THE HEALTH OF MIDDLE EASTERN IMMIGRANTS/REFUGEES IN THE U.S. AND THE BARRIERS THEY FACE TO CARE: A REVIEW

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

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May 2021

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ABSTRACT

Immigrants and refugees in the U.S. tend to face many significant difficulties in obtaining good health care. In this analysis, I review what is known and unique about the health of Middle Eastern immigrants/refugees in the U.S., with a particular focus on Iraqis, and identify the barriers to healthcare that they commonly face. The most significant obstacles noted include cultural and religious differences, poverty, discrimination and distrust, and language barriers. In the process of discussing these factors, I reveal how this population understands health in the context of their religion and of their migration status. I also extrapolate how the barriers they face are likely to be exacerbated due to the COVID-19 pandemic and postulate solutions to these issues.

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CHAPTER 1: INTRODUCTION

My father left Baghdad and came to the U.S. alone in 1980, at only 18 years old. At that time, he felt that a war between Iraq and Iran would be inevitable, and he did not want to start the next chapter of his life in that kind of environment. Instead, he applied to a university in Toledo, Ohio and later transferred to Temple University in Philadelphia to pursue a bachelor's degree in engineering. A few years later, my mom came to join him. Her family had always been publicly opposed to the regime of Sadaam Hussein, and Sadaam's administration retaliated by forcing my grandfather into retirement and coercing my mother to work with his political affiliates after she completed her bachelor's degree in architecture. She did not want the position, but Sadaam's allies made it clear that she would never be able to get another job in the country if she did not do what she was told. Rather than give in to his intimidation, she married my father and applied for a master's in interior design at Drexel University, allowing her to begin the process of immigrating to the U.S.

Over time, my parents not only built a family here; they also helped build a community of Arab Americans in the Northeast. When their friends from Iraq considered leaving the country, my parents encouraged them to come to Philadelphia. As the years went by, their small group grew larger and began to include immigrants from other Arab countries, such as Egypt, Lebanon, Turkey, and Morocco. I think back to my childhood and remember the rich culture that my parents integrated into our lives, with the Arabic language flowing across our tongues and the Mediterranean flavors in our satisfied bellies. We always had a village of chai-drinking aunties and uncles in our home,

teaching us the poetry they grew up with and the traditional dances that they hoped to one day perform at our weddings. Our families had achieved the "American Dream," and we felt safe – at least for a while.

Most Americans can tell you exactly where they were and what they were doing when the events of 9/11 occurred. In my case, I was sitting in my 4th grade homeroom in a private Catholic school when my teacher turned on the classroom's television to watch the news. I didn't understand what was happening at the time; all I knew was that people started looking at me differently. People were scared of me—a 9-year-old American Muslim girl whose parents came from Iraq to escape the dictatorship of Sadaam Hussein. While others look back at the days following the attack on the Twin Towers as a time when "we were all Americans," I look back at those days as a time when I was feared and hated for something that I had no control over. My older brother had a worse time than I did; he was bullied by students in his class for looking "like a terrorist." The taunts and acts of malice followed us home as well. I even remember coming home one day to find a dead bird in our family's mailbox. I couldn't understand how it had gotten in there; I imagined all the scenarios in which it could have flown in and gotten stuck. My mom only shook her head and ushered me into the house; she knew, as I do now, that someone had left it there for us to find.

Even after I moved on to high school and college, I still felt the lingering judgment from the events that occurred at the Twin Towers years before. Certain people didn't want to get to know me, or even to learn my name. I began to gravitate toward other "non-White" students and colleagues, who readily accepted me into their friend groups. Despite often being the only Arab and Muslim person in my class, I was able to

connect with minority students from all different backgrounds over the discomfort we sometimes felt in our predominantly White Catholic neighborhoods. I realized that we shared a unique bond tied to our status as first generation American-born children of immigrant parents, a bond that was independent of our actual religion or ethnicity. The sacrifices our parents made for us gave us a sense of gratitude and pride, but we recognized that they came with personal hardships. We all wanted to give back, and one of the ways I personally did that was by volunteering with an organization called Refugee Health Partners (RHP). One of the many roles of RHP was to arrange student-run health clinics geared toward refugee and immigrant populations in South Philadelphia. It was during that period of time that my eyes opened up to all the obstacles this group of patients faces in regard to maintaining good health. I found that most of these men and women had poor health literacy, which was only compounded by their struggle with comprehending the English language. They also struggled to afford their medications and find childcare to freely attend medical appointments. Many had chronic, uncontrolled health conditions due to lack of follow up with their physicians and confusion about their treatment options. The student-run clinics attempted to bridge some of these gaps in care by working with language interpreters, offering ESL courses, and providing free or discounted services whenever available, but I knew the problem was more widespread than what I was seeing in this one pocket of Philadelphia. Whereas the population I worked with at the clinic was mostly Bhutanese, there was a small subset of Iraqis located mostly in the Northeast that was also served by RHP. I began to wonder if these Iraqis and their peers shared similar healthcare-related concerns, a topic that has been of special interest to me since then.

In this thesis, I will review what is known and unique about the health of Middle Eastern immigrants/refugees in the U.S., with a particular focus on Iraqis, and identify the barriers to healthcare that they commonly face. In the process of doing so, I will reveal how this population understands health in the context of their religion and of their migration status. I will also extrapolate how the barriers they face are likely to be exacerbated due to the COVID-19 pandemic and postulate solutions to these issues.

CHAPTER 2: METHODS

In preparation of writing this thesis, I performed a literature review to find out what information already exists in regard to the health of Iraqi or Middle Eastern immigrants and refugees. It is important to define the terms "refugee" versus "immigrant". A refugee is, "any person who has been *forced* to flee their country due to war, persecution, or because their home government cannot or will not protect them" (Mack, 2020). Refugees must register with an official agency that allows them to gain access to state and international resources aid while settling into their new environments, and they are afforded certain legal protections that include economic and social rights. An immigrant, on the other hand, is "an individual who *willingly* leaves their country of origin and legally enters another country where they are granted permission to permanently resettle" (Mack, 2020). Immigrants may choose to resettle for many reasons, including the desire for a better education or new job opportunities. To illustrate, while my parents' decision to leave the Middle East was motivated by the threats of war and an unsupportive government, they were not refugees; they were immigrants who made a conscious decision to relocate and settle down in the U.S. Whereas refugees and immigrants share similarities in terms of barriers to health, certain factors discussed below disproportionately affect refugees by virtue of the urgency with which they often have to leave their homes and families behind.

During my literature search, I found several articles that described both physical and mental health in refugees and immigrants, particularly after 9/11. I also found qualitative studies in which Iraqi refugee women in the U.S. were interviewed about their perceptions regarding their health and healthcare in the U.S. After gathering this

information, I decided to informally interview several Arab American immigrants, refugees, and their children in my own community in Philadelphia in order to hear and compile their personal stories. I asked each of them to share anecdotes about 1) “racisim or discrimination you or someone you know has faced in the U.S. following the events of 9/11,” 2) “biases you have experienced in health care related to your race or religion,” or 3) “any other barriers to health care that you or a loved one has experienced.” Each person gave me permission to share their quotes anonymously in order to help demonstrate the obstacles that this population faces in maintaining good health in the United States. I then weaved these stories into my thesis, as illustrated below.

CHAPTER 3: PERCEPTION OF HEALTH IN IRAQI REFUGEES

In 2014, Salman and Resick published a qualitative study describing health among twelve Iraqi refugee women who resettled to an eastern city in the U.S. between 2003 and 2010. Some general themes emerged from interviews with these women about how they perceive health. Overall, these women felt that health is a highly valued treasure and a gift from God. They described the definition of health as the ability to function in their daily roles, free from physical symptoms of illness. One participant explained, "health is involved in the way you take care of your family, how you live your life. If you're healthy, you can fulfill all of the duties outside and inside the house." Others described health as being safe and secure, noting that being in unsafe situations with their families made them feel sick. Back in Iraq, men, women, and children were often targeted for violence, murder, or kidnapping by both civilians and armed groups, whether for money, for revenge, or as punishment for their political affiliations. Families had to flee to survive, but they suffered from lack of food, shelter, and access to health care during this time. One woman declared, "...we just wanted to be safe because our lives (both her husband's and hers), my kid's life, was in danger at that time...I was sick!" (Salman and Resick, 2015). She expressed hope for a safe haven for herself and her family so that she could stop worrying about the future and therefore feel well.

In the context of resettlement, however, these women still noted poor physical and mental health, including symptoms of abdominal pain, anxiety, chronic disease, thyroid disease, and other psychosomatic illnesses. One explained, "Physically, my body is healthy, mentally—no… Yes, I cry more nowadays and get upset more" (Salman and

Resick, 2015). This feeling is not limited to one person. Previous research on the mental health of Iraqi immigrants has shown that 50% of this population experiences emotional distress, anxiety, and depression (Taylor et al, 2014), while 31% experiences clinically significant PTSD (Jamil et al, 2005). A large contributing factor to this poor mental health was related to grieving. The women in this study experienced huge losses in leaving their friends, their homes, and their lives behind. "When we had to sell the house that we lived in, it's like we were pulled from our roots," one participant lamented. Another, who had to leave her married daughters behind with their husbands, disclosed, "how can I live here and my girls are far away from me? I cannot focus; this is what keeps making me sick" (Salman and Resick, 2015). This indicates that the departure from their home and family seemed to have a particularly strong effect on these women's wellbeing.

The participants described fear and helplessness related to lack of employment, despite some of them having high levels of education and experience in Iraq. They mentioned unexpected differences in health systems as a major barrier to health. In Iraq, every citizen is entitled to receive free health care, whereas being in the U.S. brought up new concepts of health insurance, obtaining prescriptions for medications, and long waits to schedule appointments with a primary care physician. One frustrated participant remarked, "When somebody gets sick you have to make an appointment with the doctor. What is the value of this appointment 2 weeks later than when you actually need it? […] At times, you can go to the doctor, and they won't give you medicine even though you are sick. At most, they will tell you to take over-the-counter medicine" (Salman and

Resick, 2015). Another study that sought to understand barriers to care among Iraqi refugee women in the U.S. found similar results. These women noted complexities in the U.S. healthcare system such as difficulty contacting clinics, long wait times, lack of follow up of test results, and unclear or incomplete treatment plans as reasons that they only sought care when they really felt unwell. Some felt that they were ignored or not believed by physicians. One complained, “I left Iraq to find a better life, but unfortunately, I believe that the medical treatment in Iraq is better! Nobody believes us here. They make us feel like we are liars when we talk about our sicknesses and about our symptoms” (Perfetti et al, 2019). With little support after such losses and trauma, it is no wonder why refugees perceive their physical and mental health as poor.

CHAPTER 4: RELIGIOUS AND CULTURAL DIFFERENCES

A majority of Arabs coming from the Middle East in recent decades are Muslims settling into a majority-Christian country. As such, the contrast in religious beliefs can cause some misunderstandings and hesitation with respect to seeking medical care in the U.S. Although it is not mandatory, many Arab-Muslim patients desire to be treated by Arab-Muslim healthcare providers that appreciate their cultural and religious backgrounds; that being said, this desire cannot always be met. Only 1.5% of physicians in the U.S. in 2015 were Arab American (Thomas and Page, 2017). Therefore, understanding Islam's relationship with medicine is vital to physicians practicing in areas with large Arab-American Muslim populations. Despite some misconceptions, Islam challenges its followers to seek out education and to learn as much as we can about science and medicine. According to the Quran, God gifted us with our bodies, and it is our responsibility to take care of them. When we are struck by illness, there are two possible causes: the disease is either a test from God or a consequence of *hasad* (envy), embodied in the Quran as the "evil eye." In either circumstance, in addition to prayer for health and protection, we are expected to engage in healthy lifestyle choices and learn as much as we can about available medical therapies to cure disease. These treatment options are considered favors granted by God for our use. As time goes on and new medical advancements develop, we are encouraged to discuss more ethically questioned practices (e.g. elective abortion; organ donation; use of assisted reproductive technologies) with religious clergy to come to a determination about the permissibility of the procedure. In this way, Islamic authorities play an important role in determining

Islamic bioethical opinions and are often just as central to medical decision making as doctors (Inhorn and Serour, 2011).

In addition to understanding the general relationship that Islam has with medicine, physicians need to appreciate some of the daily practices that Muslims observe. Many Muslim patients participate in the daily fast from sunrise to sunset during the holy month of Ramadan; while those who are ill, pregnant, or elderly are exempt, many patients who take medications for chronic conditions still wish to participate and consult their physicians regarding changes to their medication schedule. For instance, a man in my community who suffers from diabetes worked with his primary care doctor to determine a new insulin regimen during Ramadan that would allow him to fast without inadvertently dropping his blood sugar levels too low. Other considerations with pious Muslim patients include their desire to eat halal meals (Islamically-butchered meat, pork-free, alcohol-free), their reluctance to undress for examination in front of an opposite-sex provider, and certain end-of-life practices that include a pilgrimage to Mecca (*hajj)* prior to death as well as particular customs of washing and handling a body for immediate burial after death.

There are numerous hospital systems that attempt to address the general lack of knowledge about different cultural practices during "Cultural Competency" courses, but I have been disappointed with the execution of some of these lessons. One of my colleagues once noted, "I learned that when a Muslim woman comes into the hospital with her husband, you shouldn't address her; you should only talk to her husband." While there are certainly pious Muslims who do believe this, women are generally able to make their own healthcare decisions and may not always want their husbands to be involved in

the process. The bottom line is that not all Muslims are alike; we all come from different backgrounds and have different levels of piety. Therefore, it is important to be aware of the variety of practices and to ask patients about their preferences before making any assumptions.

CHAPTER 5: POVERTY FOLLOWING RESETTLEMENT

One of the most common barriers to healthcare faced by minority groups in the U.S. is poverty, and this is no exception in the Arab American community. Often, the resettlement process that refugee groups undergo drives and reinforces the lack of resources and capital in this population; this is exactly what happened for many Iraqi families that I met through my work with Refugee Health Partners. The Iraqi refugee crisis began in February 2006, after the bombing of the Golden Mosque in Samara -- a holy site for Shiite Muslims -- sparked a civil war between the Shiite and Sunni Muslims in Iraq. Millions were forced to flee their homes; while some relocated to Syria (which later faced its own war), more than 142,000 refugees resettled in the U.S. over the next twelve years with the help of multiple resettlement agencies (Perfetti et al, 2019). While prior Iraqi immigrants had been educated middle-class families fortunate enough to escape the regime of Sadaam Hussein, this group of Iraqis were mostly uneducated, monolingual Arabic-only speakers from a low socioeconomic status (Inhorn and Serour, 2011). Daniel Masterson, a prior employee of the United Nations High Commission for Refugees (UNHCR), wrote an essay describing the problems with the Iraqi Refugee Resettlement program. He explained that the U.S. government purchases plane tickets for refugees to get to the U.S., but this purchase is considered a loan that needs to be repaid. Refugees are then given a one-time payment of $450 for housing, 80 days of free health insurance, and 1-3 months of resources to assist with settling in. Once this support ends, refugees are left to navigate this new country on their own; many struggle to find work, especially with limited English language proficiency (Masterson, 2010).

Along with other programs, such as the US Refugee Admissions Program (USRAP), the UNHRC initially resettled many refugees in and around Detroit, Michigan, where prior Iraqi immigrants had moved when the city was experiencing an economic high. However, with rising rates of unemployment in this population given the economic decline of the automobile industry, resettlement to this area stopped. At that point, many Iraqi refugees were forced to either work in low-wage positions (e.g. store clerks, gas station attendants) or rely on the U.S. welfare system to provide for themselves and their families (Inhorn and Serour, 2011). Even populations of Iraqis resettled in different parts of the U.S., such as Philadelphia, faced economic hardships that contribute to difficulties accessing medical and dental care. A participant in one research focus group, who happened to be a widow, noted: "I don't have anyone at home to help me and I have 4 kids. The welfare programs provide food stamps and some money. I got $750. How are we supposed to survive?" (Perfetti et al, 2019). Another participant shared her own narrative:

> "I tried to rent an apartment but they tell you that you don't have sufficient credit because I don't have a paycheck. And you know the apartment is full of bed bugs and the kids are crying all the time but there is nowhere to go. Recently some kind people gave us new mattresses so I stayed. This is a huge burden that affects our health" (Perfetti et al, 2019).

This situation highlights the point that Masterson makes: these resettlement programs do not provide sufficient resources for refugees to thrive once they arrive to the U.S. He proposes: 1) "Increasing the amount of resettlement funding per refugee," which may

necessitate decreasing the number of refugees resettled under the program; 2) "Coordinating efforts with local resettlement agencies to identify Iraqis who are most vulnerable to hardship in the U.S. and focusing additional resources on their cases"; 3) "Increasing orientation and educational programs for Iraqis before and after resettlement"; and 4) "Regularizing the number of Iraqi resettlements per month per region" to allow social service agencies to appropriately adjust their staffing and resources (Masterson, 2010).

While these steps would certainly improve the quality of life of Iraqi refugees, poverty is not the only issue. Following 9/11, the relationship between Arabs/Arab Americans and the U.S. government had significantly changed. As noted by Shah and colleagues,

> "The aftermath of September 11th damaged previously established trust between Arab American immigrants and government agencies, causing Arab American immigrants to stay away from any public service, including health care, that appears to be connected to the U.S. government" (Shah et al, 2008).

This new level of distrust did not just affect immigrants and refugees; it also affected their first-generation U.S. born children.

CHAPTER 6: DISCRIMINATION AND DISTRUST

My post-9/11 experience, described in my earlier introduction, is in no way unique. There is no shortage of tales about discrimination that Arabs and Muslims have faced in this country, such as being "randomly" chosen for extra security checks at the airport or asked to remove a *hijab* (religious head scarf) to prove that there is no concealed weapon beneath. One of my peers noted:

> "This is just the standard TSA Islamophobia that every Muslim/Muslim-appearing person gets when at the airport. I cannot count the number of times I had my hijab patted down, and my hands tested for chemicals. It's easy to say it's standard protocol for TSA to always use those giant body scanners instead of the simple metal detectors, but I distinctly remember walking up to the line where people were just told to go through the metal detector. Then I swear, as soon as they saw me, they switched over to the full-body scanner, and I was treated to the works, lucky me."

These increased security checks often cause problems for Arab and Muslim travelers that wish to cross borders into and out of the U.S. For example, I have cousins in Toronto that often travel to the U.S. for leisure and to visit our grandparents. One time, my Iraqi-born cousin was driving to New York with his Canadian friends. As was common, he was asked to pull over at the border for an extra security check; however, on this particular occasion, his friends were each separated and interviewed about how they knew my cousin and why they were traveling to the U.S. with him. They were shocked that this was a normal occurrence for him. Other friends of mine have had similar experiences:

> "My family used to live in this very small town close to the border of Canada. We used to spend so much time there for shopping, eating, visiting family and friends. We never had any issue going back and forth across the border. In fact, my father (who was a chaplain at the correctional facility) knew some of the customs officers stationed there. After 9/11 happened, that ease disappeared completely. […] It seemed like every time we wanted to cross the border, we were stopped and made to exit the car to have it searched. I became very familiar with the border patrol holding room. […] It got to the point where we just expected to be pulled over, if not from seeing my father's name, then from seeing my mom's hijab, or the color of our skin. We stopped going as much after that."

Sometimes, the discrimination and ignorance we (Muslims) face on a daily basis are more of annoyances in our lives. When my mother first immigrated to the U.S., the mostly white students in her master's program were shocked that she was driving a car to school. They (very sincerely) asked her, "You know how to drive? I thought people rode camels for transportation in your country." She had to take the time to teach all of her classmates and future colleagues about just how advanced "her country" is, explaining that she had learned how to drive when she was 15 years old. Now, more than 30 years later, many stereotypes about Middle Eastern people still exist. For instance, most of my strong, well-educated, and *very* independent female friends who choose to wear hijab as a symbol of their devotion to God have endured lectures by white non-Muslims about how

this accessory is a symbol of oppression by presumably controlling and abusive Arab men. Some people find it best to respond to certain situations with laughter, as my pharmacy-employed friend did when receiving this gift from a customer:

> "Today, a lady in the drive through said, 'I have something for you,' and handed me a bible. She said, 'you need Jesus.' I put it back in her bag along with her prescription. I laughed so much when she left. My White coworkers didn't laugh at first because they thought I might be offended, but once I laughed, they did too."

Occasionally, however, the only rational response can be fear. One qualitative, focus-group study (n=36) of Arab American immigrants in New York City revealed that women wearing the hijab were often victims of physical harm or other threatening behavior because they are so easily identifiable as Muslim (Inhorn and Serour, 2011). Some of them were also denied access to housing and public services based on their appearance. Other studies have shown that many Arab immigrants fear racial profiling and deportation as consequences of being Arab in a post-9/11 America (Inhorn and Serour, 2011). Because of these concerns, some immigrants try to change and hide who they are. One of my mother's friends immigrated to the U.S. several years ago and stopped wearing her hijab altogether out of concern for herself and her family's wellbeing after receiving threats by neighbors in her community. These are all considerations that many outwardly Muslim-appearing individuals face when seeking care from White, non-Muslim physicians.

There was one particularly interesting story I was told by a young Syrian woman that agreed to share her experience of going to the ER with me:

> "One time after I waited in the hospital to be seen for 5 hours, the doctor told me my abdominal pain is psychological and I'm making it up. He did blood work but didn't bother doing any ultrasounds/MRI, etc. So I had to suffer for 5 months until I found a Middle Eastern doctor who believed me enough to run more tests and found out my gallbladder that was inflamed and needed to be removed immediately."

What I found most significant about this narrative is not necessarily what the doctor did or said to her. It's how she *perceived* his words and his actions as discriminatory. There is no way to know now why the doctor chose not to order further tests for her pain, but her perception of his actions as racially motivated drove her toward a physician that she felt she could trust on the basis of his Middle Eastern background. Another friend shared a story about coming to terms with her mother's hesitation to see her doctor due to feeling like he would not listen to her:

> "This one time, I was home and able to go with my mom to her annual check-up. Her doctor was so cold and impersonal. My mom was quiet during it, mainly just answering yes or no to her questions, but even when she did bring up some other issues or questions in her heavily accented English, the doctor barely acknowledged her. It was such a quick visit that I felt accomplished nothing. […] I remember how uncomfortable she was

> in that room with someone who is supposed to take care of her and know her, and honestly, how can I fault her for not confiding in someone who is basically a stranger, someone who she doesn't trust to have her best interests at heart?"

Other studies have found similar accounts by Iraqi refugee women, exemplified by a previous quote I included: "Nobody believes us here" (Perfetti et al, 2019). As Angela Ross Perfetti and her colleagues noted: "The women's reports of not being believed by healthcare providers raise questions about the role of race and gender in determining their experiences of barriers to care, and in particular, the intersection of anti-Muslim and anti-immigrant sentiment with cultural beliefs about health and illness to create barriers to care" (2019). What it comes down to is a lack of trust between patient and provider that needs to be remedied.

CHAPTER 7: LANGUAGE BARRIERS

One of the common themes that has surfaced in my research on the health of Iraqi/Arab immigrants in the U.S. is the language barrier as an obstacle to assimilation and to better health outcomes. In the study previously described by Salman and Resick, these language difficulties were found to be just as significant for refugee women who had lived in the U.S. for years and spoke English well as it was for women who lived in the U.S. for a matter of months and had limited English proficiency (Salman and Resick, 2015). My grandmother lived in England for a year as a student, became an English teacher back in Iraq, and made sure all of her children could speak English fluently growing up. She has now been in the U.S. for about 30 years. One day, I accompanied her to a doctor's appointment and the nurse was collecting information about her medical history. My grandmother kept insisting that she had her bladder removed in Iraq, although she has been able to urinate normally since then. It took several minutes before we were able to clear up that she had her *gallbladder* removed in the past and that her urinary bladder was actually intact; she thought the difference was negligible. If someone who considers themselves fluent in English could still experience such misunderstandings, how do those with a more basic grasp of the language get by? A friend of mine translated this story of her mother's own struggles to communicate with her healthcare providers:

> "Sometimes when I'm speaking with my doctor, I don't feel comfortable telling her how I feel because I can't even articulate it. The doctor seems like she's in a rush or busy and has other patients to see, and I just don't have the fluency in the English language to explain to her what's going on.

> Same thing goes for the sheets they hand you in the beginning of the appointment for symptoms, problems, etc. I can't read English fluently, so I struggle to even fill those out correctly and accurately. Other times when the doctor explains to me my diagnosis, I honestly don't understand half the things she's saying because it's not my first language firstly and secondly the medical references are often too confusing for an average person who does speak fluent English to understand let alone someone who barely speaks any English. There was this instance once where the doctor was explaining to me how they saw something on my ultrasound and she mentioned stomach cancer. I heard stomach cancer and I freaked out because I've had breast cancer before and have gone through chemotherapy and just the thought of going through that again really really frightened me. It turns out it wasn't even anything, but because I couldn't really fully understand what she was saying, I thought the worse."

Other women in my community have experienced similar concerns and have noted a lack of Arab interpreters during their health visits. This raises a question of how ethical these visits really are. Can one truly provide informed consent for medical procedures when he or she does not speak the same language as the person explaining it to them? In a paper written about the ethical issues in immigrant health care and clinical research, Patricia Marshall and her associates propose that “an ability to communicate effectively with patients and their families” is critical in solving ethical dilemmas in doctor-patient interactions (Marshall et al, 1998). As such, one might argue that it is quite irresponsible and

even *immoral* to present difficult information to a non-native English-speaking patient without first offering appropriate interpretive services and being sensitive to the patient's limited health literacy.

CHAPTER 8: IMPLICATIONS OF THE COVID-19 PANDEMIC

It is important to note that while my research has primarily focused on refugees and immigrants from Iraq and other Middle Eastern countries, most of my findings are not actually specific to this population. Dr. Syed Ahmed and colleagues said it best when they noted, "the structural barriers that surfaced in this study are common among low-income, urban, minority populations and are not necessarily specific to Iraqi refugees (Ahmed et al, 2001). These barriers and negative health consequences are likely to be exacerbated by the COVID-19 pandemic. In fact, the CDC has reported that the number of U.S. adults with symptoms of anxiety and depression has quadrupled since the start of this pandemic, with women and people of color disproportionately experiencing these symptoms. It is thought that the pandemic's impact on social determinants of health (e.g. rising unemployment and housing and food insecurity) has significantly contributed to increased stress levels and difficulty obtaining basic necessities. Moreover, the widespread quarantine and limitation of "elective" healthcare services has removed people from their social supports and restricted their access to preventative healthcare services, such as cancer screenings and routine check-ups (Warren and Smalley, 2020). According to a piece in the Health Affairs blog, the statistics we have seen regarding COVID-related deaths only address losses directly from the virus. They don't factor in the indirect "spillover" effects from the reduced access to non-COVID-related care (Chen and McGeorge, 2020). This is not only due to the decreased supply of health care services; it is also due to patients' fear of exposing themselves to the virus by going to the ER for "a little bit of chest discomfort." Due to care avoidance, people with chronic

conditions such as hypertension and diabetes are not getting monitored as frequently as they should be and risk worsening of their disease.

Based on our knowledge from past pandemics (e.g. H1N1), it is reasonable to infer that minority populations in the U.S. are and will continue to be impacted more strongly by these consequences of the COVID-19 pandemic than their majority counterparts. Eva Clark and her associates made this conclusion as well, noting that, "Certain 'hot spots' have already demonstrated high rates of COVID-19–related mortality in minority populations, particularly those of impoverished communities, likely due to increased prevalence of comorbid conditions as a result of unequal socioeconomic factors and inadequate access to timely healthcare" (2020). They anticipate similar outcomes in immigrants, who have comparable comorbidities and socioeconomic statuses to their American-born minority peers, and they suggest the need to enact local, state, and national legislation to improve healthcare access for these communities (Clark et al, 2020). I will disclose some possible solutions to address these inequalities below.

CHAPTER 9: POTENTIAL SOLUTIONS

More research about the physical and mental health of Middle Eastern immigrants is needed. However, the available evidence indicates that this population perceives their physical and mental health as poor and that they experience many barriers to healthcare, including cultural/religious differences, poverty, discrimination and distrust, and language barriers. Many solutions have been proposed to address these obstacles, as summarized by Marcia C. Inhorn and Gamal I Serour. In regard to cultural and religious differences, they note that it would be helpful to increase the pipeline of Arab-Muslim physicians that Arab immigrants and refugees can better connect with and to provide training on mental health for Muslim clergy outside healthcare settings. Separately, hospitals across the nation require improved cultural competency trainings that stress the range of practices that their patients may adhere to. To address poverty, refugees need more and prolonged resources after resettling in the U.S. They should be resettled in cities in the U.S. that have adequate job opportunities, and they need language and employment training with childcare services available in order to access those jobs. Longer terms of healthcare coverage would be useful, as well as charity programs focusing on Arab immigrant populations.

Discrimination and distrust are more difficult to resolve, as they require long term changes in ways of thinking for both Arab and non-Arab individuals. There is a need for physician outreach to Arab-immigrant communities as a first step with a focus on building trust with them. Finally, language barriers can be removed by increasing English education opportunities, improving access to Arabic-speaking providers and interpreters, and implementing Arabic-language health education materials in hospitals and clinics

that serve Arabic-speaking patients (Inhorn and Serour, 2011). Most of the initiatives proposed by Inhorn and Serour are under the purvue of the healthcare sector, but eventual changes in foreign policy at the local, state, and national levels are also important in order to expand access to resources for immigrants and refugees and to improve relationships between U.S.-born and non-U.S.-born populations. While many of these solutions are difficult to implement during this pandemic, all of them can significantly improve the actual and perceived health of Middle Eastern immigrants and refugees in the long-term and should be heavily considered in areas with a large population of Arab Americans.

CHAPTER 10: CONCLUSION

Although many gaps in the knowledge base exist, Middle Eastern immigrants and refugees in the U.S., particularly following the events of 9/11, generally experience poor health, both physically and mentally, and face many barriers to accessing good health care. The overarching themes that emerged include cultural/religious differences, poverty, discrimination/distrust, and language barriers, similar to the obstacles faced by other minority groups in this country. In the context of the COVID-19 pandemic, Middle Eastern immigrants are likely to be impacted more negatively than their non-minority peers due to their poor socioeconomic status and their greater rate of medical co-morbidities. Some of the proposed solutions in the healthcare sector incorporate fostering the pipeline of Arab-American physicians in the U.S., improving cultural competency trainings in hospitals so that healthcare workers can be more aware of the particular issues faced by Middle Eastern immigrants/refugees, reaching out to Arab leaders in communities to build trust between physicians and patients, and providing better Arabic language resources and interpreters for improved communication. Other solutions require involvement from government sectors in order to increase access to social, economic, and healthcare-related resources for this population. Overall, there is a long road ahead to address the healthcare disparities faced by under-served minorities in the U.S. It is time to begin that journey in order to reduce the negative health and financial consequences that have only been exacerbated by the COVID-19 pandemic.

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