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Health Literacy and Refugee Women During the COVID-19 Pandemic: Outlooks for ESL Classes

Lara-Zuzan Golesorkhi[a]

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ABSTRACT

During the COVID-19 pandemic, refugee women in the United States faced significant challenges to sustain their livelihoods, such as losing jobs and health care, becoming essential workers, and finding oneself again in unprecedented situations of limited mobility. These impacts reflect dynamics in migrant health literacy including language proficiency (skills-based approaches) as well as experiences, identities, and power relations in society (socio-cultural approaches). In this article, I explore these dynamics through a gender perspective with a focus on intra-familial health brokering, empowerment-based health education, and health information mapping by drawing on ethnographic research from Portland, Oregon. This includes interviews with 15 refugee women and representatives of organizations working in the context of migration as well as observations of service-providing community efforts. My interviews and observations demonstrate that disruptions in language learning, socio-cultural barriers, and limited access to health-related information resources have posed significant challenges to refugee women's livelihoods during the pandemic. I suggest that English as a Second Language (ESL) classes can be imperative in addressing these challenges as the classes provide a space for language learning, intercultural dialogue, and information sharing in gender-responsive ways.

KEYWORDS

refugee women; health literacy; English as a Second Language; ESL; COVID-19

RESUMÉ

Pendant la pandémie de COVID-19, les femmes réfugiées aux États-Unis ont été confrontées à des défis importants pour maintenir leurs moyens de subsistance, comme la perte d'emplois et de soins de santé, le fait de devenir des travailleurs essentiels et de se retrouver à nouveau dans des situations inédites de mobilité limitée. Ces impacts sont le reflet de dynamiques au niveau de la littératie en matière de santé des migrants telles que la maîtrise de la langue (approches basées sur les compétences) ainsi que les expériences, les identités et les relations de pouvoir dans la société (approches socio-culturelles). Dans cet article, j'explore ces dynamiques à travers une perspective de genre mettant l'accent sur le courtage de santé intra-familial, l'éducation à la santé basée sur l'autonomisation et la cartographie des informations sur la santé en m'appuyant sur une étude ethnographique de Portland, Oregon. Cette étude comprend des entretiens avec 15 femmes réfugiées et représentants d'organisations œuvrant dans le contexte de la migration ainsi que des observations d'efforts communautaires de prestation de services. Mes entretiens et observations démontrent que les interruptions dans l'apprentissage de la langue, les barrières socio-culturelles et l'accès limité aux ressources d'informations liées à la santé ont posé des défis importants au maintien des moyens de subsistance des femmes réfugiées pendant la pandémie. Je suggère que les cours d'anglais langue seconde sont impératifs pour faire face à ces défis puisque ces cours fournissent un espace pour l'apprentissage de la langue, le dialogue interculturel et le partage d'informations de manière sensible au genre.

CONTACT

[a] golesork@up.edu, Department of Political Science and Global Affairs, University of Portland, Portland, OR, U.S.

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INTRODUCTION

In the United States, migrant women, including refugee women, have been disproportionately impacted by the COVID-19 pandemic. Migrant women are often employed in sectors that have been especially affected by job losses (e.g., waitstaff, housekeepers) and have higher unemployment rates than other workers (Gelatt et al., 2020). At the same time, working in frontline industries (e.g., health care, food production, etc.) has put migrant women at increased risk of getting COVID-19, yet challenges remain in accessing health resources and services, including COVID-19 testing and treatment (Gelatt & Capps, 2020).

For refugee women, these impacts are especially pronounced as inequalities in earnings and occupational levels exist in comparison with "women of other migration statuses" (Boyd & Pikkov, 2005; Potocky-Tripodi, 2003). Refugee women also tend to have lower language proficiency and health information-seeking behaviour than refugee men and women of other migration statuses, and they face heightened mental health concerns and limited social support (Banulescu-Bogdan, 2020; Barnes et al., 2004; Deacon & Sullivan, 2009; Lloyd, 2014; Nelson-Peterman et al., 2015; Zimmermann, 2019).

These impacts of the COVID-19 pandemic on refugee women's livelihoods reflect dynamics in migrant health literacy such as language proficiency (skills-based approaches) as well as experiences, identities, and power relations in society (socio-cultural approaches) and raise important questions: How do refugee women attain health literacy? In what ways has the COVID-19 pandemic affected refugee women's health literacy? And what role do English as a Second Language (ESL) classes play in the attainment of health literacy?

I address these questions by drawing on interviews with 15 refugee women and representatives of organizations working in the context of migration as well as observations of service-providing community efforts in Portland, Oregon. In situating my ethnographic research in discourse and data on migrant health literacy, I show that refugee women's health literacy is informed by acquiring language proficiency, mediating cultural barriers, and obtaining health-related information resources. These factors speak to gender dimensions in migrant health literacy, notably intra-familial health brokering, empowerment-based health education, and health information mapping. I suggest that ESL classes can be imperative in this context as the classes provide a space for language learning, intercultural dialogue, and information sharing.

I begin my analysis with an engagement of conceptual frameworks on migrant health literacy such as skills-based and socio-cultural approaches. Based on this conceptual discourse, I discuss data (quantitative and qualitative) on migrant health literacy through a gender perspective. I then present my ethnographic research findings from Portland and highlight lived experiences in relation to dynamics in migrant health literacy, namely, language proficiency, socio-cultural aspects, and informational resources. In the final section, I explore the role of ESL classes in advancing refugee women's health literacy during the pandemic and beyond. I outline opportunities and challenges of integrating health literacy into ESL curriculums and gesture to research areas that remain to be further explored.

METHOD

This article draws on a mixed-methods approach, including ethnographic research (interviews and observations), conceptual

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discourse, and qualitative and quantitative data on migrant health literacy. Between May and July 2020, I conducted interviews with 15 refugee women and representatives of organizations working in the context of migration.[1] Participants were selected based on the following criteria: (a) refugee women who had been resettled in Oregon since 2011 and (b) representatives of organizations who had worked directly with refugees for at least three years. I used semi-structured interview format, and the conversations were held in English. I complemented the interviews with observations of service-providing community efforts.

The research design (interviews and observations) received Institutional Review Board approval from the University of Portland. Contacts to refugee women and organizations were established through email and phone outreach, given my capacities at a Portland university. All participants were briefed about the interview process, and the interviews were conducted over the phone or Zoom. The participants completed an informed consent form prior to the interviews and filled out an anonymous screener questionnaire with demographic information that was, upon meeting the eligibility criteria (noted above), appended to the rest of the participants' study data. The research was supported through a university grant.

DISCOURSE: CONCEPTS AND THEORIES IN MIGRANT HEALTH LITERACY

Migrant health literacy has been conceptualized through various approaches. Skills-based approaches, for instance, emphasize language proficiency as a key determinant in health literacy. This includes the ability to "perform basic reading and numerical tasks required to function in the healthcare environment" (Bresolin, 1999, p. 553). In line with this definition, "patients with adequate health literacy can read, understand, and act on health care information" (p. 553), denoting that health literacy constitutes "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (Selden et al., 2000, p. v). According to the skills-based approach, health literacy is thus largely measured by level of language proficiency.

In the US context, limited English-language proficiency (LEP) is generally described as the restricted ability to read, speak, write, and/or understand English by persons for whom English is not their first language. LEP has been established as a critical albeit complex dynamic in migrant health literacy. While research suggests that "materials written in plain English and at a lower grade level result in better health understanding" for persons with LEP, increased language proficiency does not immediately or solely contribute to improved health knowledge (Andrulis & Brach, 2007, p. 3; Pignone et al., 2005). Although LEP can be overcome through translations of materials or an interpreter, persons with LEP may not be able to read translated materials that have not been simplified. Furthermore, "easy-to-read" materials in English may still pose challenges to persons with LEP because they reflect universal assumptions about Western constructs of health and health care, pointing to the importance of considering linguistic aspects (skills-based approaches) and cultural aspects (socio-cultural approaches) in migrant health literacy (Andrulis & Brach, 2007). Nutbeam's (2000) three-level conceptualization of mi-

[1] The ethnographic portion of the research was conducted with the assistance of three students at my university. Some of these findings are also discussed in Golesorkhi et al. (2022) and in Golesorkhi et al. (2020).

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grant health literacy provides important insights here.

To Nutbeam (2000), health literacy operates on three different levels: functional, interactive, and critical. Functional health literacy encompasses basic skills in reading and writing in the sense of having sufficient language proficiency to understand health-related materials (i.e., prescriptions, appointment cards, medicine labels, and health care directions). Interactive health literacy involves the ability "to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances" (p. 263). Interactive health literacy thus moves beyond functional health literacy in that migrant health literacy is not conceptualized to be strictly determined by measures of reading and writing, but more by what health literacy enables one to do. Critical health literacy further emerges from these understandings and includes the ability to analyze information and to use such information to foster autonomy in health-related matters (Nutbeam, 2000).

Complementing these skills-based approaches in migrant health literacy, socio-cultural approaches focus on linkages between migrant health and experiences, identities, and power relations in society (Chao & Kang, 2020; Salant & Lauderdale, 2003; Zanchetta & Poureslami, 2006; Zarcadoolas et al., 2005, 2006). As Shaw et al. (2008) demonstrate, the importance of traditional and cultural coping mechanisms (e.g., spiritual healers, herbal remedies) cannot be underestimated in addressing linguistic, cultural, and health divides for migrant patients. Singleton and Krause (2009), for example, find that cultural constructs manifest through various health belief models that affect migrant health literacy. These health belief models include magico-religious beliefs (i.e., supernatural forces as causes for illness), deterministic beliefs (i.e., health outcomes as externally preordained and unalterable), familialism (i.e., health-related decision-making is done as a family unit), and different forms of time orientations (i.e., present vs. future orientations in health-related decision-making) (Andrews & Boyle, 2008; Galanti, 2008; Purnell & Paulanka, 2008).

Parker and Ratzan (2010) have discussed this development from skills-based approaches to additional or complementary socio-cultural approaches in migrant health literacy. In their commentary, Parker and Ratzan present an emerging view of migrant health literacy in which health literacy is made up of several different intervention points—namely, culture and society, the health system, and the education system. This emerging view establishes that migrant health literacy reflects a "dual nature of communication" by aligning skills and abilities with the "complexity and demands of what needs to be done for health" (Parker & Ratzan, 2010, p. 28). Relatedly, Sørensen et al. (2012) outline an integrated health model of 12 dimensions of migrant health literacy that reflect connections between skills-based approaches and socio-cultural approaches. These dimensions refer to "knowledge, motivation and competencies of accessing, understanding, appraising and applying health-related information within healthcare systems" (p. 1). The importance of considering skills-based and socio-cultural approaches becomes evident when examining emerging data on gender dimensions in migrant health literacy.

DATA: GENDER DIMENSIONS IN MIGRANT HEALTH LITERACY

Emerging data (qualitative and quantitative) on gender dimensions in migrant health literacy, such as intra-familial health broker-

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ing, empowerment-based health education, and health information mapping, reflect skills-based approaches and socio-cultural approaches in migrant health literacy. For instance, intra-familial health brokering, understood as the ways through which family members share and convey health-related information among each other, presents a key gender dimension in migrant health literacy as it pertains to acquiring language proficiency (skills-based approaches), whereas empowerment-based health education is connected to mediating cultural barriers (socio-cultural approaches), often through community-focused practices (see Chao & Kang, 2020; Hill, 2004; Im & Swan, 2019; Ingleby, 2012; Mas et al., 2013, 2015; Papen, 2009; Perry, 2009; Rudd et al., 2004). Similarly, health information mapping, and thereby efforts to obtain health-related information resources by determining existing resources and identifying additional resources, reflect gender dimensions in both skills-based and socio-cultural approaches in migrant health literacy.

In terms of intra-familial health brokering, Flores et al. (2005) compared first language spoken at home with parental LEP in regard to impacts on migrant children's health. Based on a survey of 1,100 participating children and families, Flores et al. found that parental LEP was associated "with triple the odds of a child having fair or poor health status, double the odds of a child spending at least one day in bed for illness in the past year, and significantly greater odds of a child not being brought in for needed medical care" (p. 418). In this context, Flores et al. stress that as a measure of the impact of language proficiency on migrant children's health, parental LEP is indeed "superior to the primary language spoken at home" (p. 418). Flores et al.'s findings gesture to key considerations of gender dimensions in migrant health literacy relative to intra-familial health brokering, as further explored by Santos et al. (2018).

In their study on the contributions of immigrant adolescents as linguistic and cultural resources for their families, Santos et al. (2018) show that immigrant adolescents often act as navigators in health care systems, yet much remains unknown about how they acquire health literacy while also developing their own health behaviours. To address this gap in the literature, Santos et al. undertook a targeted inquiry into research on immigrant adolescent health literacy. In drawing on scholarship across different fields, Santos et al. point to a study by Orellana et al. (2003), which explores how intra-familial health "brokering activates a range of linguistic and pragmatic skills" with important gendered implications for migrant health literacy (p. 7). The experience of "Lucila," an immigrant adolescent girl, is a case in point here:

> I remember that day and I remember the tension I felt as I listened to my mom angrily complain about the lady [medical professional], and the pressure I felt to translate "properly." I didn't know what to say. I wanted the complaint to sound like it came from a grown-up, my mother, but I also wanted to stress how rude [the lady] was, writing that she was very impatient with our situation and that my mom felt very uncomfortable with her and that it was really hard for her to express herself and to understand the lady.
>
> (Orellana et al., 2003, p. 519)

Also addressing the role of intra-familial health brokering in migrant health literacy, Khuu et al. (2016) have explored health care providers' perspectives on migrant health literacy as it concerns migrant children's health. A total of 16 health and mental health professionals serving immigrant and refugee parents and children were interviewed as part of Khuu et al.'s study, which indicates that trust and engagement in the health care system and health care work-

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ers are especially important in regard to migrant health literacy. The study's results suggest that the parents' country of origin and previous exposure to "Western health care systems" play a prominent role in health literacy levels—as do the parents' culture and shared beliefs regarding health. This is especially the case in matters of gender-specific health-related matters (see also Gany et al., 2006; Poureslami et al., 2011).

These findings regarding intra-familial health brokering speak to connections between skills-based approaches and socio-cultural approaches in migrant health literacy. Im & Swan (2019) further examine this in terms of empowerment-based health education. Im and Swan's community-level participatory research project focused on "refugee populations whose culture deeply interweaves individual and contextual" capacities "to promote health." The project involved Afghan and Congolese refugees (most of them women) who were asked a series of open-ended questions in focus group interviews. Im and Swan find that "empowerment-based health education helps" refugee women "navigate and interpret health messages, negotiate and redefine the meaning of healthy coping, and "validate[] their cross-cultural understanding of surrounding systems and contexts" (p. 46).

Regarding the importance of obtaining health-related information resources, Zimmermann's (2019) methodological intervention of "Information Horizons Mapping" speaks to gender dimensions in migrant health literacy in important ways. As part of the mapping process, migrant women (of varied statuses) graphically represented their health-related information horizons based on a survey and open-ended questions. Zimmerman observes that overall, "refugee women were less aware of health information sources than other" migrant women. Migrant "women who did not enter the" US under refugee status drew on "an average of twice the number of sources" over women who entered the country under refugee status. A strong correlative relationship was also determined between the "number of sources each woman drew" on to "years of schooling," as well as "between a woman's frequency of internet use" to "the number of sources she drew upon. "Only approximately half of the women who drew" on "one or two information sources felt that they could access information that they could understand," and many noted distrust in medical professionals as an additional challenge (Zimmermann, 2019, p. 964).

As these gender dimensions in migrant health literacy demonstrate, migrant women, including refugee women, face specific challenges in the US health care system. These challenges have been amplified during the COVID-19 pandemic, as my ethnographic research findings show.

FINDINGS: HEALTH LITERACY AND REFUGEE WOMEN IN PORTLAND

Between May and July 2020, I conducted interviews and observations on the impact of the COVID-19 pandemic on refugee women's livelihoods in Portland, Oregon. Interviewed refugee women fled from countries such as Afghanistan, Bhutan, the Democratic Republic of Congo, Myanmar, and Syria, while interviewed representatives of organizations had been working directly with refugees for at least three years. I complemented these interviews with observations of service-providing community efforts.

Findings from my interviews and observations reveal that restricted access to resources and services, lack of information about resources and services, and fear due to ever-changing immigration and social protection policy constitute main aspects in

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the pandemic's impact on refugee women's livelihoods (Golesorkhi et al., 2020; Golesorkhi et al., 2022). I argue that these different aspects are informed by dynamics in migrant health literacy. My interviews and observations demonstrate that disruptions in language learning (ESL classes), socio-cultural barriers, and limited access to health-related information resources have affected refugee women's livelihoods in significant ways. These experiences reflect skills-based and socio-cultural approaches in migrant health literacy, pointing to the importance of considering gender dimensions—notably intra-familial health brokering, empowerment-based health education, and health information mapping—in discussions on the impacts of the COVID-19 pandemic on migrant health.

With regard to disruptions in language learning, my conversations with a Syrian refugee woman and a Rohingya refugee woman were telling. In my interview with a Syrian refugee woman, language came up in a conversation on educational aspirations. The woman shared that her education had been compromised due to remote work. Before the pandemic, the woman and her husband worked regular hours while their child was in school. This changed during the pandemic as working hours had to be adjusted due to additional childcare needs, which subsequently led to limited time for further English learning because the ESL classes that the woman had previously taken now conflicted with her increased family responsibilities.

Despite these changes, the woman found a renewed interest in a career in counselling as she saw community members struggle through this time of social isolation. She stated:

> In the US, it is possible to have a new career. I am talking to a college adviser about getting a scholarship and pursuing a degree in the mental health field. But first, I need to improve my language.

While these plans, reflecting the importance of empowerment-based health education, are in the making, the woman has been gaining experience through volunteering at a local organization that provides digital mental health support to (other) refugees.

The disruption of language learning was also an important aspect in my conversation with a Rohingya refugee woman. The woman noted language as the key challenge in sustaining her family's livelihood. Indeed, to her, language spanned personal aspirations in education and employment, as well as in staying safe and healthy during the pandemic. The woman shared that she had been learning English for a year and a half at a community college before the pandemic began. Now, with her children at home, she has faced increased childcare responsibilities, including helping her children access online schooling and complete their homework. In this context, the woman emphasized that while she can help with digital skills, something that she learned at a community centre, when it comes to language, she often feels ill-equipped: "The children learn [English] quickly at school. … They say, 'Mum, your English is funny."'

Although her children speak their first language and English, the parents' language proficiency is "broken," as the woman described. This has posed challenges not only in assisting their children with schooling but also in navigating other livelihood concerns during the COVID-19 pandemic. In gesturing to gender dimensions in migrant health literacy such as intra-familial health brokering, the woman stressed that for her children, it is often difficult to "know how to explain back" in regard to health-related matters. As a mother of three daughters (aged 13, 7, and 1) experiencing these challenges, the woman

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opened up about her depression and her weak health, noting that "if you only depend on your husband, you are not enough. … You have poor health, so you work to provide for your family, especially if you cannot help in other ways." She reflected here on her concerns about relying on her children to understand health-related information.

This intricate relationship between language proficiency (skills-based approaches) and cultural aspects (socio-cultural approaches) in migrant health literacy was also prevalent in my interview with an Afghan refugee woman. The woman reported on an incident in which she sought medical help for her son who was not feeling well and had shortness of breath. In their first encounter with a primary care doctor, the woman was told that her son was "fine" and just needed some rest. Overnight, the son's shortness of breath worsened. The woman took him to the emergency room, where he was given oxygen and then taken in for further evaluation. One week after her son was released from the hospital, he was back in the emergency room with the same issues, although the woman was told upon his previous release that this was unlikely to reoccur. She recalled:

> There are lots of problems in receiving proper care here [in the US]. Especially as a refugee and immigrant. Your concerns are not taken seriously and often, because of language barriers, we [patient and physician] don't understand each other. When I tried to explain what was going on with my son, I used Google Translate to communicate with the doctor. He then replied, "Oh yes, maybe he [son] has this," but he didn't provide a diagnosis and just told my son to rest. I know that he has to rest but he could barely breathe. The health care [system] is insufficient here.[2]

In sharing this experience, which reflects the significance of health information mapping, I followed up with a question about language learning and how increased language proficiency might help in situations like this. The woman responded, "Language yes, it's important. But also culture. Sometimes, we [patient and physician] don't understand each other because of language but also because of different manners and behaviours."

The woman further discussed how COVID-19 disrupted her language learning, expressing that there are generally very limited opportunities for language learning. She posed the probing question: "How do you learn English in two hours a week?" To her, this was not enough, so she decided to learn on her own to complement what was offered. This included language learning with her neighbours, to whom she, in exchange, brought home-cooked meals as a means of sharing her culture. The pandemic interrupted these self-organized language-culture meet-ups, but the woman was hopeful that she could resume them soon.

My interviews with people working at organizations in the context of migration complemented many of the experiences shared by the women, especially in regard to gender dimensions in migrant health literacy. For example, in my interview with an ESL teacher, I learned about the challenges that teachers have faced during the pandemic and how they might impact language learning in the future. The teacher, a volunteer at a community college, mentioned that to her, language and culture are intertwined, and that the importance of this connection has increasingly manifested during the pandemic. She explained how the online space has become a new community platform to do what is usually done in person (e.g., empowerment-based health education). Moving community online, however,

[2]It is important to note here that, although not explicitly mentioned in the interview, due to COVID-19 restrictions, many health facilities limited access to accompanying persons to help patients. Health literacy strategies that refugee women may have developed before (e.g., having a community health worker with them during health visits) were no longer options.

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has come with certain challenges, and so has language teaching:

> None of us [ESL teachers] knew how to teach online. So we meet every week as a network to figure out how to do it. Resource sharing has been difficult, and the needs of students and teachers have changed in this online space. … Our students first need to learn how to access online resources. Students have a hard time understanding how to get on [into Zoom meetings], and some simply don't have Wi-Fi access at home.

The mentioned network through which much of the information sharing has taken place was one of my sites of observation. This, a locally designated Facebook page has been an important hub for the exchange of information regarding ESL teaching. During the pandemic, however, the group has expanded its usual language-learning-focused material and added pertinent migration-related COVID-19 information, demonstrating innovative ways of health information mapping. Examples include the dissemination of various handouts and videos about the virus and how to stay safe. Some ESL groups and teachers have also offered free or discounted lessons in response to the job losses and financial constraints experienced by many migrants.

Challenges to participating in online learning spaces and accessing health-related information resources have been heightened for refugee women. As also discussed in Golesorkhi et al. (2020) and Golesorkhi et al. (2022), the interviewed ESL teacher noticed that "since the pandemic began, refugee women with children" had been participating less due to additional or new family responsibilities. This was also emphasized in my noted interviews with refugee women. "Before the pandemic, many ESL classes were taught at libraries and churches," which also provided childcare while the mothers were learning. According to the teacher, "this has changed during the pandemic and will have long-term effects on the women's English-language proficiency" and, by extension, intra-familial health brokering.

Refugee women's decreased participation in ESL classes has led some community-based organizations to offer alternative ways for women to stay connected with others while at the same time keeping up with their English-language learning, thereby connecting skills-based and socio-cultural approaches in migrant health literacy. For instance, my observations of a place-based organization in East Portland showed that "conversation circles" were created as a means to address social isolation, build community, practise language skills, and stay informed about COVID-19. These conversation circles took place on a weekly basis and regularly featured guest speakers who talked about health-related and other pertinent matters. This initiative quickly gained popularity, with waitlists emerging shortly after its launch, and reflects the combination of various gender dimensions in migrant health literacy, notably, empowerment-based health education.

Other local organizations also pursued finding complementary ways to support the health, including the mental health, of refugees in Portland. In another interview, I learned about a volunteer-run organization that offers digital psychosocial support to refugees. This includes "mental health support through telehealth appointments with multilingual psychiatrists and sharing videos featuring mental and emotional well-being advice" (Golesorkhi et al., 2020). In other ways, local organizations have addressed dynamics in migrant health literacy through information sharing. For example, community-based organizations have created translated materials including policy updates, lockdown procedures, health and safety guidelines, and guidance on ac-

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cessing support services regarding employment, housing, legal, and food assistance. This information is now accessible in up to 57 languages and has helped migrants not only to withstand prevalent misinformation about COVID-19 but also to overcome language and socio-cultural barriers with critical gendered implications for information mapping and intra-familial health brokering (Golesorkhi et al., 2022).

Based on my ethnographic research findings and my discussion of conceptual discourse and data on migrant health literacy, I contend that refugee women's health literacy is informed not only by the ability to understand health information but also by the ability to navigate health care systems (skills-based approaches and socio-cultural approaches). This includes acquiring language proficiency, mediating cultural barriers, and attaining health-related information resources, all speaking to gender dimensions in migrant health literacy—namely, intra-familial health brokering, empowerment-based health education, and health information mapping. I suggest that ESL classes can be imperative in addressing these dynamics as these classes provide a space for language learning, intercultural dialogue, and information sharing in gender-responsive ways.

OUTLOOK: THE ROLE OF ESL CLASSES IN REFUGEE WOMEN'S HEALTH LITERACY

As I learned in my interviews and observations, ESL classes serve as spaces not only for language learning but also for intercultural dialogue and information sharing—key dynamics in migrant health literacy. Activities in ESL classes that develop and advance health literacy include participatory engagements such as acting out making a health appointment, reporting medical problems, and asking about prescription side effects. Other activities involve creating community-based health literacy curriculums and programs as well as teaching digital health skills. As Mas et al. (2013, 2015) show in their case study analyses of an integrated curriculum (health literacy in ESL), community-based efforts are crucial to migrant health literacy. Mas et al. have studied the development, implementation, and evaluation of an integrated curriculum and find that "community settings constitute a viable option that should be considered" in migrant health literacy programming, not least for empowerment-based health education (p. 432).

Additional guidance on activities that address migrant health literacy in ESL classes, notably, health information mapping, can be found in the Virginia Adult Learning Resource Virginia Adult Learning Resource Center's (2012) Health Literacy Toolkit, for example. This toolkit includes recommendations for ESL teachers on how to incorporate health literacy in lesson plans and provides an overview of pertinent laws and policies regarding health care. As per the toolkit, ESL teachers might develop lesson plans that speak to varied health literacy components: for example, in "Teach Back," the provider (ESL teacher) asks the patient (ESL student) to repeat back information to assess comprehension; and in "Ask Me 3," the provider (ESL teacher) encourages the patient (ESL student) to ask questions about health problems and care plans.

Despite these varied opportunities that ESL classes might facilitate in advancing health literacy, ESL teachers are not health care professionals (although they are not mutually exclusive) and face obstacles in balancing language education with health education. Instructors may "find the personal aspect of health discussions uncomfortable" and may "need to broaden their knowledge on the availability of health resources" for respec-

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tive migrant communities (Singleton, 2002, p. 4). Furthermore, "teachers may worry about being unfamiliar with their students' cultural beliefs on health issues" and premise health discussions on Western-centric assumptions (Singleton, 2002, p. 4).

In this context, the importance of intrafamilial health brokering, as a gender dimension in migrant health literacy, must be stressed. Perry (2009) describes health literacy brokering as "a complex activity that may involve … translation of word meanings, mediation of cultural content, or explanation of genre aspects" (p. 257). In this sense, linguistic brokering is often coupled with cultural brokering. Indeed, Papen (2009) notes that migrants "seek health literacy mediators who can help them" with language and "cultural barriers" (equally Chao & Kang, 2020; Hill, 2004; Rudd et al., 2004). Relatedly, Ingleby (2012) warns that if teaching migrants to become "health literate" is done without regard for the migrants' own ideas and values regarding health, "it will be an attempt at assimilation—and like most such attempts, it will usually fail" (p. 22).

In conceiving of ESL classes as spaces where migrant health literacy can be fostered and advanced, the outlined opportunities and challenges demonstrate how skills-based and socio-cultural approaches in migrant health literacy are connected. In connecting these approaches, ESL classes can provide language learning, intercultural dialogue, and information sharing in gender-responsive ways. However, more research is needed on gender dimensions in migrant health literacy as well as the role of ESL classes in advancing refugee women's attainment of health literacy.

CONCLUSION

Migrant health literacy presents an important research area that remains to be explored further. As impacts of the COVID-19 pandemic on migrant communities continue to emerge, research on migrant health literacy is imperative to knowledge at the migration–health nexus. As I found in my interviews and observations, impacts on refugee women's livelihoods in Portland have been informed by dynamics in migrant health literacy. All of the interviewed women experienced disruptions in their language learning, which may have long-term effects on the women's language proficiency and, subsequently, their health literacy. This, as well as the socio-cultural barriers discussed in my interviews and the efforts made by community-based organizations to overcome challenges in obtaining health-related information, reflects the urgency of inquiries into migrant health literacy, especially from a gender perspective. My analysis points to the need for improved health literacy among migrant communities, not least for refugee women. I suggest that ESL classes can play a role as these classes provide a space for language learning, intercultural dialogue, and information sharing, thereby bridging skills-based approaches and socio-cultural approaches in migrant health literacy that address gender dimensions such as intrafamilial health brokering, empowerment-based health education, and health information mapping.

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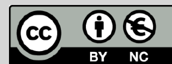

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