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[Start: 00:07]

CH: The first thing we’d like to do is start out talking about your background, and where you grew up, and what influenced your professional and academic path. [00:18]

IN: Four places. I was born in Venezuela but I did not live there more than—at the age of two and a half, I guess, we had returned to Lebanon. My dad, who joined us a few years later, said you don’t have another passport, your only passport is Lebanese, so don’t forget about your Venezuelan birth certificate and about another country. This is the only country and you have to stick around. I think that lesson stuck. So I grew up in Lebanon and studied in Beirut because this was where my father was working. I went to schools in the city, mainly private schools because unfortunately public schools and public education are weak [???].

And then after my high school education I went to the American University of Beirut. Practically I have lived most of my life within and around the American University of Beirut. That’s where I went to undergraduate and did my medical studies. When I finished medicine I made a challenging decision, a difficult one, of whether I continue in clinical medicine or look into public health. I was influenced by several incidents, especially in the community projects that we did as medical students. I had always been fascinated by the bigger factors that impact the life of people. As a medical student I felt maybe I could have more engagement with people’s priorities, not as a medical doctor that’s dealing with individual patients, but look at health from a population perspective. I don’t know whether I was very clear about what I was getting into, but I thought that it’s exciting enough and worth taking a risk with.

So I stepped out of medicine and did public health at Hopkins, finished my PhD and did an occupational medicine fellowship, returned to Lebanon, to the faculty of health sciences at AUB and I’ve been there since then. [2:48]

CH: Tell me about the transition that you had going from Lebanon to Johns Hopkins and the academic knowledge there that you received. It must have been different, right? [3:13]

IN: Mm-hmm. Actually the transition was not easy for different reasons, not only academic. When I moved to Hopkins in 1984 to join the MPH program there, master’s in public health, after finishing my MD and one year of internship, it was war in Lebanon. Lebanon went through 15 years of civil war, 1975 to 1990. So I’ve spent several, many years, part of our university education and going to medical school was happening when war was raging in the country, the civil war and occupations and all of that.

The biggest shock for me was to move out of a war zone, living in a place where you think security is about car bombs, about potential shelling, about shooting, about these kinds of security. When I moved to Hopkins, to the School of Public Health, the first orientation we received was again about security, but it was about personal security: You will be mocked, you might be attacked, don’t walk alone, don’t do this, because it was in a neighborhood that was a little bit unsafe. So that was one sort of amazing contradiction. In Beirut where your personal safety of being attacked by somebody to mug you or threaten you personally, your life and safety, did not exist. We didn’t worry about that. We worried about political security and what could happen there, shifting to a country, to Baltimore, where that bigger security is not a problem but everybody talks about don’t go into that neighborhood, and step away and be careful about one thing and another. That was one major thing.

The second is the fact that when you talk in public at one of the courses, like injury prevention, one professor was talking about one death is too many. For me, for a person coming from a place where war was taking place, we were living with frequent deaths and reporting of conflicts and innocent people and victims of these conflicts. And then to get to a place where people tell you that even one death is too many—these are the kind of—I would say for four or five months I would hesitate to go out after six because again of the issues of security, don’t go there after certain times. There was a transition of a few months when I did realize again that where I was, was not the normal circumstances for living, and we were moving into a place where people could carry on with their regular life at any time and all of that. That was definitely a big—I wouldn’t say, not a surprise, but it was a big shift to get used to this new setting.

Then academically we were moving with an American university and we followed the American education, liberal education, so we were used to the American system of education, that was not the problem. The language of instruction at our university is English, so this was not the bigger thing, but the shift from clinical training as a medical student to public health required again a different way of thinking about the population and about how do you look at health from the population point of view. But it was a good move. [7:37]

CH: Was there a defining moment in your work, anything that solidified how you wanted to move forward with your education? [7:51]

IN: As a medical student—it’s interesting now, because as dean of the School of Public Health, which we call the Faculty of Health Sciences, actually offers all public health courses to the School of Medicine. There is no Department of Public Health. We serve as a virtual department. When I was a medical student, my interactions with professors of public health at the Faculty of Health Sciences was an eye-opener for me.

One of the turning points was a community project that we were supposed to do. We were like seven or eight classmates, and it was in one of the Palestinian refugee camps. I have to say that was for me a big changer. It didn’t impact my classmates. For them it was another project, but for me, it made me ask questions about why: Why are people living in these conditions? This was like two years after the sub-Russia [???] massacres. The community was still in shock of what had happened, so we started seeing, and we went to health centers and saw physicians greeting patients, but for me the problem was not there, and health is not about some kind of a medical complaint that is treated by a physician. There is a major medical issue that needs to be addressed.

That was a turning point. I started asking whether a physician can be engaged, what kind of profession would help me to reach out. The professors who were teaching us public health became the people that I interacted with to ask that question. And through their advice and encouragement I felt that perhaps it was worth taking a different route. [10:08]

CH: We’re going to talk about your landmark book here in a moment, but it brings up a question that I had on here. It was one of the first questions that I put down, and that was: When you talk about political determinants of health in the Arab world, and what you’re talking about with a defining moment, how do you have impact while you’re navigating that political atmosphere? Because that creates—just by virtue of you addressing it—that creates waves. [10:48]

IN: When I talk about the politics and the political determinants of health, I remind myself and colleagues that it’s not about doing politics. It’s not about becoming politicians. It’s about understanding that what’s impacting our daily lives is beyond the direct and immediate things that you’re living. And there are policies and there are laws that we need to address. So that’s where you could take your public health and discipline to a higher level: Why should I engage in questions like this?

Corruption becomes an issue that you need to look at. Favoritism is a question that you need to look at. Sectarianism and [???] is something that you need to look at. The whole issue of justice and occupation and the loss of human rights is an issue that you need to look at. Palestinian refugees in Lebanon, they’ve been there for 70 years and they still are not allowed to own property, they are not allowed to work in more than 30 professions, and there is a limitation there. We are not calling for a change in political systems, we’re not calling for riots and demonstrations and uprisings and revolutions. What we’re calling for is simply that we need to put health within a wider, clearer context. Otherwise we won’t understand why we’re failing, because sometimes you do fail because of these political obstacles. So at least let’s be aware of them.

And let’s try to identify potential like-minded partners, work with NGOs—this is where working with civil society transforms from we are going to the civil society or the communities to help them, rather you see them as the people who could actually introduce social and political change if they understand their rights, and if they understand how can you do that. We don’t have a recipe and we’re not advocating for any, but I think that public health professionals have turned their backs to the reality that politics and political determinants are extremely—are there. You cannot escape them. [12:34]

CH: We’ve also been joined today by Dr. [Adnan] Hammad and we’re going to introduce him in a moment, but I first want to talk about your book, *Public Health in the Arab World: Towards a Multidisciplinary Perspective* [Cambridge University Press] that was printed in 2012. In there you talk about the lack of accurate health data available for the Arab population. But in what I read, this book is way more than just about the data. It is about addressing the multidisciplinary approach that it takes to pull together an effort like what you have. Can you tell me how long it took to produce the book? [14:15]

IN: The title of the book ended being *Public Health in the Arab World*. We dropped—

CH: So you dropped the other, *Towards a Multidisciplinary*—OK.

IN: Yes. So we dropped that part because we thought that it’s enough to keep the focus on the content and the geographic location. But the book itself carried that spirit. I’ll explain in a minute now.

When we got the OK from the Cambridge University Press to put that book out, it took us like three years to get that book out.

There’s an interesting story before that. We submitted proposals for the book to I think about 15 international publishing houses. We did it intentionally. We wanted to get the book out through an international publishing house, not through a local or a regional one, because we wanted to make sure that nobody questions the credibility of the book and we wanted to send a message that public health professionals and academics from the region can talk about the region and can express it through that book. We got 14 rejections from the international publishing houses, most of them telling us that the proposal is perfect, one of the best they reviewed, but nonetheless there’s no interest in the Arab world and we don’t have readership for a book like this.

So when we got to Cambridge University Press—this was about 2005—we decided that it’s not about the book. The book is not the objective, it’s not the target, it’s not the end. Actually the book is a means, a means towards establishing a wider network of people who are concerned about public health in the region. So we did it completely differently. We identified authors, we invited authors to Beirut, to our faculty, we’d hold 2-3 day workshops discussing what a book like this should be about. This was sort of multiple perspectives or multiple disciplines talking about what public health is all about, even a definition of what the Arab world is about, and whether we can write one book about the whole Arab world when the countries are different.

But what happened through that, and we had like three workshops as the manuscripts developed, was that we created a network of those people. By the time the book was out we had launched a listserv that we called Public Health in the Arab World. Now we have 2,000 subscribers to that listserv and it’s the only listserv that exists that connects people who are interested in health and the Arab world—not necessarily from the region. They are international, from anywhere.

We decided that the book is not about diseases. It was not about what is the epidemiology of diabetes, the epidemiology of cancer, the epidemiology of other diseases. We had some of them that addressed health outcomes. We had one on injuries, we had one on NCDs [noncommunicable diseases ?], and we even had one on infectious disease. But we started engaging with a different dimension of public health. We had chapters on social inclusion, gender and health in the Arab region, the whole issue of war and conflict and the experiences of different regions of the country. We talked about public health education and how it developed and how it’s still failing or not up to the standard that is expected. We took dimensions that were different than usual.

One chapter on occupational health was looking beyond the workplace hazards into the social and political and economic factors that impact the health of people and the health of workers. It allowed that kind of open discussion.

So it was worth the wait. It was intentional to build collegiality among people. And it became the only—it was, when we decided to do it, we realized that there was not a single academic book on health in the Arab world. There are reports by the World Bank, occasionally by some UN agencies, but no academic book.

The fact that we got it through Cambridge University Press gave it that extra credibility. Even the cover of that book was drawn by one of our MPH students, a doctor who was doing an MPH student. Actually she became part of the editorial team, listening to us, and she came up with this cover for the book. It was all home-grown, led and owned by people from the region, led by our faculty.

When it was out in 2012, the Arab world had changed by then, because all the Arab uprisings, all that Arab Spring had started in 2011. So all of a sudden the Arab world that was of no interest to the publishers and no interest to many international organizations, all of a sudden it became the focus of news and the international organizations asking the question, what is happening in that region? So the book was very well received and people felt that there is an academic reference that [???]. [20:16]

CH: We’re going to bring in Dr. Hammad to this conversation now, because one of—this is the connection and we can go in any direction you want to on this, but one of the things we’ve learned is that what happens in the Mideast, when you have refugees and immigrants that come to the United States, those same problems apply. There’s war and conflict, public health impacts people in the United States also when they come over. Can you tell me how your collaborations have worked together? And first of all, Dr. Hammad, would you please explain your background a little bit? I don’t have all of your work right in front of me. [21:11]

AH: My name is Adnan Haddad. I came to this country back in 1993-1994. I came as an immigrant with two children who were 4 and 2, and my wife. I remember when we lived in the Jerusalem area. We were escaping from what I would call the war conflict. We came as volunteers, maybe refugees to these countries to protect the life our children. That was really our main purpose to come to the United States of America.

We were maybe one of the lucky ones to have education background and professional background that enabled us to work in this country. My wife ended up working at Childen’s Hospital of Michigan and I was lucky and privileged to connect with a community based organization called ACCESS. At that time it was called the Arab Community Center for Economic and Social Services. I interviewed with a gentleman named Ismael Ahmed who used to be the head of the Department of Health and Human Services here in the State of Michigan. Then he was the executive director of ACCESS. I met him at ten o’clock, he gave me the job at eleven and asked me to run a meeting with the Wayne County Health Department at two. [22:50]

CH: You’re a fast learner. [22:56]

AH: The next day he came and he said we feel you came in on a white horse to lead this area, because health was not really well established at ACCESS at that time. The health department at ACCESS was a two-people program and the budget was around $40- or $50,000. He said I can’t really afford to give you a lot of money because I don’t have money here. When I came from Jerusalem I was a hospital director at that time, coming to Michigan. I told him OK, money is not very important but I just wanted to know can I come to work. He said maybe what we’re going to pay you is not going to be enough to come to work. We can pay you $8.15 an hour. [23:50]

CH: Wait, wait. Eight dollars and fifteen cents an hour? [23:53]

AH: Yes. He said this is what we can pay you. When I calculated this money I didn’t have enough to take my kids to day care. I was short about $700 to come to work. Then I went to my wife and I said Raja—Raja is a physician working at the Children’s Hospital in Michigan—and I told her I just fell in love with those people. I really belong here. I want to make a difference to this community. Because you see, like Iman said when he was at Johns Hopkins, my perception about America was what we used to see in the movies—tall buildings and fancy stuff, and I ended up in this [???] end of Dearborn and saw kids without shoes, very poor people, very working class people, very underserved people. And I just felt this is where I can make a difference.

So I asked Raja if she can subsidize my salary to go to work. Raja is a good woman and a good wife, and she said of course. One of us works for a living and the other works for charity. So you go. And this is how we started at ACCESS.

I was privileged to be the founder of ACCESS Community Health and Research Center. And then I took that responsibility to start building new programs, public health programs mainly, and protecting the dignity and health of that community. And this is where I came across to know Dr. Nuwayhid back in 2009, 2010 when I visited with him to join forces in a global health initiative called the Biennial Conference of Health Issues in Arab Communities.

We were planning a conference to have in Aleppo, Syria, but it was canceled because of that conflict. So my new home, because of these deliberations that relate to the principle that even epidemiology does not recognize borders—Mostly what you just said was very true. The impact of the MENA [Middle East and North Africa] region conflict on health directly impacted the Arab-American community.

In my career of 25 years with ACCESS, I have never been outside of the provision of services for refugees. We started with Lebanese refugees, and then the Iraqi refugees, and then the [???] refugees, and then the Bosnian refugees, and now the Syrian refugees. The ACCESS Community Health and Research Center was always the hub, the integrated hub of providing health, mental health, and the full spectrum of public health services and social determinants of health to all those refugees. So it does really impact that.

I remember establishing with other colleagues, good colleagues, at ACCESS, the first psychosocial victims of torture center in the State of Michigan. That was really funded by the Office of Refugee Resettlement. I’m just telling you why we have all these traumas and these psychological setbacks among our refugees, in order to rehabilitate them and be successful Americans for the future.

So yes, I am very privileged to work with Dean Nuwayhid for all these years. We have done a lot of work, both in the MENA region and in the United States of America. I think he has been an effective and productive partner to contribute to all these scientific contributions that relate to other Arab Americans and through the biennial conference on Arab-American health, both in Dearborn, Oman and hopefully next year we’re going to go to Beirut as well, to do one of those conferences. [28:12]

IN: Our faculty sees itself as an institution that’s trying to advance and promote the whole field of public health and improve the health of people in the region as a whole. Although we’re part of a university in the city of Beirut, in Lebanon, we see our role going beyond the country itself. We have built a lot of networks, so the book was actually a networking activity more than simply an intellectual academic activity. It has that other arm of networking, and we connect with academic institutions across the region.

It’s clear to us that the challenges are too many in the region for any institution to deal with them alone. The political borders are real and the political divisions are real and deep and you could use the academic work as a bridge to cross over and work across the Arab world. So when I met Adnan it was like, there’s again a group of people that do belong to the region but are now living outside the region as migrants or refugees in other countries. For us that was another extension of our work.

Of course the Syria conflict crisis accentuated it. It was something that nobody anymore can hide behind the reality that this is a global crisis. It’s not a local one.

If Adnan will allow me—Adnan did not mention that he grew up in a refugee camp and worked hard to get out of the refugee camp, to study and then pursue higher education in the UK, and then go back to Jerusalem, go back to the camp where he was. He insisted on living inside the camp even after doing all that and connecting with refugees. He himself being from that background I think could clarify his commitment and readiness to work. I think this sort of perspective or outlook is what’s bringing him closer to us and us closer to him. [30:45]

CH: Can you tell me how institutions like MSU can contribute to the work that you do? How do we work together with you to advance public health and the different needs that are there? How would that collaboration work for you? [31:11]

IN: One of the most classical ways of doing it, and I think the low-hanging fruits, is to think of students on both sides, students who could come to the region and be exposed to the reality of health in places other than the US or Michigan. And for our students also to come over and learn that again, even here in this country there are challenges that public health professionals still need to address, and the fact that these connections or these challenges are global challenges because they are sort of—the basics of all of this is the issue of justice and equity and making sure that those who do not have, have access at least to certain protective services.

At the level of the faculty members, I do believe that there is a lot of opportunity to do joint research, and research that is relevant to the region, and research whose findings could actually be translated into some actions.

Then you have—specifically in certain programs—you need technical support, technical expertise in certain things. I think just bringing to MSU the whole issue of public health at the regional level, talking about the Arab region, and this connection between the Arab community here, the Arab world, and the two universities will always be a good thing to engage in. [33:09]

AH: I also would like to add that Michigan State University’s engagement program has always been in the forefront of making fruitful working relationships with the Arab American community, through the work that I used to have with Michigan State University, representing ACCESS as its senior director for the Community Health and Research Center. Our relationship with Hi, Miles, and Dr. [Bengt] Arnetz and so many others, from Stephanie and Stephen and—those people have always been engaged in the work that we do.

But one landslide victory that the Arab American community had in collaboration with Michigan State University, in particular, is the advocacy on their part to mark the Arab American community as a minority group in the behavioral health risk survey that is published by the State of Michigan. That was a landslide victory. I fought about 20 years for that inclusion. Because you see, every other year, you see this beautiful book published from the State of Michigan, highlighting the health risk behaviors of the Michigan population, and the way it’s designed, they compare communities. They compare White Americans with African Americans, with Latinos, with—but there is no mention about Arab Americans. Arab Americans do not exist.

That has always been a setback for our community. We can’t advocate for program interventions, we can’t advocate for program development, but most importantly, if I want to ask what is the percentage or rate of mortality or infant mortality rates among Arab American kids in the State of Michigan, no one can give me an answer. If I want to ask the question what is really the rates of breast cancer among women who are 40 and above, no one would give me an answer. So Miles and myself and Hi really worked so hard with the State of Michigan to make this happen. And in 2015 I can’t tell you how happy I was when I saw the first behavioral health risk survey with an Arab American sample. And we’re going to have another one—we increased the sample and the next publication is going to also have the Arab American community.

That was a good partnership. That was an excellent partnership! Very impactful partnership—when we advocate with other states in the United States of America, we tell them look at Michigan. Look how Michigan is treating and viewing the Arab American community in a way that we are now in the statistical books and now we will know how to, ah— [36:44]

CH: Parse that information. [36:46]

AH: Exactly. That was one of the highlights of the collaboration. [36:50]

CH: Thank you for talking about that, because—so when you went to Johns Hopkins and you were studying public health, were there designations for the Arab population? [37:02]

IN, AH: No. [37:05]

CH: I just heard you say usually they were lumped in with Whites or Caucasians? [37:11]

IN: Right. National statistics in the country, here in the US, only recently they are mentioning Middle East but generally speaking we are considered as Whites. [37:28]

CH: OK.

IN: Occasionally individuals are given a choice of whether they—to categorize themselves. [37:36]

CH: To self-identify. [37:37]

IN: Yes, self-identify. The challenge that Adnan and his team face is not only from the State of Michigan, even within the Arab community, because some people in the Arab community were worried about again being stigmatized as a minority. So you have some people in the community who would prefer to be considered White rather than be considered different. This is my guess, that the change was internal and external, because it’s all about identity, and whether if you introduce yourself as an Arab American in a tense political environment, globally and in the country, whether you’re risking yourself. It’s like, as some would say, I don’t want even to identify myself as an Arab because that might raise suspicions in the minds of some.

So this show of identity that I will talk about tomorrow is another thing that we tend to forget, is why do people present themselves—how do they self-identify and how are they perceived by others have an impact on health and your access to health services. Adnan’s argument was if we identify ourselves as Arab Americans, as a minority, then we could get or try to solicit special support, financial and health services and social services that are dedicated and located to the community—while others are saying yes, but this will undermine our integration and might push us into more social exclusion because we are seen as different from the others. In so many different ways what I am talking about tomorrow is exactly about this issue of who am I and how others perceive me impacts my rights, my access to things, how I am treated and all of that. [39:51]

AH: Actually the Chaldean community, when they started to come here, after Iraq, of course they were going through some hardships. Iraq was in bad shape—it’s still in bad shape, by the way—but a huge influx of the Chaldean community came from Iraq to here with the help of the church, because they are Christians and they want to get them out of Iraq. Chaldeans, strictly speaking, they are the mosaic of Iraq. They are the originals of Iraq. They are the descendants of Abraham. And for this community to leave Iraq is just something that does not make you feel this is right because they are one of the original community. They are the ones who spoke Jesus’s language. When they came to Michigan, all their life they are Arabs. They are Iraqis, they are Arabs. When they came to Michigan they don’t want to be associated with Arabs. They don’t want to be associated with Arabs even—of course, it was September 11 and September 11 was harsh on us, very harsh. I started to notice that a Chaldean, instead of wearing a necklace with a little cross, they used to wear a necklace with a bigger cross, like: I am a Christian. Just make sure that— [41:26]

IN: Don’t confuse me— [41:27]

AH: Don’t confuse me with Arabs. I am a Christian [laughs]. I used to ask my friends, why are your crosses becoming ten times more—They say Adnan, it’s September 11. We can’t—so you are right about that. People were very intimidated, very afraid, especially the ones who come from war zones, from war backgrounds. They already are traumatized, and things like this would actually make what I would call retraumatization. Retraumatization is what is reflected in these behaviors, not to associate with— [42:11]

IN: The issue that if you leave a place you are cutting your roots, that’s very traumatic. When you are leaving your country, and this is a place that they’ve been there for thousands of years if you think about it, before the advent of Islam and all that preceded Islam—for them to cut their roots, turn their back to their history and move to a new country, that’s very traumatic. [42:44]

CH: Yes it is. [42:46]

AH: And the whole issue of identity, and over the generations who are we and where did we come from and why— [42:57]

CH: It’s been a great conversation and I want to say this is typically my favorite question of all whenever we talk to anybody and I’ll be interested to hear what you have to say, each of you. What does the future hold—in this particular case, for public health for Arab citizens and Arab immigrants and Arab refugees? [43:29]

IN: I leave the US for you [laughs] and I think if you take things at face value, as what we’re seeing now, it’s not good. One could easily feel pessimistic about the situations we’re talking about over the Arab region now, with war and conflicts in maybe 10 countries— [44:14]

[Miles McNall comes in]

IN: [to Miles] I was sharing with the ladies that if one looks—takes things at face value and just assesses what’s around in the region, one unfortunately comes up with a very gloomy picture—talking about countries in war, we have Syria, Iraq, Yemen, parts of Sudan, Somalia, Libya with active raging wars there. Maybe in Iraq not a war, but—and then you talk about political instability and Lebanon suffers from that, Egypt suffers from that, Tunisia, Algeria now because the president is running for the fifth time at the age of 85 and he has double strokes, and people are going to the street saying enough is enough. And then people are taking to the street saying enough is enough and we need a new president and an open election. The same people are worried that could something happen in Algeria that is similar to Syria and similar to Yemen and other countries.

So that fear of demanding your rights and demanding freedom of speech and change in political systems has come with a very huge price for the region. Add to this the whole Palestinian question and the fact that you still have occupation in the West Bank and Gaza that hasn’t been resolved, it always again adds fuel to that fire. Add to this that the region is water insecure, is food insecure and there’s a minimal network of collaboration. You cannot get out of this. Unfortunately, it’s a gloomy picture.

Yet this is where our road comes in, of saying there are a lot of pockets of hope and in spite of everything that is happening in the region, actually you have more stories of hope and tolerance than the bigger stories or—the noisier stories of hatred and intolerance. I think our road is to make sure that we uncover those stories and we bring hope to people saying that the majority actually are ready to live together, work together, and open up and connect to their countries and to each other. That’s the hope and the optimism that we can never leave.

I think that what Syria did to the region and to the world that shook the whole world, because now it’s no more about people fighting in their own country, it’s everybody is being questioned about what do you do about refugees, what do you do about wars and what are the international responsibilities and duties in that aspect. It’s not like they’re killing each other, that’s their problem, when they figure it out come and tell us.

There’s a lot of things that we can do, going back to your question, what can MSU do is exactly the kind of questioning that cannot be dealt with at the local level and the regional level. These issues are now global and universities like MSU, with the global engagement and outreach program, should be those programs are saying that what’s happening in Africa, what’s happening in Asia, what’s happening in Myanmar and what’s happening in Syria is not a local/regional problem that we observe from afar. It’s something that relates to the politics of this country and other countries, the UN system and all of that. We have all a role in trying at peace, or hope for some kind of change. [48:37]

AH: As Arab-Americans I think we are in this position where we are Arabs but not Arabs and we are Americans but not Americans, and we call ourselves Arab-Americans. Psychologically speaking we are still in contact and in touch with our cultural background and memories of the old country. We still feel strong about investing in the old country by sending our kids to learn Arabic and by building maybe a home, if we have a village there, or just to make sure that we still have our roots. Many Arab-Americans, they have a home here and they have a home in the old country. Also they may be visited once a year or once every three years but they feel very strong about having a home. They feel very strong about having a station that they say yeah, I am Lebanese and I have a home there, or I am Syrian and I have a home there.

That has been the case for the last maybe 120 years, since Arab-Americans came to this country. It was late 1800s, 1880. Their number increased tremendously after the Ford Company started to manufacture cars and why we have the largest concentration of Arab-Americans in the State of Michigan (after [???]) is because of that reason. Ford used to go to Yemen and other parts of the Middle East and bring cheap labor and give them $5 a day. Thousands of Arab men came from the region just to make cars, and we’re still making cars in the State of Michigan.

Having said that, I think we have been struggling and trying to streamline with American society and American civil laws and American culture and American challenges too. I’m a little more hopeful than the region itself because Arab-Americans have been trying very hard to change from within.

This is a lesson that we have learned from our Jewish community in the United States of America. We have learned a good lesson from our Jewish community that in the United States of America, if you want to change your status, you need to change your status from within. This year, for example, the last midterm election, we had two women in the Congress. And I consider this a landslide victory for Arab-Americans and Muslim-Americans to actually have two women. [51:38]

CH: And one of them actually from— [51:41]

AH: One of them from ACCESS.

CH: Yeah.

AH: Me and Rashida [Tlaib] used to talk for hours about stuff at ACCESS. I think this is a good example that this community has been working so hard to change attitude, knowledge, and perception about Arab-American communities.

After September 11 the first thing that we did—I remember I had a presentation to give on Wednesday at university and the coordinator of that presentation on Wednesday told me maybe it’s not a good idea you give a presentation today. She sent me back.

We have planned and implemented the first national Arab American museum in the United States. In less than 15 months we raised $16 million dollars to build that museum. Instead of crying and hiding under the table, we did not leave any single mainstream American organization that we did not visit with.

Actually I went to my neighbor and told him hey, come up, we need to talk because I don’t want you to be confused about Arab-Americans. This is what we stand for, those people do not represent us who did that horrible thing in New York and this is our contributions to the United States of America. Look at my wife, she is a physician, I am a public health doctor, my kids—and of course he had no problem to—but you know that September 11 kind of contaminated the whole thing. And if we were here it pushed us 15 years back or 20 years back.

Instead of being traumatized we really sprang out. We went to the police stations to talk to them, we went to Ford Motor Company, we went to Chrysler, we went to GM, we went to neighbors, we went to all these mainstream organizations—reached out as a community. And I think that was a good strategy to do that, you know.

So where public health fits here: Public health—maybe Dr. Newayhid would agree with me—public health is the only human entity that is left for us to predict our well-being, both in the United States of America and in the MENA region. Because to be honest with you, public health, with its definition as the full spectrum of social determinants of health, it represents integrity, protection of community, access to health, no poverty, good housing, good water and good drinking water. It is the only good thing that is left for people to hold and fight with to protect the dignity and human beings in both the United States of America and the MENA region. And I can see that connection between Arab Americans and the United States of America—we have about 45 million people here and their connection with the MENA region is going to be strengthened in that future because of that relationship. [55:09]

CH: Thank you. [55:16]

[Recording ends]