

Palestinian Citizens of Israel's Compliance with COVID-19 Regulations

Subjects: **Health Policy & Services**

Contributor: Mohammad Khatib , Ivonne Mansbach-Kleinfeld , Doaa Zaid , Anneke Ifrah , Malik Yousef , Ahmad Sheikh Muhammad

With the continuing surge of COVID-19 waves well into 2022, it has become increasingly clear that vaccination alone, which many expected would make the need for behavioral changes redundant, is not sufficient to restrain the spread of the virus and that the adoption of the behavioral changes recommended by public health services worldwide, in particular social distancing and mask wearing, will still be in the future an indispensable part of the strategy to restrict the contagion.

COVID-19

compliance

recommendations

Palestinian citizens of Israel

Arabs in Israel

minority

women's roles

norms

1. Sociodemographic Status of Palestinian Citizens of Israel

Arabs in Israel are an indigenous group that constitutes 21% of Israeli citizens; nearly 80% of them are Muslim, 9% Druze, 10% Christian, and 1% belong to other smaller religious groups ^[1]. Arabs in Israel have individual civil rights albeit with a disadvantaged de jure status in relation to Jewish citizens (see Basic Law: Israel as the Nation-State of the Jewish People). This disadvantage is expressed in many spheres, such as in lower socioeconomic status, higher unemployment rates, lower educational levels, and political and social marginalization ^[2]. In 2021, 38.8% of the Arabs in Israel, 49% of Arab children, and 38.9% of their elderly lived below the poverty line, whereas among non-Orthodox Jews, the average poverty rate for all ages was 11.9%, 13.2% for children, and 15.3% for the elderly ^[3]. High poverty levels have been intensified by the lack of development and government investment in infrastructure, health services, and the educational system in Arab cities and towns ^[4]. Arabs in Israel have poorer health and poorer self-rated health than the Jewish majority ^[5].

Personal insecurity due to increasing levels of organized crime and violence is also a daily concern for all Arabs in Israel ^[6]. Before COVID-19, nearly 37% of Arab men aged 18–23 were not in education, employment, or training (NEET) ^[7]. This situation worsened during the pandemic ^[3]. With few choices available for young people, one solution is to join the ranks of organized crime, which is rampant in Arab cities and towns in Israel ^[8].

Employment among Arab women is much lower than that of their counterparts in the general population (37% as compared with 77%, respectively) ^[4]. Low employment rates are mostly attributable to limited opportunities due to the segregation of their towns and villages and to institutional discrimination, lack of appropriate access to public

transportation, and fewer childcare solutions: only 8% of subsidies for daycare centers in 2020 were allocated to the Arab population, while toddlers in this group comprise 24% of all toddlers in Israel ^[9].

Localities in Israel are assigned a rank according to their socioeconomic conditions, which can be used as a gross proxy measure for socioeconomic status ^[10]. In Israel, 95% of Arab localities, as compared to 17% of Jewish localities, are found in the four lowest socioeconomic ranks ^[11]. Most Arabs in Israel live on the geographic periphery. The mainly Bedouin population in the Southern District is younger than the population in other districts (49% are aged 0–14 years), has a large shortage of health, education, and welfare services, lacks physical infrastructure and employment, and approximately 31% of families report having difficult or extremely difficult living standards, while about 50% of families hardly succeed in securing their monthly needs or do not succeed at all ^[12].

2. Gender Roles among Arabs in Israel

According to Sabbah-Karkabi (2022), patriarchal norms regarding gender roles and family orientation continue to be upheld, and “gendered social values continue to shape family life” ^[13] (p. 2) for Arabs in Israel. “Sociocultural, economic, and political processes were shown to be essential to maintaining family patterns, and educated families, especially those who live in Palestinian localities [Arab cities in Israel], are committed to an established community structure in many aspects of their lives” (pp. 5–6). The importance of keeping traditional values and roles has been dealt with by Blau (1964), who addressed the subject of control mechanisms in cohesive groups and how social control strengthens the group and its individual members, particularly in discriminated and oppressed societies ^[14]. Blau explains the need for reciprocity in social exchange as a symbol of mutual support, much needed in close-knit communities that are frequently discriminated against by mainstream society.

Haj-Yahia and Lavee (2018) claim that although there are variations among Arabs in Israel according mainly to educational level and type of locality, changes in family patterns can be observed insofar as women's education and paid work is concerned; still, most groups are patriarchal and “spouses live together with their husband's extended family, thus restricting the nuclear unit's space, its boundaries and its authority” ^[15] (p. 16). A study among the Bedouin Arab minority in Israel maintains that they are characterized by “collectivistic, authoritarian and patriarchal values ... [and] gender and age-based inequality are prevalent” ^[16] (p. 2). The impact on the modernization process of an increased level of education and reduction in the size of rural society due to the scarcity of land is limited because “Arab cities in Israel are similar to large villages. In Arab cities in Israel, industrialization and economic development—the most significant characteristics of cities that promote processes of modernization—are almost entirely absent ... [with] underdeveloped infrastructure, an absence of industrial plants ... and few industrial zones” ^[15] (p. 29), while intergenerational solidarity due to widespread religious observance, frequent contact between generations, and an agreement on patterns of parenting and marriage help preserve traditional social norms.

Studies on the division of household tasks among Arab families in Israel have dealt with routine housework and childcare, but few studies deal with a woman's caring role for the family's elderly and sick, which requires distinct skills and attitudes from those involved in childcare and has different costs insofar as the emotional involvement,

time expenditure, motivation, and physical strength involved. A study among women aged 60 and older found that Arab society in general and Bedouin Arab society in particular commonly accept that women are the main caregivers who should look after family members, mainly those who suffer from physical or mental illnesses, and that younger women should look after older women ^[16]. Ayalon found that adult children who care for older family members “do it out of duty and respect. Many emphasized their religious tradition that promotes elder care ... [and] emotional and religious obligations ... which dictate strong family solidarity and intergenerational care of the younger generation toward older family members” ^[17] (pp. 846–847). However, she claims care is not shared equally, and it is usually a daughter or daughter-in-law who carries the load. The role of women as the main caretakers of the elderly and sick in the family is not limited to Arabs in Israel, and studies in other countries have found, not unexpectedly, that more daughters than sons provide care to their elderly parents ^[18].

Although there is an increasing conflict between traditional gender roles and the expectations of the growing number of higher-educated working women, still “one of the traditional roles of Muslim Arab women [in Israel] is to be the caregiver, and in particular take care of older members of the family” ^[19] (p. 2207).

Sabbah-Karkaby found that among Arabs in Israel, higher-educated men whose spouse has a similar educational level are more likely than those with a lower educational level to share childcare, although “it seems that when there are children in the 0–5 years age range, which require more intensive caring, it falls mainly on women as social expectations dictate that she is to be the main caregiver” ^[13] (p. 15).

3. Compliance and Gender, Education, Occupation, Age, Chronic Disease, and the Presence of COVID-19 in the Family

Most studies on the relationship between gender and compliance with health-related mandates report that women are more likely than men to agree with restraining measures regarding COVID-19 and to comply with them ^{[20][21][22]}. Surveys carried out through social media worldwide and among Arabs in Israel have found higher compliance rates among women than men and higher general compliance rates among older than younger participants ^[23]. Paramita and others ^[24] stress the importance of social structure and cultural beliefs when explaining gender differences in compliance with COVID-19 containment measures in traditional population groups and maintain that compliance is better explained by the ‘traditional vs. egalitarian’ gender role dichotomy than the ‘male–female’ dichotomy. Studies in developing countries where women have a subordinate role in the household in relation to men have found that women report less compliance or worse self-management than men because they give precedence to the needs of their family members before their own ^[25].

Education has been found in most studies carried out in Western societies to be positively associated to compliance with COVID-19 containment measures ^[21]. Those with lower socioeconomic status are overrepresented among essential workers who cannot exercise proper social distancing, and during the COVID-19 pandemic, a major concern affecting compliance among Arabs in Israel was the loss of income ^[26].

Older persons have been found to have higher compliance rates than younger persons, and this has been mainly attributed to greater risk-taking behavior as well as there being fewer symptoms and a less severity of the disease among younger people [27]. Regarding chronic conditions, a study including 11 countries found a higher compliance among those with chronic conditions than among those without a chronic illness [28]. Additionally, higher compliance rates were found among those who had been infected with COVID-19 or had an infected family member [29].

4. Compliance and Perceptions Regarding the Vulnerability to Infection and the Seriousness of the Disease

The Health Belief Model (HMB) [19] is a popular theoretical framework used to analyze and predict people's preventive health behaviors and their compliance with medical advice [30]. One of its key components is the individual's perceived risk of contracting a disease, which has been found to be correlated significantly with the adoption of preventive health behaviors in diverse populations [30][31]. A study on the self-perceived risk of contracting COVID-19 found that the only consistent predictor for keeping social distance and improved hand hygiene was the fear of COVID-19 [32]. Other studies confirm that the belief in one's personal risk of infection predicts a greater probability of engaging in hand washing and social distancing [33]. In contrast, another study assessing social distancing and mask wearing in the US found that neither the perceived nor actual risk predicted social distancing and mask wearing, but rather, the better predictors were political party affiliation and belief in the importance of compliance [34]. Another study noted that the "perceived severity ... may depend on other non-personal factors such as the proximity of the study population to high risk areas, information, or even the phase of the pandemic in which surveys were administered" [35] (p. 8). A study in Germany found that a lower educational level was associated with a higher perceived severity but a lower perceived probability of being at risk [21]. Regarding the effectiveness of the behavioral change, Georgieva and others [28] found that "people do not mind experiencing a degree of discomfort if they are convinced that the containment measures are effective" (p. 3816). A study including a large international sample found that the strongest facilitators of compliance were wanting to protect the self, feeling a responsibility to protect the community, and being able to work or study remotely, while the strongest barriers included having friends or family who needed help with errands and the need for socializing in order to avoid feeling lonely [36].

5. Compliance and the Content of the Recommendations and Behavioral Changes Required

An important question when analyzing compliance with different recommendations is whether each recommendation should be considered as involving distinct actions that embody and demand specific behavioral changes—and then the emphasis is placed on the characteristics of the recommendation—or whether they should be combined into an overall composite 'compliance index', where the emphasis is placed on the characteristics of the individual who is expected to comply. The choice has important implications insofar as the strategies that the authorities need to adopt in order to increase compliance. Most studies conceptualize compliance with different

recommendations as a single composite index that pits 'compliers against noncompliers' [20][37][38]. Wright and others [27] studied compliance with mandates similar to those in the present research and found high levels of compliance with wearing masks and indoor/outdoor mixing, and somewhat lower rates with hand sanitation and social distancing. However, in their conclusions, they did not analyze the content of the recommendations themselves but rather emphasized the demographic characteristics of the respondents, stating that "most individuals reported broad consistent levels of compliance across the six behaviors ... [and that] individuals choose to comply with all guidelines, rather than some but not others" [27] (p. 250).

Given the cultural differences among the different population groups in Israel, it is important to specifically address the implications of the particular actions required by each recommendation and the potential conflict between the values and norms of Arabs in Israel and the expected behavioral changes. For instance, Goren and others, when analyzing Arab society in Israel, claim that when "members of social groups regard the government's policies as inappropriate for their lifestyles and cultural practices, there will be a weaker association between their technical ability to comply with the government's instructions and their actual intentions of doing so" [39] (p. 3).

References

1. Central Bureau of Statistics. Statistical Abstract of Israel; Central Bureau of Statistics: Jerusalem, Israel, 2022; p. 73.
2. Hadad Haj-Yahya, N.; Saif, I.; Fargeon, B. Arab Society and the Coronavirus Crisis: Entry Data Effects, and Recommendations for a Stronger Recovery. The Israel Institute for Democracy: Jerusalem, Israel, 2020. (In Hebrew)
3. Endbal, M.; Karadi, L.; Pines, R.; Kasir, N. Poverty and Social Gaps: Annual Report: Annex Table 2 (Hebrew); National Insurance Institute-NII: Jerusalem, Israel, 2022.
4. Sheikh Muhammad, A.; Abu-Mukh-Zoabi, L.; Shehadeh, M.; Miaari, S.; Moadi, F.; Fahoum, L. The Reality of Arab Women in Israel, (Arabic); The Galilee Society: Shefa-Amer, Israel, 2012.
5. Khatib, M.; Mansbach-Kleinfeld, I.; Abu-Kaf, S.; Ifrah, A.; Sheikh-Muhammad, A. Correlates of psychological distress and self-rated health among Palestinian citizens of Israel: Findings from the Health and Environment Survey (HESPI). *Isr. J. Health Policy Res.* 2021, 10, 3.
6. Khatib, M.; Sheikh Muhammad, A.; Omar, F.; Rezek-Marjeh, S.; Tanous, O. Perceptions of violence and mistrust in authorities among Palestinians in Israel, an unrecognized public health crisis: A cross-sectional study. *Lancet* 2022, 399, S37.
7. Miaari, S.; Hadad Haj-Yahya, N. NEET among Young Arabs in Israel, (Hebrew); The Israel Democracy Center Institutions: Jerusalem, Israel, 2017.
8. Haj-Yahia, R. This is how young Arabs are recruited for the crime. *Haaretz*, 31 December 2021.

9. State Comptroller and Ombudsman. Report of the State Comptroller; Jerusalem, Israel, 2022. 2022-A-002. Available online: <https://www.mevaker.gov.il/sites/DigitalLibrary/Documents/2022/2022.5/2022.5-Taktzirim-EN.pdf> (accessed on 13 December 2022).
10. Central Bureau of Statistics: Characterization and Classification of Geographical Units by the Socio Economic Level of the Population 2019. Available online: https://www.cbs.gov.il/he/mediarelease/DocLib/2022/375/24_22_375b.pdf (accessed on 23 November 2022).
11. Haddad-Haj Yahya, N.; Khalaily, M.; Rodnitsky, A. The Inaugural Annual Statistical Report on Arab Society in Israel (English Executive Summary); Israel Democracy Institute: Jerusalem, Israel, 2022.
12. Sheikh Muhammad, A.; Khatib, M.; Rezek-Marjeh, S. The Palestinians in Israel; 5th Socio-Economic Survey; The Galilee Society, Rikaz Data Bank: Shefaram, Israel, 2017.
13. Sabbah-Karkabi, M. The diverging gender inequality across households: The case of Palestinian-Arab families in Israel. *Curr. Sociol.* 2022, 1–22.
14. Blau, P.M. *Exchange and Power in Social Life*; Routledge: London, UK, 2017.
15. Haj-Yahia, N.; Lavee, Y. Division of labor and decision-making in Arab families in Israel: Processes of change and preservation. *Marriage Fam. Rev.* 2018, 54, 15–33.
16. Abu-Kaf, S.; Nakash, O.; Hayat, T.; Cohen, M. Social Support and Psychological Distress among the Bedouin Arab Elderly in Israel: The Moderating Role of Gender. *Int. J. Environ. Res. Public Health* 2022, 19, 4358.
17. Ayalon, L. Family relations and elder care among Arabs in the North of Israel. *Res. Aging* 2018, 40, 839–858.
18. Grigoryeva, A. Own gender, sibling's gender, parent's gender: The division of elderly parent care among adult children. *Am. Sociol. Rev.* 2017, 82, 116–146.
19. Vitman-Schorr, A.; Ayalon, L. The changing status of Israeli Arab women as reflected in their role as main caregivers. *J. Fam. Issues* 2020, 41, 2203–2222.
20. Galasso, V.; Pons, V.; Profeta, P.; Becher, M.; Brouard, S.; Foucault, M. Gender differences in COVID-19 attitudes and behavior: Panel evidence from eight countries. *Proc. Natl. Acad. Sci. USA* 2020, 117, 27285–27291.
21. Rattay, P.; Michalski, N.; Domanska, O.M.; Kaltwasser, A.; De Bock, F.; Wieler, L.H.; Jordan, S. Differences in risk perception, knowledge and protective behaviour regarding COVID-19 by education level among women and men in Germany. Results from the COVID-19 Snapshot Monitoring (COSMO) study. *PLoS ONE* 2021, 16, e0251694.

22. Levkovich, I.; Shinan-Altman, S. The impact of gender on emotional reactions, perceived susceptibility and perceived knowledge about COVID-19 among the Israeli public. *Int. Health* 2021, 13, 555–561.
23. Ali-Saleh, O.; Obeid, S. Compliance with COVID-19 Preventive Guidelines Among Minority Communities: The Case of Israeli Arabs. *J. Racial Ethn. Health Disparities* 2022, 10, 1576–1587.
24. Paramita, W.; Rostiani, R.; Winahjoe, S.; Wibowo, A.; Virgosita, R.; Audita, H. Explaining the voluntary compliance to COVID-19 measures: An extrapolation on the gender perspective. *Glob. J. Flex. Syst. Manag.* 2021, 22, 1–18.
25. Ayobami, A.; Abidemi, F. A gender perspective to drug therapy non-compliance among diabetic patients. *Int. J. Soc. Sci. Humanit. Rev.* 2018, 8, 49–56.
26. Bodas, M.; Peleg, K. Self-isolation compliance in the COVID-19 era influenced by compensation: Findings from a recent survey in Israel. *Health Aff.* 2020, 39, 936.
27. Wright, L.; Steptoe, A.; Fancourt, D. Patterns of compliance with COVID-19 preventive behaviours: A latent class analysis of 20 000 UK adults. *J. Epidemiol. Community Health* 2022, 76, 247–253.
28. Georgieva, I.; Lantta, T.; Lickiewicz, J.; Pekara, J.; Wikman, S.; Loseviča, M.; Raveesh, B.N.; Mihai, A.; Lepping, P. Perceived effectiveness, restrictiveness, and compliance with containment measures against the COVID-19 pandemic: An international comparative study in 11 countries. *Int. J. Environ. Res. Public Health* 2021, 18, 3806.
29. Kim, S.; Kim, S. Analysis of the impact of health beliefs and resource factors on preventive behaviors against the COVID-19 pandemic. *Int. J. Environ. Res. Public Health* 2020, 17, 8666.
30. Rosenstock, I.M. The health belief model and preventive health behavior. *Health Educ. Monogr.* 1974, 2, 354–386.
31. Dryhurst, S.; Schneider, C.R.; Kerr, J.; Freeman, A.L.J.; Recchia, G.; van der Bles, A.M.; Spiegelhalter, D.; van der Linden, S. Risk perceptions of COVID-19 around the world. *J. Risk Res.* 2020, 23, 994–1006.
32. Harper, C.A.; Satchell, L.P.; Fido, D.; Latzman, R.D. Functional fear predicts public health compliance in the COVID-19 pandemic. *Int. J. Ment. Health Addict.* 2021, 19, 1875–1888.
33. Wise, T.; Zbozinek, T.D.; Michelini, G.; Hagan, C.C.; Mobbs, D. Changes in risk perception and self-reported protective behaviour during the first week of the COVID-19 pandemic in the United States. *R. Soc. Open Sci.* 2020, 7, 200742.
34. Fullerton, M.K.; Rabb, N.; Mamidipaka, S.; Ungar, L.; Sloman, S.A. Evidence against risk as a motivating driver of COVID-19 preventive behaviors in the United States. *J. Health Psychol.* 2022, 27, 2129–2146.

35. González-Castro, J.L.; Ubillos-Landa, S.; Puente-Martínez, A.; Gracia-Leiva, M. Perceived vulnerability and severity predict adherence to COVID-19 protection measures: The mediating role of instrumental coping. *Front. Psychol.* 2021, 12, 2638.
36. Coroiu, A.; Moran, C.; Campbell, T.; Geller, A.C. Barriers and facilitators of adherence to social distancing recommendations during COVID-19 among a large international sample of adults. *PLoS ONE* 2020, 15, e0239795.
37. Shinan-Altman, S.; Levkovich, I. COVID-19 precautionary behavior: The Israeli case in the initial stage of the outbreak. *BMC Public Health* 2020, 20, 1–7.
38. Clark, C.; Davila, A.; Regis, M.; Kraus, S. Predictors of COVID-19 voluntary compliance behaviors: An international investigation. *Glob. Transit.* 2020, 2, 76–82.
39. Goren, T.; Vashdi, D.R.; Beeri, I. “Apples and Oranges”: Examining social groups’ compliance with government health instructions during the COVID-19 pandemic. *Int. J. Health Policy Manag.* 2021, 11, 1172–1186.

Retrieved from <https://encyclopedia.pub/entry/history/show/107999>