Shryock 2000; Abraham et al. 2011), or to "blend in" to white US society as an "invisible" ethnic minority population (Naber 2000; Ajrouch and Jamal 2007; Jamal and Naber 2008). September 11, 2001, set in motion a series of untoward events, including the Bush Administration's declaration of war in both Iraq and Afghanistan, the implementation of both "Homeland Security" and the "Patriot Act" in Bush's "War on Terror," and the eventual withdrawal of US troops from Iraq and Afghanistan, leaving a trail of violent conflict in its wake.

Given this chain of events, Arabs and Muslims already living in the United States or arriving there as new refugees have faced a great deal



of suspicion and resentment—what several scholars have described as a "backlash" against Arabs and Muslims more generally (Bakalian and Bozorgmehr 2009; Cainkar 2009; Peek 2011). Indeed, incidents of racial discrimination, negative stereotyping, and hate crimes have all been documented in the United States over the past decade (Howell and Shryock 2003; Marvasti and McKinney 2004; Abraham et al. 2011).

Given such discrimination, resettlement in America has been both paradoxical and problematic for many new Arab Muslim refugees. On one hand, America's instigation of, and ongoing involvement in, wars in their Middle Eastern home countries, especially Iraq, means that they have been forced to flee to the United States. On the other hand, once they arrive, these refugees are unwelcome, facing sometimes bitter discrimination and hostility in a post-9/11, anti-Arab, anti-Muslim environment (Ewing 2008; Bakalian and Bozorgmehr 2009; Cainkar 2009; Abraham et al. 2011; Hanoosh 2011; Howell and Shryock 2011).

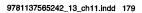
Intersecting Oppressions: African Americans and Arab Muslims in the United States

To understand the forms of discrimination facing Arab Muslims in the United States, it is useful to turn to intersectionality theory, which was first proposed by black feminist scholars to understand the intersecting forms of oppression being faced by Black women in America (Crenshaw et al. 1996; Collins 2008). Intersectionality theory captures the simultaneous and interlocking forms of oppression based on categories such as gender, race, class, age, ethnicity, religion, national origin, sexual orientation, disability, or appearance. Instead of acting independently, these systematic forms of oppression may intersect in individuals' lives, leading to multiplicative, instead of merely additive, effects. For example, being black and being poor may represent powerful and intersecting forms of oppression, which exacerbate preexisting gender discrimination facing black women in a male-dominated society (Mullings 1996; Collins 2008).

Although African American and Arab Muslim populations in the United States are rarely compared or studied together, they share many underappreciated commonalities, which intersectionality theory can illuminate. In the case of Arab Muslims, intersecting forms of oppression include discrimination based on ethnicity, religion, social class, race, gender, and appearance (e.g., veiling). Indeed, multiple intersecting forms of oppression are operative in the lives of *both* African American and Arab Muslim communities in the United States, when they are compared side by side.

Unhealthy communities: First, both African Americans and Arab Muslims are at increased risk for health problems because of environmental risk factors. Both groups tend to be concentrated in urban industrial centers, where they are exposed to environmental toxins through occupational exposures, ambient air pollution, and toxic waste disposal in their





neighborhoods. In addition, they share nutritional constraints attributable to the lack of healthy, affordable foods in urban landscapes devoid of major grocery stores (Mullings and Wali 2001; Schulz and Mullings 2005).

Medical discrimination: Second, both communities may regard the US health care system with some suspicion and distrust, for reasons that are cultural in nature or based on experiences of racism (Caesar and Williams 2002; Skloot 2010). For Arab Muslims, including recently arrived immigrants, language barriers, illiteracy (in both English and Arabic), and lack of Western understandings of the body and its physiology may represent major barriers to negotiating care, especially for women and immigrants coming from rural areas of the Middle East (Kulwicki 1996; Inhorn and Serour 2011). For African Americans, problems with health care are related to a long history of racism documented for US health care, including infamous medical experiments that were once performed on African American men and women (Skloot 2010).

Racial discrimination: Such distrust is clearly linked to general histories of racism and discrimination against both Arab Muslims and African Americans within US society. Although a long history of racial discrimination, negative stereotyping, and hate crimes can be documented for both groups in the United States, today, "Arabs," "Muslims," and "blacks" are vilified by many white Americans, who regard Arab, Muslim, and black men in particular as dangerous, untrustworthy, and inherently violent (as well as fanatical, if they are Arab Muslims) (Bayoumi 2008; Howell 2011; Inhorn 2012). The very possibility that Arab Muslims might be trustworthy, law-abiding citizens—who may want to conceive and nurture children as responsible father figures—seems to have eluded both the media and popular imagination, leaving deeply entrenched caricatures that are difficult to overcome (Shaheen 2008).

Gender discrimination: These caricatures of Arab Muslim and African American men include images of male hypersexuality and hyperfertility (Inhorn and Fakih 2005; Inhorn 2012). Arab men, and Muslim men in general, are seen as polygamous fathers of children from multiple wives, harkening back to Western Orientalist fantasies of the harem. Similarly, African American men are often portrayed as "informal" polygamists, spawning offspring with multiple, unmarried sexual partners (as well as spreading HIV/AIDS to them) (Edin and Nelson 2013). If Arab Muslim and African American men are portrayed as hypersexual, hyperfertile polygamists in the Western popular imagination, then their women are concomitantly described as oppressed, brutalized, veiled victims, who require liberation from both patriarchal and religiously based oppression (Abu-Lughod 2013).

Religious discrimination: Gender relations between Arab Muslim men and women are presumed to be based on religion (Abu-Lughod 2013), namely, Islam, which is generally viewed as an extremist, oppressive, fanatical, gender-discriminating, and hate-mongering religion by the majority of Americans (Cainkar 2009; Grewal 2013). Islam tends to be viewed in



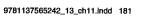
the United States as a religion of intolerance rather than tolerance. Thus, those who practice the religion are viewed with suspicion and fear. This would include both Arab Muslim *and* African Americans who belong to the Nation of Islam (Grewal 2013).

Economic discrimination: The racism and stereotyping directed at both Arab Muslims and African Americans lead to much blaming and scapegoating, including for conditions of poverty. Although a significant percentage of both Arab Muslims and African Americans have achieved middle-class status or higher (Read et al. 2005; Robinson 2011), a significant proportion of both are lower-income groups, with many families existing below the US poverty line (Edin and Kefalas 2007; Schopmeyer 2011). Both groups have been affected by changes in the urban industrial workforce and the outsourcing of US factory jobs to foreign countries. Both groups have been forced to rely on the US welfare system in order to supplement meager family wages, with negative implications for family structure and health status. Indeed, economic impoverishment and accompanying low social class status are major problems for both these ethnic minority populations in the landscape of America. Poverty affects the ability of Arab Muslims and African Americans to seek higher education, improve their standard of living, and access affordable health care for themselves and their children.

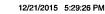
Arab Detroit, Michigan

Let us turn now to metropolitan Detroit, Michigan, a northern industrial city with one of the largest populations of both Arab Muslims and African Americans in the country. According to the findings from the Detroit Arab American Study (DAAS) Team (2009), a major University of Michigan-based survey funded by the Russell Sage Foundation, metro Detroit has one of the oldest, largest, and most visible Arab populations in North America. Arab Americans trace their ancestry to four major sending areas: Lebanon/Syria (37 percent), Iraq (32 percent), Palestine/Jordan (12 percent), and Yemen (8 percent). Seventy-five percent were born outside the United States, with most continuing to speak Arabic, even if they have acquired English-language skills. The population reports them being deeply religious, with 58 percent Christian and 42 percent Muslim. Most Christians have achieved middle-class status and are dispersed throughout Detroit's suburbs, while two-thirds of all Muslims live in the "ethnic enclave" community of Dearborn, Michigan, sometimes dubbed "Arab Detroit."

Compared to Arab Americans nationwide, the Arab Americans of metro Detroit are more likely to be Muslim immigrants, refugees from war-torn Lebanon and Iraq, or from poor rural communities of Yemen. They have larger families and lower family incomes, with a quarter of the population struggling on family incomes of less than \$20,000/year. Fifteen percent of those surveyed also said they personally have had a "bad



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experience" after September 11 because of their ethnicity. These experiences included "verbal insults, workplace discrimination, special targeting by law enforcement or airport security, vandalism, and in rare cases, vehicular and physical assault" (DAAS Team 2009).

Arab Muslims in metro Detroit live in close proximity to African American communities, including the predominantly black city of Detroit, which is adjacent to Dearborn and surrounds another Arab enclave called Hamtramack (Schopmeyer 2011). The metropolitan Detroit area is among the most racially segregated cities in the country. As whites have moved to the suburbs, the city of Detroit has become increasingly black, with more than 80 percent of all Detroit residents now African American, according to US census (US Census Bureau 2015).

Furthermore, the racial segregation of Detroit is mirrored in the city's economic inequalities (Schulz and Lempert 2004). Among the 77 cities in the United States with populations above 200,000, Detroit ranked first in the percent of population below the poverty line. In Detroit, 38 percent of all persons live below the poverty line, and 39.5 percent of all female-headed households live below the poverty line. For Arab Americans living in Detroit, the poverty rates were even higher, with 37.5 percent of all families living in poverty and 44.1 percent of female-headed households in poverty, according to US census data. This stands in stark contrast to the predominantly white suburbs of Detroit, where just 5 percent of white residents, 7–10 percent of Arab Americans, and 13 percent of African Americans live in poverty.

To summarize, a current portrait of Detroit would show three major sectors: (1) a poor, virtually black inner city; (2) a predominantly poor Muslim Arab suburb (Dearborn) attached to Detroit's southwestern border, the home of a growing population of mostly Shi'a Muslim refugees from Lebanon and Iraq; and (3) a ring of suburban white affluence, including many Christian Arabs (primarily Iraqi Chaldeans), who have achieved wealth and consider themselves to be "white," according to the DAAS survey data (DAAS Team 2009; Schopmeyer 2011).

The Study of Health Disparities in Arab Detroit

In the midst of this segregated city, a five-year (2003–2008) medical anthropological study was conducted by the author in an Arab-serving reproductive health clinic in the heart of Arab Detroit. The study was based on extensive ethnographic interviews conducted with 95 Arab immigrants—55 men and 40 women—most of whom were Iraqi, Lebanese, and Palestinian war refugees, as well as some Yemeni economic migrants fleeing their impoverished home country. Interviews were conducted in English, Arabic, or a mixture of English and Arabic, depending upon the primary language and preference of the interviewee.

Few of these individuals were born in the United States. Most had emigrated alone or with their families under conditions of economic or





political duress in their home countries, including all the Iraqis, who came as political refugees. Thus, their lives had been disrupted in significant ways. For example, most were poorly educated, with few having completed high school. Most were either struggling with the English language or could not speak English at all, thus restricting their ability to communicate in US health care, social service, and employment sectors.

Without English or high-school educations, few of the Arab Muslim women in the study had ever worked, relying instead on their husbands for economic support. Most of the men in the study were employed in low-wage, blue-collar, or service-sector occupations, mainly as gas station attendants, dishwashers, and busboys in Middle Eastern restaurants, truck drivers, construction workers, auto mechanics, used-car salesmen, or store clerks. Salaries were generally low, with many men and their wives living in small apartments in Dearborn and generally "ekeing out" subsistence lives below the poverty line. In 2006, with accelerating problems in the Detroit-based auto industry, unemployment rates in this community began to skyrocket. Several of the study participants were living off a combination of unemployment benefits, Social Security, welfare, and food stamps.

Without regular employment, most of the men and women in the study did not have private health insurance to cover the costs of their medical care. Most did not own credit cards. As a result, virtually all their financial transactions, including visits to medical clinics, were handled in cash.

In general, the Arab Muslim men and women in the study describe their lives as "hard" and "stressful," given the traumatic conditions that had led them to flee their home countries and the problems of economic hardship, exclusion, and discrimination that faced them in America. The intersection of these various forms of oppression can be briefly illustrated through the story of Fatima and Shahira (two pseudonyms), Iraqi refugee sistersin-law, who shared their reproductive trials and tribulations as follows.

Health Disparities: The Story of Fatima and Shahira

Fatima and Shahira were sisters-in-law, both Iraqi Shi'a refugees who ended up being resettled in Dearborn, Michigan. Fatima, the younger of the two, was a child refugee from the First Gulf War, who had lived for four years, from 1991 to 1995, in the horrible squalor of the Saudi Arabian refugee camps where the Shi'a Iraqis fled after their failed, US-backed uprising against the brutal regime of Saddam Hussein. After four years, Fatima's family finally received political asylum in the United States, arriving first in Arizona, then resettling in southeastern Michigan with 80,000 other Iraqi refugees. Fatima grew up and married another Iraqi refugee, an uneducated taxi driver whose family was still living in war-torn Iraq at the time. Fatima's husband made so little money that he was unable to afford health insurance, or to pay for the hormonal medications necessary to overcome Fatima's ovarian problems, which had rendered her infertile



throughout their five years of marriage. As the Michigan economy deteriorated further with the decimation of the Detroit auto industry, Fatima had sought help for herself and her husband at the local social service agency in Dearborn. As she explained: "The last time I went in, I told them I don't have Medicaid [i.e., medical welfare], my husband is not working, and he really wants to. I told them, 'give me any paper to fill out' [for Medicaid and for work], and they just said, 'Go online and see for yourself.'"

Meanwhile, Fatima had brought her husband's older sister, Shahira, to the Arab-serving infertility clinic. Shahira had recently fled from Iraq, as well as from a seven-year marriage in which she was blamed for the infertility. A 36-year-old divorcee, who looked weathered beyond her years, Shahira wanted to give children to her new husband of one year, who had lost his only daughter in the First Gulf War. But Shahira had serious infertility problems—fibroid tumors in her uterus—which ultimately required costly surgery. However, because fibroid surgery was not covered by Shahira's Medicaid insurance plan in the United States, Shahira flew by herself in October 2007 from Detroit to Damascus, Syria, in order to access the surgical procedure at a cost that she could afford. Although the surgery relieved the pain from Shahira's fibroid tumors, her savings were depleted by the cost of surgery and travel to the Middle East. At the time of the interview, Shahira was not yet pregnant in the second year of her second infertile marriage. At the age of 36, time was no longer on her side.

Conclusion

Stories like these speak to the suffering of recently arrived Arab Muslim immigrants and war refugees, who face significant health disparities and overlapping forms of discrimination in American society. For the Arab Muslims in this study, most were not living the "American dream" of "assimilation" into a "multicultural democracy." Rather, as this chapter makes clear, many Arab Muslims, like African Americans, now experience the intersectional effects of oppression, including poverty and post-September 11 anti-Arab, anti-Muslim sentiments in US society as a whole. Sadly, Arab Muslims in America now share with African Americans their poor health status and the combination of fear and prejudice displayed by many white Americans. Both these populations face significant barriers to integration in US society, where race and class divisions—as well as many other forms of discrimination—continue to oppress the poor minority.

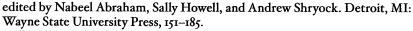
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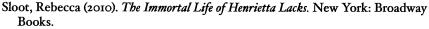
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