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COVID-19 Contagion among Communities with Limited English Proficiency: Lesson from Volunteerism

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Abstract

The COVID-19 affects all communities in the United States, but its impact differs from one community to another. Undoubtedly, the vulnerable populations are more impacted than others, especially refugees and immigrants. This study seeks to understand the impact of COVID-19 on marginalized communities and the need to communicate health-related information equally. A lesson learned from observation during an ongoing pandemic, including what I learned through my volunteer work between mid-March and August 2020. The study finds that neighbors with limited English Proficiency (LEP) and limited education could quickly transfer the COVID-19 virus to another neighbor with high income and well-educated. Disparities in access to care and underlying causes among LEP communities may lead to spreading the virus. Making health information available in different languages and more TV channels and radios that disseminate COVID-19 information in multiple languages is essential. It is imperative for public health during the resiliency process to thoroughly

prepare and consider vulnerable communities' health and need to legislate proper health communication and education for all for any possible pandemic in the future.

Introduction

The COVID-19 affects all communities in the United States and globally, but its influence varies from one community to another and poignant in rural areas (Mueller et al., 2021). Indeed, the marginalized populations are more impacted than others, especially refugees and immigrants (Laurencin & McClinton, 2020). It is most likely due to language barriers and a lack of knowledge about health information availability. Since the first day of the pandemic, as a doctoral student, I had joined the Student Response Team (SRT) to volunteer at different places across the State of Nebraska. My volunteer duties included being a professional and experienced interpreter for the Arabic and Kurdish languages with all their dialects and as a public health professional (Chengane, Cheney, Garth, & Medcalf, 2020). COVID-19 in Nebraska communities showed tremendous disparities in accessing health care services and the way of obtaining the correct health information. This problem has been exacerbated among refugees and immigrants with limited English proficiency (LEP) across the state (McClure, Vasudevan, Bailey, Patel, & Robinson, 2020; Middleton, Reintjes, & Lopes, 2020).

The study data was collected between March 2020 and August 2020 by joining as a volunteer to the Student Response Team (SRT), State Health Departments, Community Centers, and other places across Nebraska. This study included observing individuals with COVID-19 issues that the researcher contacted through volunteer work as an interpreter for both Kurdish and Arabic languages and healthcare professionals. The themes developed through taking notice after each contact. Majority of individuals observed were refugees and immigrants.

A lesson learned from my volunteerism may change the direction of public health and services provided to LEP communities in the United States. The COVID-19 shows that even if individuals are not equal in acquiring the disease, they may equally transfer it to other healthy people. The high morbidity rate among LEP refugees in the United States made it clear from the public health lens that it calls for action to give more attention to such communities because we are all together in this pandemic. During contact tracing, I noticed that many people had perceived the virus due to an insufficiency in knowing how to protect themselves from the infection. Countless people have experienced and

took the necessary steps of prevention, but they were unable to apply it correctly, which resulted in being infected (Van den Broucke, 2020).

Furthermore, minor health care prevention made many of them contact the virus. Instead of social distancing, many individuals from refugee communities necessitated care of minor items such as cleaning door handlers, leaving other necessary steps as fundamental prevention aside. The message sent by a public health professional were misinterpreted to communities with language barriers.

Communities with LEP health information sources

American Community Survey analyzed data from the U.S Census Bureau in 2015 cited that one in 10 adults in the United States reports LEP (U.S. Census Bureau, 2015). Many refugees and immigrants are most often unaware of health service availability and lack of knowledge about health care services in the United States. During the first three months of the pandemic, LEP communities depended on the information about COVID-19 from sources of their country of origin and in their native language (Gallotti, Valle, Castaldo, Sacco, & De Domenico, 2020). Many of those countries were presuming that viruses did not exist, and its political game made the morbidity rate high among refugees (Al-kuraishy, 2021; Mesa Vieira, Franco, Gómez Restrepo, & Abel, 2020). Health departments and public health professionals' role was imperfect in disseminating health information in refugees' preferred language at the beginning of the pandemic, which pushed them to look for untrusted health information from their country of origin.

Furthermore, I noticed from my volunteerism as interpreters that many individuals from those communities felt a governmental agency had forgotten them as well as public health when they found themselves with no health insurance. Besides, working in places where virus prevalence is high, such as meatpacking companies and Walmart, put refugees and immigrants at high risk of contracting the virus. 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).

Additionally, the public health departments across the states lack proper interpreters with solid health backgrounds (Mesa Vieira et al., 2020).

Many interpreters had violated patients with COVID-19 privacy by declassifying patient's information to their communities. Besides, through looking at patient social media account to check for the infected individuals' last movement.

Your Neighbor May Infect You

Disparities in accessing health care and making health care services available for a group of people while others didn't obtain it could affect all equally. Likewise, social factors and family income might interfere during a pandemic. As a lesson from volunteerism, I learned that any neighbor with LEP, no health insurance, low income, and little education could quickly transfer the COVID-19 virus to another neighbor with high income and well-educated. This is a risky situation that could end other neighbor life due to health disparities. Our individual actions matter with COVID-19, and that could harm another. The public health professional may take this point in their consideration, moving forward in the resiliency process.

Underlying Causes

Study data revealed that several factors contribute to the severity of the virus related to the length of exposure, type of exposure, and personal genetics (Laurencin & McClinton, 2020). But these studies overlooked marginalized communities with rare dialects. Additionally, the availability of information in different languages and having more Tv channels and radios that disseminate COVID-19 information in the language they prefer made many individuals prefer to go to other sources that might not be trusted sources for health information. Social determinants of health and health literacy among the marginalized population across the state were overlooked for years. Marginalized communities had no idea where to go for testing and what the instruction is and when they should go for testing making these communities slow to recover (Dodds & Fakoya, 2020). The ability to access healthcare services in such communities is usually endangered and exacerbated by language obstacles and lack of health insurance.

The Implication for Public Health Practice

It is imperative for public health during the resiliency process to thoroughly prepare and take vulnerable communities' health in their consideration for any possible pandemic in the future. Public health should move toward creating a creative health promotion approach based on scientific knowledge targeting communities with LEP and other vulnerable populations in low-income neighborhoods. It is essential to

look at all individuals from the lens of the new public health approach. The neighbor with low income and LEP could risk close when transferring the virus.

The public health departments should hire more health care professionals with the ability to speak more than one dialect and language. They should be well prepared with a robust medical background and knowledge of the Health Insurance Portability and Accountability Act (HIPAA) privacy. Future consideration needs to make more funds available for the health departments across the country and encourage them to be more autonomous and empower creativity in their practice. Inequality in representing individuals from many underrepresented groups in the U.S. in the public health field made COVID-19 hitting some of these communities so hard. Public health should address health disparities and social determinants of health through the socio-ecological model's implication at the early stages of any pandemic. Recovering from COVID-19 requires building a robust public health system taking marginalized communities as a starting spot. Living conditions for refugees and immigrants can weaken the ability to follow public health guidance, including basic hygiene measures, quarantine, or self-isolation. Many refugees are in close contact and gather in groups due to their strong social ties.

Conclusion

As a lesson learned from volunteerism, there is an urgent need to implement universal health coverage to eliminate healthcare system access disparities. In times such as the current pandemic, the healthcare providers and public health staff can't work to protect a group of individuals while leaving others spreading the infection. Public health departments and healthcare providers need to be occupied with robust health literacy knowledge and hire more employers from underserved groups who speak more than one language. Finally, it's time to legislate proper health communication and education for all, taking marginalized communities as a standpoint.

References

1. Al-kuraishy HM (2021). Witchcraft and Myths about Covid-19 in Iraq. *Journal of Conventional Knowledge and Holistic Health*, 5 (1), Article ID 211
2. Chengane, S., Cheney, A., Garth, S., & Medcalf, S. (2020). The COVID-19 response in Nebraska: How students answered the call. *Preventing Chronic Disease*, 17 doi:10.5888/pcd17.200269

3. Dodds, C., & Fakoya, I. (2020). Covid-19: Ensuring equality of access to testing for ethnic minorities. *BMJ* 2020;369;m2122 doi:10.1136/bmj.m2122
4. Gallotti, R., Valle, F., Castaldo, N., Sacco, P., & De Domenico, M. (2020). Assessing the risks of ‘infodemics’ in response to COVID-19 epidemics. *Nature Human Behaviour*, 4(12), 1285-1293. doi:10.1038/s41562-020-00994-6
5. Laurencin, C. T., & McClinton, A. (2020). The COVID-19 pandemic: A call to action to identify and address racial and ethnic disparities. *Journal of Racial and Ethnic Health Disparities*, 7(3), 398-402. doi:10.1007/s40615-020-00756-0
6. McClure, E. S., Vasudevan, P., Bailey, Z., Patel, S., & Robinson, W. R. (2020). Racial capitalism within public health—how occupational settings drive COVID-19 disparities. *American Journal of Epidemiology*, 189(11), 1244-1253. 2020. doi:10.1093/aje/kwaa126.
7. Mesa Vieira, C., Franco, O. H., Gómez Restrepo, C., & Abel, T. (2020). COVID-19: The forgotten priorities of the pandemic. *Maturitas*, 136, 38-41. doi:10.1016/j.maturitas.2020.04.004
8. Middleton, J., Reintjes, R., & Lopes, H. (2020). Meat plants—a new front line in the covid-19 pandemic. *BMJ* 2020; 370 doi: <https://doi.org/10.1136/bmj.m2716>
9. Mueller, J. T., McConnell, K., Burow, P. B., Pofahl, K., Merdjanoff, A. A., & Farrell, J. (2021). Impacts of the COVID-19 pandemic on rural America. *Proceeding of the National Academy of Sciences (PNAS)*, 118(1). doi:10.1073/pnas.2019378118
10. S. Census Bureau. (2015, October 28). Detailed Languages Spoken at Home and Ability to Speak English. Retrieved from <https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html>
11. Van den Broucke, S. (2020). Why health promotion matters to the COVID-19 pandemic, and vice versa. *Health Promotion International*, 35(2), 181-186. doi:10.1093/heapro/daa042