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Serving Refugees in a Pandemic: Insights from Yazidis in the Midwest

Falah N. Rashoka M.S

Megan S. Kelley

Marc A. Garcia

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By Falah Rashoka, Megan S. Kelley, Marc A. Garcia

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There is a critical need for research to examine factors that hinder or facilitate access to healthcare in the context of COVID-19. The coronavirus pandemic has exacerbated barriers to healthcare for marginalized communities globally, leaving many without access to needed health services. Resettled refugees, in particular, must grapple with added challenges to locating and obtaining culturally appropriate healthcare services.

Recent focus groups shed light on the experiences of Yazidi refugees in the U.S. Midwest during COVID-19. Yazidis are a historically persecuted religious and ethnic minority group from northern Iraq (Kizilhan, 2017). Many Yazidis migrated to the U.S. on Special Immigrant Visas after providing interpretation services for the U.S. Army. Focus groups reflected diverse perspectives from health care providers, social workers, Yazidi community members, and cultural centers. Findings reveal four critical areas that limit access to healthcare: (1) language barriers; (2) economic barriers; (3) social barriers; and (4) cultural stigma. In this commentary, we explore how these barriers contribute to adverse health experiences and outcomes during the COVID-19 pandemic, and offer insights relevant to public health practice with marginalized communities.

Language Barriers

Healthcare providers with limited experience serving Yazidis are often unaware that they speak a very distinct Kurdish dialect – Kurmanji. The Kurmanji, Sorani, and Bahdini dialects are so unique that each has its distinct terms for specific medical conditions and diseases. Interpreter services are often provided by phone, which can (1) limit the ability of interpreters to draw on non-verbal cues to enhance communication and (2) add confusion and anxiety to situations that can already be very stressful for patients with Limited English proficiency (LEP) (Mirza et al., 2014; Morris et al., 2009).

The COVID-19 pandemic has led to the implementation of policies designed to limit potential exposure and to make the most of limited personal protective equipment in the healthcare environment. These policies have a disproportionately negative impact on the care provided to individuals with LEP. For example, hospitals and clinics do not allow family members or personal interpreters to interpret in exam rooms. In addition, hospital workers attempt to limit the duration of their exposure to patients, which can be especially detrimental for patient encounters in which a longer time is needed to obtain interpreter services to facilitate effective communication. Together, practices such as these lead to misunderstandings and higher mortality rates among non-English speakers.

Yazidi refugees experience difficulty obtaining accurate information about health conditions and healthcare services. Common health information sources – such as public service announcements, news stories, and clinic brochures are often provided only in English. When translated, these tend to be made available in the languages of more well-established immigrant groups. As a result, Yazidi community members often have inaccurate expectations about healthcare norms and available services; many are unaware of what to do or where to go for COVID-related care.

Economic Barriers

Language barriers often contribute to socioeconomic disparities. Many refugees and immigrants work in low-wage jobs without health insurance. For people with low-wage jobs, affordable housing often coincides with higher population density, lower provider density, greater exposure to pollutants and toxins, limited access to public transportation, and reduced opportunities for protective health behaviors such as healthy eating and physical activity – conditions that increase the risks of exposure to and severity of COVID-19.

Focus group members shared that due to their limited English language skills, many in the Yazidi community work for meatpacking companies. The working conditions in meatpacking plants have made them ideal environments for the proliferation of COVID-19; indeed, they have become COVID-19 hotspots globally (McClure et al., 2020; Middleton, Reintjes, & Lopes, 2020). Employees who contract the virus may pass it on to their family members and neighbors. However, regardless of their higher rates of exposure, the compounded effects of low wages,

high healthcare costs, lack of health insurance, language barriers, and lack of familiarity with the healthcare system lead many the Yazidi refugees to avoid seeking healthcare services when they feel sick or need care.

Social Barriers

The process of cultural adaptation is complex and perhaps especially so for refugees who are forced to flee their countries of origin. Refugees often experience social isolation upon relocation to their new country and can become severed from their social ties, networks, and environments (Makwarimba et al., 2013). The experience of social isolation can be especially salient for the elderly, who may have limited educational and occupational opportunities to connect with others. In addition, the majority of Yazidi refugees experience post-traumatic stress disorder, depression, and anxiety resulting from experiencing attempted genocide at the hands of ISIS in 2014 (Cetorelli et al., 2017). However, cultural attitudes about mental health treatment and other previously addressed barriers keep Yazidi community members from seeking out mental healthcare, even if they personally believe it could be helpful.

COVID-19 has led to the development of new social and cultural expectations that intensify the experience of social isolation. There are limitations upon group gatherings, upon the use of public parks and facilities, and upon business capacity for both employees and consumers. High rates of unemployment due to these limitations, which have disproportionately affected low-wage workers, disconnect people from workplace social networks. Even digital social connection, which depends upon access to technology, is not a reliable option for low-income refugee communities with limited access to technological resources.

Social Stigma

The ongoing COVID-19 crisis has provoked social stigma and discriminatory behaviors towards those affected within many close-knit small refugee communities, particularly recently resettled refugee populations (CDC, 2020). Like many other refugee communities, the Yazidi community in the U.S. is composed of robust social networks; however, social stigma within refugee communities drives individuals to hide the illness to avoid being stigmatized and discriminated against by other community members. Furthermore, stigmatization among individuals with COVID-19 prevents Yazidi refugees from seeking health care to test for COVID-19 and may prevent them from practising healthy behaviors that can prevent the virus's spread.

Refugee women with COVID-19 deliberately continue regular social interactions to prevent future stigmatization and discrimination resulting from negative perceptions about infection and recovery. The combination of stigma and discrimination associated with exposure to the

coronavirus may negatively affect refugees' cognitive and mental health outcomes and lead to an increased sense of isolation, anxiety, and depression.

Conclusion

Public health departments, state and local agencies, healthcare providers, social workers, and others who serve refugees and immigrant populations should coordinate systematic approaches to address common barriers to healthcare that have been exacerbated by COVID-19. Public health, healthcare, and state and local agencies should work closely with refugee and immigrant community members to ensure that COVID-19 testing, treatment, vaccination, and education efforts are accessible, affordable, and culturally and linguistically appropriate to the needs of the community. Timely translation and dissemination of information related to COVID-19 are, for many, a matter of life and death. Organizations should provide reliable translated information about symptoms of COVID-19, where to go for testing, non-pharmaceutical intervention practices such as the use of facial coverings and physical distancing, and how to access community-level resources and updates. Such information should be provided through channels preferred by local communities and might include an element of social connection (Glanz, Rimer, & Viswanath, 2008). Health educators and practitioners may investigate promising practices for facilitating physically distant access to personal interpreters for LEP patients. Adopting an ecological perspective to address barriers at the individual, interpersonal, community, and institutional levels can help service providers develop holistic strategies to meet the needs of refugees and other marginalized populations during the ongoing pandemic.

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About the Authors

Falah N. Rashoka is currently an instructor and doctoral student at the Department of Nutrition and Health Sciences at the University of Nebraska-Lincoln. Also, he is an MPH candidate at the University of Nebraska Medical Center (UNMC) College of Public Health. His research interests focus on healthcare access, health security, health disparities, infectious disease among marginalized communities, and health promotion.

Megan S. Kelley is an assistant professor in the Department of Nutrition and Health Sciences at the University of Nebraska-Lincoln.

Marc A. Garcia is an assistant professor in the Department of Sociology at the University of Nebraska-Lincoln.