December 2023

Healthcare Practices in the United States Aimed at Improving Care and Language Access Services for Limited English Proficiency Refugees: A Systematic Review

Bemnet Kebede
University of Nevada, Las Vegas

HEALTHCARE PRACTICES IN THE UNITED STATES AIMED AT IMPROVING CARE AND LANGUAGE ACCESS SERVICES FOR LIMITED ENGLISH PROFICIENCY REFUGEES: A SYSTEMATIC REVIEW

By

Bemnet Kebede

Bachelor of Science in Public Health
University of Nevada, Las Vegas
2016

A thesis submitted in partial fulfillment
of the requirements for the

Master of Public Health

Epidemiology and Biostatistics
School of Public Health
The Graduate College

University of Nevada, Las Vegas
December 2023

UNLV | GRADUATE COLLEGE

Thesis Approval

The Graduate College
The University of Nevada, Las Vegas

November 2, 2023

This thesis prepared by

Bemnet Kebede

entitled

Healthcare Practices in the United States Aimed at Improving Care and Language Access Services for Limited English Proficiency Refugees: A Systematic Review

is approved in partial fulfillment of the requirements for the degree of

Master of Public Health
Epidemiology and Biostatistics

Erika Marquez, Ph.D.
Examination Committee Chair

Christopher Johansen, Ph.D.
Examination Committee Member

Tim Bungum, Dr.P.H.
Examination Committee Member

Reimund Serafica, Ph.D.
Graduate College Faculty Representative

Alyssa Crittenden, Ph.D.
Vice Provost for Graduate Education & Dean of the Graduate College

Abstract

Objective: The United States has accepted over 3 million refugees from all around the world since 1975. However, many Limited English Proficiency (LEP) refugees face significant barriers when seeking healthcare due to limited access, lack of knowledge, mistrust in physicians, language differences, cultural concerns, and overall complexity of the U.S. healthcare system. The purpose of this systematic review was to identify practices in the last 10 years that have improved healthcare and language access services for LEP refugees living in the U.S.

Methods: A search was conducted in four electronic databases PubMed, Embase, CINAHL, and Scopus from January 2013 to May 2023. Studies were included if they were 1) focusing on practices or interventions 2) aimed at improving healthcare and language access services 3) for limited English-speaking refugees. Studies were excluded if published in countries outside the U.S.

Results: The initial search yielded 1649 articles. After review, 12 articles met the inclusion criteria; these articles consisted of interventions, language access practice guidelines, and quality improvement. The results of the literature found that successful interventions involved cultural brokers and qualified medical interpreters in the design and development of interventions for refugee target groups, as well as the relevance of timely and comprehensive training for providers regarding the treatment of LEP refugee populations.

Conclusion: Implications for future research include the identification of alternative methods to engage cultural brokers, recruitment of qualified medical interpreters, and training medical providers while partnering with local refugee communities. Future research should focus on identifying best practices for building long-term partnerships between medical providers and

refugee communities. In conclusion, this literature review contributes to the overall knowledge of the patient-provider relationship for LEP refugee population in the U.S.

Keywords Refugees. Language. Immigrant Health. Systematic Review. Language Access Service.

Table of Contents

List of Tables

Introduction

Communication is crucial in ensuring that patients are able to understand instructions, warnings, and other significant details that may enhance their quality of life. Communication barriers can have a negative impact on healthcare, especially among LEP refugees. Among refugees coming into the U.S., a significant proportion are LEP, with language barriers being a major impediment to healthcare access (Feinberg et al., 2020). Language proficiency or lack thereof, affects health literacy because patients are less likely to follow physician directives if they need help understanding the provided procedures. LEP refugees often experience communication barriers, difficulty understanding medical information, and limited access to healthcare services, which may lead to poor health outcomes (Feinberg et al., 2020). LEP and health literacy are crucial factors that affect the ability of refugees to live a healthy life when they are seeking or receiving care.

Language access barriers in healthcare can create significant challenges for LEP patients and may result in health disparities. Healthcare professionals may have trouble communicating clearly with refugees who do not speak the language well, which can result in miscommunications and care mistakes. Culturally appropriate healthcare (which includes language access) recognizes the importance of addressing cultural values and practices in healthcare delivery to provide respectful and responsive care. Culturally appropriate healthcare is the equivalent of providing culturally competent medical care. Language access services and culturally appropriate healthcare are essential for LEP refugees in the U.S. to ensure that they receive quality care that meets their unique linguistic and cultural needs (Matlin et al., 2018). By providing language access services and culturally appropriate care, healthcare providers can improve health outcomes for LEP refugees and reduce health disparities.

While seeking medical care, refugees in the U.S. confront other challenges in addition to those associated with communication and language barriers. These challenges include a lack of health insurance, transportation restrictions, and cultural differences. It may be challenging refugees to acquire inexpensive healthcare treatments due to their lack of insurance or restricted coverage. Some refugees face transportation restrictions, which can limit access to healthcare options. A lack of transit options might be particularly problematic in remote places or for refugees with mobility issues (Omenka et al., 2020). Cultural challenges can arise due to the wide ethnic and racial variability within the U.S. population, resulting in miscommunication and poor health outcomes.

Exploring the current status of U.S. refugee healthcare practices is essential to achieve a more comprehensive understanding of the needs of refugees in the U.S. as well as those of the healthcare professionals providing care. The proposed literature review identified practices in the United States (U.S.) that may improve the delivery of healthcare and language access services for limited English proficiency (LEP) refugees.

Provider challenges may substantially influence how refugees obtain treatment, with implications for patients, providers, and the more extensive healthcare system. A lack of access to translators, multilingual workers, provider and refugee education can lead to mistakes and misunderstanding among providers and their refugee patients (Fennelly, 2006). From an economic standpoint, these difficulties could lead to more significant medical expenses and a burden on the healthcare system's resources. Inadequate treatment for refugees can marginalize these communities further and worsen health inequalities. Hence, understanding challenges in provider practice is essential to enhancing the healthcare experiences and results for refugees in the U.S. (Fennelly, 2006).

Although practices, interventions, resources, and guides are available worldwide for culturally appropriate healthcare that meets LAS needs, it is unclear which practices are available or most effective in the U.S. for its unique refugee population. This systematic review aims to fill this gap by identifying practices that have improved healthcare and language access services for LEP refugees living in the U.S. by Identifying healthcare practices and interventions that improve health care and language access services for LEP refugees in the U.S.

This review highlights healthcare providers' challenges and identify interventions that have improved language access services and support. Results from this review provide information and guidance for healthcare professionals who are providing care to LEP refugees at the primary and secondary healthcare levels. The findings of this review will help inform future research and policy initiatives aimed at enhancing healthcare delivery for LEP refugees in the U.S.

Background

Refugees are individuals who have fled their own country due to a fear of persecution, violence, or unrest and are now seeking shelter in another country. By the end of 2021, 89.3 million individuals will have abandoned their homes due to persecution, violence, wars, or a violation of their fundamental human rights; 27.1 million of these individuals are considered refugees. (UNHCR, 2022). Less than 1% of these refugees are successfully relocated to a new country; the others live out the rest of their lives in camps, in other nations, or as migrants (UNHCR, 2020). Countries seeking to find a permanent solution for individuals, who must leave their native country, but lack the resources to return, have determined that resettling refugees is the best option. Globally, countries have various procedures and legal requirements that can encourage or discourage seeking asylum and resettlement.

Following the unexpected entry of more than 250,000 displaced Europeans, the United States Congress passed the initial refugee statute in 1948. The Displaced Persons Act of 1948 allowed for an extra 400,000 displaced Europeans to be resettled. Ultimately, regulations allowed people escaping Communist governments, mostly from Hungary, Poland, Yugoslavia, Korea, and China. By the 1960s, Cubans escaping Fidel Castro entered in huge numbers (ORR, 2021). The majority of these surges of refugees were supported by private ethnic and religious groups in the United States, laying the groundwork for today's partnerships in U.S. resettlement operations. The U.S. Government recognized the necessity for refugee resettlement services and established The Refugee Act of 1980 in response to the difficulties of resettling a vast number of refugees. The act made resettlement services uniform across states and created the U.S. Refugee Admissions program to oversee local resettlement agencies (ORR, 2021).

The U.S. Refugee Admissions Program provides a pathway for resettlement through local non-profit resettlement agencies who provide refugees with resources for education, housing,

employment and medical care. In the U.S., there are ten nonprofit resettlement agencies that have a cooperation agreement with the Department of State to host individual refugees who are granted approval for entry. The role of resettlement agencies is to help refugees during the first five years of resettlement in the U.S. by linking them with social or linguistic services, assisting them with job applications, enrolling children in school, gaining access to medical services, and applying for Social Security cards (U.S. Department of State, 2023).

For healthcare, the Refugee Health Promotion (RHP) program was established to provide funding to support the physical and mental wellbeing of refugees on a regular basis (ORR, 2023). The RHP program has three essential objectives, strengthen health literacy, care coordination to improve physical and emotional wellbeing, and establish health and wellness groups for newly arrived refugees. RHP services include developing programs for personalized health engagement, coordination of medical services, and acculturation and support services for refugees (ORR, 2023).

According to the United Nations High Commissioner for Refugees (UNHCR), the United States has accepted over 3 million refugees from all around the world since 1975 (UNHCR, n.d.) Over the past ten years, countries contributing to the highest numbers of U.S. refugees include Burma (21%), Iraq (17%), the Congo (13%), and Bhutan (12%) (DHS, 2022). Despite the relative geographic distance of the United States from many of the world's refugee crises, these challenges directly affect U.S. immigration policy.

The number of refugees residing in the United States fluctuates depending on the political instability of other nations and the urgency of the problems these individuals face. The racial variability of refugee populations may pose additional challenges for the U.S. healthcare systems in addressing their unique healthcare needs, including language and cultural barriers (Feinberg et

al., 2020). While Language Access Services (LAS) and culturally appropriate care are essential for all refugee populations, the specific needs and challenges may vary based on the refugees' country of origin and cultural background.

Challenges and Barriers for Refugees

Many factors may influence how U.S. refugees perceive healthcare. Language challenges present a significant barrier, as many refugees may not speak English well and have difficulty interacting with healthcare professionals. The accessibility of healthcare services is another important consideration since refugees may reside in places with poor access to healthcare facilities or have difficulty paying for care (Omenka et al., 2020). Cultural misconceptions and discrepancies between refugees and healthcare professionals can also impact the standard of treatment. For example, female refugees may not feel comfortable seeking care from a male provider due to cultural traditions. The attitudes and expectations of refugees towards healthcare in the U.S. might also be influenced by prior experiences with healthcare in their home countries or during their migratory route (Omenka et al., 2020).

For refugees, the intricacy of the U.S. healthcare system may be complex, especially for those unfamiliar with the system's complexities. Many migrants come from nations with diverse healthcare systems and attitudes about health and sickness. Cultural perspectives and experiences can also affect how refugees view healthcare. Cultural obstacles like the stigma associated with mental health or conventional healing methods may impede refugees from seeking help or adhering to treatment regimens (Omenka et al., 2020). Although many refugees use homeopathic or holistic medicine as part of self-management, they do not view these treatments as a replacement for modern western medicine (Morris et al., 2009). It is imperative to address these

cultural aspects to improve the healthcare experiences of refugees in the U.S. and ensure they receive culturally appropriate care (Feinberg et al., 2020; Omenka et al., 2020).

Several variables may potentially impact the trends in care-seeking behavior among U.S. refugees. Some U.S. migrants might choose to receive treatment from religious and spiritual leaders and institutions such as churches or mosques due to a variety of factors, including lack of access to culturally competent providers, language access challenges, cost of care, mistrust in providers and the U.S. healthcare system and discrimination (Omenka et al., 2020).Many viewed seeking preventative care as a waste of time and drain of their resources (Omenka et al., 2020).

The U.S. healthcare system's complexity may have an effect on migrants on both a personal and economic level. For example, a combination of factors may cause refugees to seek non-emergent care in emergency rooms, which can be expensive and tax the healthcare system's resources (Fennelly et al., 2006; Matlin et al., 2018). One of these factors is a lack of knowledge of how the U.S. healthcare system functions, particularly the referral process from primary to specialist care and how to effectively utilize insurance. Another factor is that many physician offices do not have medically trained interpreters when providing care, whereas emergency departments are required by law to have language access services on site. Additionally, transportation is a common barrier to receiving care, which may lead to refugees over utilizing ambulance services to the emergency department. Furthermore, refugees may put off seeking care because they are unsure or confused about the healthcare system, which might aggravate their health concerns and eventually result in higher healthcare expenses (Matlin et al., 2018; Omenka, 2020).

Individually, migrants may find it difficult and stressful to navigate the healthcare system for several reasons. Accessing care may be challenging due to language problems, cultural

differences, and a lack of knowledge of the system, which can cause irritation, worry, and feelings of loneliness (Fennelly, 2006). Cultural differences may affect the standard of care received, For example, some migrants may confront prejudice or experience anxiety while speaking with healthcare professionals about sensitive medical issues. Lack of faith in healthcare professionals and the healthcare system may also result from the system's complexity, making it harder for refugees to get timely, high-quality care (Omenka et al., 2020). Refugees who live in the U.S. may also exhibit harmful health behaviors, including delaying medical attention and visiting emergency rooms for non-emergent ailments (Omenka et al., 2020). These actions may have an adverse effect on the health of refugees, resulting in higher healthcare expenses, and an increased burden on the resources available to the healthcare system (Fennelly, 2006).

Refugee Cultural and Language Experience

Refugee perceptions of healthcare can positively or negatively impact their interactions with providers and medical professionals. In their home countries, refugees often wait to seek care until conditions are severe, and may not see the value of preventative care. Cultural beliefs and previous health care experiences have created the expectations that U.S. doctors have the ability to "cure" chronic diseases instead of managing disease (Morris et al., 2009). Additional expectation is that receiving care will occur immediately and not require numerous visits (Morris et al., 2009). These expectations are often not met by the U.S. health care system resulting in frustration and disappointment from refugees (Morris et al., 2009).

Many refugees in the U.S. often share a collectivism view toward seeking medical care. Collectivism in the context of seeking health care refers to the idea that health beyond the individual to the family and community (Lenderts et al., 2021). For Example, refugee patients are more likely to have their families with them during medical appointments. In contrast, non-

refugee U.S. patients are more likely to have an individualistic perspective while accessing medical care. Individualism refers to the self as different and separate from others (Le, & Kato, T. 2006). The difference between the individualistic and collectivistic approach is that it changes how these individuals interact with the U.S. health care system. To ensure that refugees in the U.S. receive high quality, culturally sensitive treatment that fits their specific healthcare requirements, it is imperative to address these issues (Omenka et al., 2020).

Providing culturally appropriate healthcare is essential to healthcare delivery, particularly for LEP refugees, who face numerous barriers to accessing healthcare services. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are a tool for health care organizations to improve their provision of culturally and linguistically appropriate services. (CLAS). The National CLAS Standards provide health care organizations with a set of action steps to meet the needs of LEP individuals from culturally and linguistically diverse backgrounds (Barksdale et al., 2017). Several studies have found that adherence and enforcement of the federal CLAS regulations is inconsistent within the U.S. (Barksdale et al., 2017). Some healthcare organizations in the U.S. lack an understanding of how to implement the CLAS standards, leading to diminished quality of care for LEP refugee patients. Culturally relevant healthcare involves recognizing and respecting patients' cultural beliefs, practices, and values and tailoring healthcare services to meet their specific needs (Matlin et al., 2018). Understanding and addressing the distinctive cultural beliefs and practices of refugees is necessary for providing culturally appropriate healthcare.

In addition to the development of CLAS standards, the NIH and CDC define health literacy as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and

others" (Paasche-Orlow & Wolf, 2007). Health literacy is critical to advancing health eqiuty and occurs at both the personal and organization levels. Health literacy on a personal level refers to the ability of an individual to find, understand and use health information services. (CDC, 2023) Organizational health literacy is the ability for an organization to equitably enable individuals to find, understand and use health information and services (CDC, 2023). Previous research has found that refugees with LEP are more likely to have levels of low health literacy (Feinberg et al., 2020). Refugees may experience poor health outcomes a direct result of having low levels of health literacy (Paasche-Orlow & Wolf, 2007). Health literacy is not the sole responsibility of the patient (refugee) as an individual, and instead dependent upon how health information is delivered (Feinberg et al., 2020). Health care organizations have a responsibility to improve communication and patient navigation that can encourage patients to become engaged in the healthcare process and manage their own health. Language access is a key component in Health information delivery.

Language access services provide LEP individuals equal rights to the same services as English-speaking individuals (Migration Policy Institute, 2014). For many refugee's language is synonyms with culture. Language access services and support play a crucial role in ensuring the delivery of culturally appropriate healthcare for LEP refugees by facilitating effective communication between patients and the healthcare team. For example, refugees are likely to experience challenges that are more significant if they speak a single language that their healthcare team is not fluent in, this suggests that the U.S. healthcare system may need clear strategies to deal with these language barriers (Bang et al., 2023). Language access services include translation, which is access to text based written word. Language services also include interpretation, which is oral and signed languages that capture tone and inflection (OMH n.d).

There is a need for health professionals to know the difference between interpretation and translation and provide access to both for refugee patients. Language access services should be provided to individuals with limited English proficiency, especially in healthcare settings, to ensure that language barriers do not hinder access to care. Difficulties with language and culture affect how well refugees are treated in the U.S. They require adequate language access services and support. For refugees in the U.S. to receive better healthcare, it is crucial to address both linguistic and cultural barriers.

Challenges for Providers and the U.S. Healthcare System

Healthcare providers in the United States face numerous challenges when providing care to refugees, particularly regarding communication and language barriers. Refugees often come from diverse backgrounds and may speak different languages, making effective communication between healthcare providers and patients challenging. This can substantially impact the standard of care and patient outcomes.

Provider Communication and Language Challenges

The inability of healthcare professionals to communicate adequately with refugees is a significant problem. Previous studies have found that healthcare professionals may not be fluent in the languages used by refugees, which makes it challenging to obtain complete health records, interpret symptoms, and explain diagnoses and treatment options (Warden et al., 2017). This challenge may lead to misunderstandings, incorrect diagnoses, and ineffective therapies, resulting in subpar care. Refugees unfamiliar with the U.S. healthcare system, including cultural norms, practices, and expectations, create additional challenges for providers. Refugees may struggle to communicate with their physicians since they may not recognize the value of adopting treatment programs, administering medications as prescribed, or attending follow-up

appointments (Terasaki et al., 2019). Finally, the dependence on language interpreters can present its own set of difficulties. Lack of accessibility to interpreters or their lack of medical terminology training may result in communication errors (Eckstain, 2011). These language challenges may have an adverse effect on the patient-provider relationship due to a lack of rapport and trust between the healthcare provider and the refugee patient.

Provider Cultural Challenges

In addition to providing culturally appropriate healthcare, providers may struggle with differences in health beliefs and practices. Refugees' cultural backgrounds may influence their views on health, disease, and treatment. For example, refugees may prefer traditional or alternative treatments to Western medicine or have cultural taboos or preferences surrounding medical procedures or treatments. In order to deliver evidence-based care, healthcare professionals must be aware of cultural differences and respectful of these beliefs (Terasaki et al., 2020). This necessitates cultural competence, also known as cultural humility, which is defined as acknowledging, respecting, and adjusting care to the various cultural backgrounds of refugees (Danso et al., 2018).

Varying perspectives on healthcare authority and communication methods may also be cultural barriers. While some cultures expect patients to be actively involved in decision-making and self-advocate, others may expect consumers to defer to healthcare practitioners without raising questions or concerns. Healthcare professionals must be aware of these variations and modify their communication methods, accordingly, ensuring that refugees are empowered and aware of their healthcare alternatives (Eckstain, 2019). By overcoming these cultural obstacles, healthcare professionals may offer equitable and patient-centered treatment to refugees, enhancing their general well-being and achieving improved health outcomes. In order to offer

effective and compassionate care, healthcare professionals must be culturally competent, use qualified translators, and consider the specific cultural needs of refugees.

In conclusion, healthcare professionals face considerable problems when providing healthcare to U.S. refugees due to communication, linguistic barriers, and cultural differences. To ensure that refugees receive high quality and fair healthcare treatments, healthcare providers need to be culturally competent, use efficient communication methods, and address health literacy issues. To better understand and address the particular needs and challenges of refugees in the U.S. healthcare system, it is necessary to increase capacity through education, training, and resources. Various organizations, including public health clinics, community health centers, and hospitals, provide healthcare for refugees in the U.S. However, U.S. healthcare providers face several challenges when caring for refugees, including a lack of training on refugee health, limited resources for hospital staff, and inadequate language access services and support (Fennelly, 2006). Providers may need to be made aware of refugees' unique lifestyles and struggles and to familiarize themselves with their cultural beliefs and practices. As a result, providers may struggle to deliver culturally appropriate healthcare, leading to dissatisfaction and mistrust among refugee patients. Moreover, providers might not have the tools and finances necessary to offer the degree of care that refugees need, particularly if those migrants have complicated medical requirements. To address these issues, healthcare personnel should receive the necessary training, education, and awareness to offer culturally competent treatment to refugees in the U.S.

Methods

Search Strategy

A search was be conducted in three electronic databases PubMed, Embase, CINAHL and Scopus from January 2013 to May 2023 to identify practices in the last 10 years that have improved healthcare and language access services for LEP refugees living in the U.S. A search was conducted using the following keywords: ((refugee) AND (healthcare practice OR language service OR interpretation service OR language access service OR communication service) AND (intervention)) AND (united states))

Inclusion and Exclusion Criteria

Studies included in this review were practice-based articles published in the United States, in the past 10 years (2013-2023). For this systematic review, a practice based article was defined as an experimental or quasi experimental intervention or a practice guide line. A practice guideline is a published statement that includes recommendations for physicians and health care providers that are intended to improve patient care. Other inclusion criteria included studies focusing on practices or interventions aimed at improving healthcare and language access services for limited English-speaking refugees, and All publications that propose, discuss, or formally assess a practice-based model or intervention were included in the systematic collection and analysis.

Studies that were excluded from this review were articles published in countries outside the USA, publications prior to 2013, and non-research-related publications (editorials, dissertations, etc.). Other review articles, articles not published in English, and articles published regarding individuals who have not obtained legal refugee status as per the U.S. definition were excluded. Finally, articles were excluded that only report on health needs, barriers, and

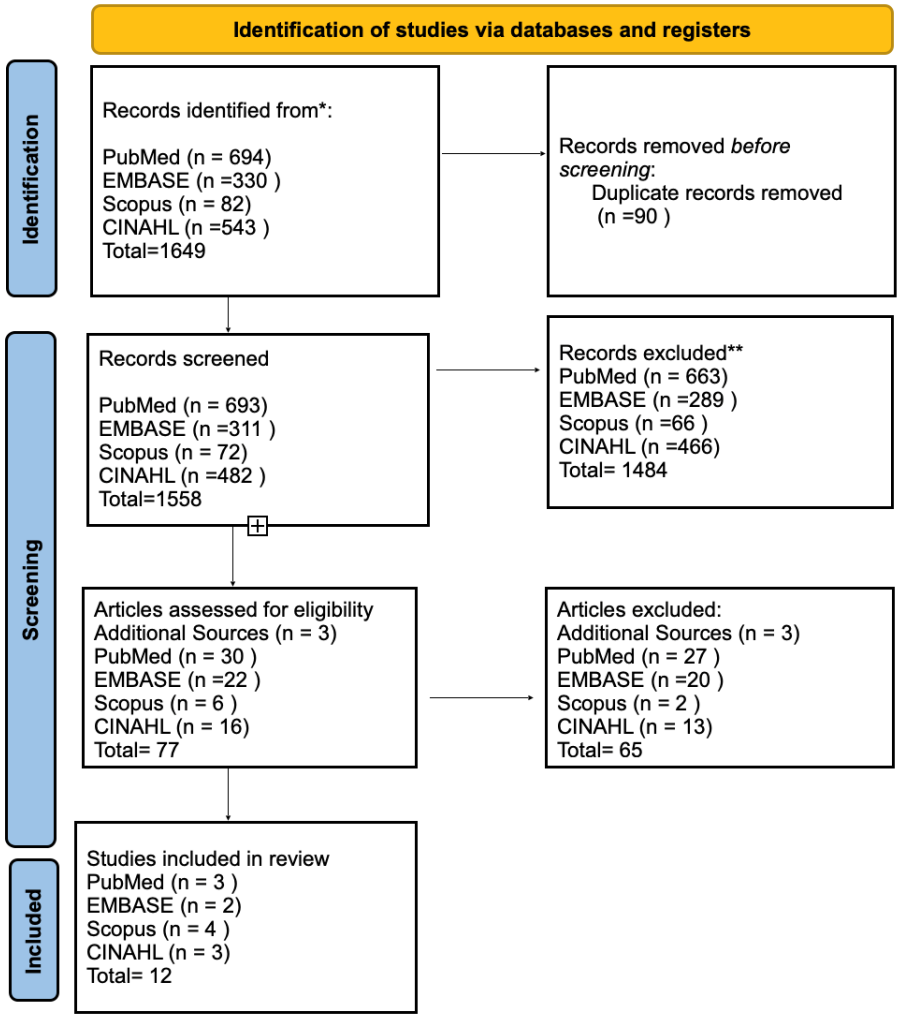
challenges to healthcare access among refugees without containing the element of specific practices.

Study Selection

Databases was searched systematically, using the methodology from Selvan et al., 2022 as a guide. The systematic search imported all references into the Refworks software system, remove duplicates, and conduct a systematic search using the following steps. Abstracts and titles were screened followed by a full-text evaluation for inclusion/exclusion criteria. Studies were included if they proposed, discussed, or formally assessed a practice-based model or intervention that improved healthcare or language access services for LEP refugees in the U.S. Reviews were collected and used for background material. Full-text article review were conducted independently by two researchers, and discrepancies are discussed accordingly. A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram summarizing the results from the screening process is reported in Figure 1. Data of interest were extracted from all eligible articles by researcher one and reviewed for accuracy by researcher two . Data extracted included the study authors, location, design, population, key findings, implications, and reported limitations.

PRISMA Diagram

Figure 1: PRISMA Diagram of Articles Included in Review



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Results

The initial search yielded 1649 articles. After removing duplicate entries, there were 1558 articles remaining. Titles and abstracts were screened by one author. Following the screening of titles and abstracts, a complete text review was conducted of 77 articles. After the full review, 12 of these articles met the inclusion criteria. The 12 articles included in the final review consisted of interventions (Tables 1-3), practice guidelines (Table 4), and quality improvement (Table 5). Among the 12 articles, 7 interventions focused on improving language access services for refugees, health care providers, or both. One article in this review conducted a quality improvement study with an intervention component, The remaining 4 articles were practice guidelines developed for healthcare providers. The 12 included articles were all conducted in the U.S., 2 in the Midwest, 3 were in the North East, 1 was in the South, and 4 were national practice guidelines. Only two articles in this review had a conceptual framework, these were the social cognitive theory and deliberate practice frameworks.

Table 1: Literature Review Evidence Table: Provider Interventions

Author/ Year	Location	Study Design	Sample Characteristics	Purpose Statement	Results of Interest	Outcome
Paetow,G./2023	Minnesota (Hennepin County Medical Center (HCMC))	Qualitative study (intervention study with a qualitative approach)	n= 20 residents= 1 faculty physician , n=1 Somali interpreter and two to four residents	Aimed to determine whether a brief cultural immersion experience, where small groups of residents share a meal with Somali interpreters at a Somali restaurant, would affect resident knowledge, attitudes, and behaviors when caring for Somali patients in a Minnesota emergency department.	100% of residents agreed or strongly agreed that this experience was worthwhile, that they would recommend it to colleagues, and that it improved their knowledge of Somali culture. 59% agreed or strongly agreed that this experience changed their attitudes, and 88% agreed or strongly agreed that it changed their behaviors when treating Somali patients. Four themes were developed from the qualitative analysis including (1) knowledge acquisition, (2) attitudinal changes, (3) behavioral changes, and (4) experience of sharing a meal.	Major theme of individuals who had developed increased empathy was their experience of being "other," allowing them to better relate to how their patients/clients felt as being "other" in our society. Connections and relationships with community members were made. The magnitude of difference between one's own culture and that of the culture they are immersed in was also mentioned as playing a role in increasing their cultural awareness.
Griswold,K.S./2021	Buffalo, NY	Intervention	Student participants: n=28 Patient participants (PPs) : included Iraqi (n = 3) and Burmese (n = 3)	Embedded a curriculum within an existing IPE program, for interprofessional student teams to learn from, about and with refugee patients and interpreters, to demonstrate and consolidate competencies for interpreted encounters.	Four major themes from student participants 1) interviewing PPs added value to learning about cultural and interprofessional communication, 2) the interpreter had an important and unique role for feedback in the encounter, 3) this is an effective opportunity for cultural competency training, and 4) cultural identity of patients and providers are an integral part of patient encounters. Three major themes emerged for the PP group debriefing: 1) the value and maintenance of confidentiality is appreciated, 2)even when the interpreter spoke the PPs language, there may be cultural differences, and 3) rapport-building with patient and interpreter is important.	Authors state they have tapped into a new teaching paradigm of 'patients as teachers' and that this paradigm can be applied to teaching about health disparities settings other than the resettled refugees, such as homeless, incarcerated and veteran populations. Taken together, this interprofessional curriculum for different health professions has the potential to positively impact health inequities due to language divide across health systems, by optimizing communication skills for working with interpreters.

Bernhardt, Lydia J/2019	Baltimore	Longitudinal Experiential Study (intervention study)	Mean of 15 students per year 2012–2016	To provide refugee/Asylee patient partners with health education, mentoring, and advocacy to improve their ability to navigate the U.S. health care system independently	Below are the major themes: 1) Using clear and precise language, 2)Listening actively and seeking to understand, 3) Communicating effectively via interpreters, 4) Appreciating the cultural lenses through which patients experience illness, 5) Emphasizing physicians' responsibility in patient follow-up, 6) Connecting across language barriers, 7) Understanding socioeconomic barriers to care and, 8) Valuing patient- centered exposure to the complexity of the U.S. health care system.	From 2012 to 2016, the RHP served 20 refugee families and engaged 60 students across four cohorts. Refugee participant retention was 20/22 (90.9%), and student retention was 57/60 (95.0%). In surveys completed at the end of their programs, students reported improvement in all measures, including understanding of different patient perspectives as well as comfort in communicating with patients across cultures and language barriers.
Farokhi, Moshtagh R/2014	San Antonio	Intervention	Thirty-two dental, 83 medical, and 118 nursing students	Aimed to raise oral health awareness for the newly arriving refugees to San Antonio while providing mentorship for the dental students. The vision for this oral health clinic is to provide dental students with an opportunity to practice their diagnostic skills, promote oral health, and increase access to oral health care for these refugee patients	This IPE collaborative project has surpassed faculty expectations of bridging the gap between theory and practice. It has produced true fellowship, scholarship opportunities for faculty and student involvement while highlighting awareness of the importance of service to the community. The use of this interprofessional model has resulted in holistic and accessible health care for the refugees in San Antonio.	Outcomes of this project have focused on the education of the refugee participants on access to oral health care by providing nutritional counseling as it relates to oral health, oral cancer screenings, and complete head and neck exams. Since its inception, students have gained skills and depth from this reflective, mentor-led community service opportunity. Additionally, the refugee patients have benefited significantly from oral health services administered in a culturally sensitive manner.

Table 2: Literature Review Evidence Table: Refugee Interventions

Author/ Year	Location	Study Design	Sample Characterstics	Purpose Statement	Results of Interest	Recommendations	Outcome
Ellis,B.H./2013	US, New England	Intervention study with a longitudinal approach)	n=30, n=18 Somali,n=12 Somali Bantu ethnicity	Project SHIFA aims: 1) provide services matched to the level of mental health distress as defined by symptoms of depression or PTSD, two primary mental health needs of refugee children, 2) asses effectiveness of Project SHIFA in addressing mental health and resource problems among refugee youths through a longitudinal assessment of students enrolled in Project SHIFA.	The program facilitated high levels of treatment engagement , with 100% of students referred for higher levels of care successfully agreeing to and engaged in treatment. All children showed improvements in resources over time. Mental health interventions with refugee youths may be more effective when resource gaps are directly addressed as integral components of treatment.	Further research that allows for comparable comparison groups and larger sample size will be necessary to determine the effec- tiveness of Project SHIFA and TST with refugees.	Project SHIFA show significant improvements in symptoms of both PTSD and depression for all participants over time.
Gondek, Matthew/2015	Buffalo, NY	Intervention	Women from Burma or Thailand (n=27), Nepal (n=38), Somalia, Angola, Congo, Ethiopia, Eritrea (n=7) Spain, the Dominican Republic, Puerto Rico, Panama, Brazil (n=2) Yemen, Iraq, Iran, Afghanistan, Lebanon, and other Middle Eastern nations (n= 26)	The primary goal of the program was to increase awareness and knowledge of breast health among immigrant and refugee women.	Flexible, language-appropriate educational programs delivered in community settings are able to reach targeted populations resulting in increased breast cancer knowledge among a diverse mix of immigrant and refugee women. Observed significant improvements across all six knowledge items based on post-program assessments. The findings demonstrate that a single-session, focused education program, along with navigation services, results in measureable improvements in knowledge and behavior changes.	Future research, beginning with formative research such as focus groups, is needed to understand how various cultural, religious, and/or social factors may have differentially influenced receptivity. Additional educational tailoring or program design revisions may be needed to address the needs and cultural values of women from specific regions.	This program was able to access diverse immigrant and refugee populations who have not been previously studied. The findings suggest that a health education program delivered in community-based settings and involving interpreters can enhance breast cancer knowledge. In addition to changes in knowledge, Authors noted improvements in the completion of mam-mography.

Table 3: Literature Evidence Table: Provider and Refugee Interventions

Author/ Year	Location	Study Design	Sample Characterstics	Purpose Statement	Results of Interest	Recommendations	Outcome
Avanthi Ajjarapu/2021	US (Midwest)	Intervention	n=30 OBGYN health care providers and Congolese Adults (n=N/A)	The CHP had two goals: (1) improve knowledge about healthcare during pregnancy and childbirth among Congolese refugees and (2) build trust between Congolese families and healthcare providers.	The CHP continues to provide key insight into the need for more culturally appropriate care among this growing community and can be used as a case study to inform efforts to reduce refugee health disparities more broadly in the U.S. As healthcare providers and medical students became more involved in the CHP, it became apparent that one way to take action to address the health disparities that exist in our community is to develop the capacity within our residency training programs to care for patients from non-Western cultures and/or cultures that differ from that of standard biomedicine practiced in the U.S.	Focus on the necessity of cultural humility, rather than cultural competence, when caring for obstetric patients from diverse backgrounds. Cultural humility forces providers to think about power imbalances that exist between a patient and provider when cultural differences exist. We describe specific barriers to care among Congolese refugees living in eastern Iowa and explore ways to utilize community-provider partnership and cultural humility training to address obstetric morbidity.	Residency and medical school education programs can integrate contextualized conversations about improved cultural awareness and sensitivity into their curricula, as well as utilize data from community-based partnerships, like the CHP, to formulate case-based simulations for resident training sessions, to both increase resident competence in practicing cultural humility and address community-specific needs as described by the community itself.

Table 4: Literature Evidence Table: Practice Guidelines

Author/ Year	Location	Study Design	Sample Characterstics	Purpose Statement	Results of Interest	Recommendations	Outcome
Squires,A./2017	US	N/A	Patients, healthcare providers(nurses) , and Medical interpreters in the US	This article provides background information about language barriers between nurses and patients and some strategies for ad- dressing these gaps. After detailing how these barriers affect patient outcomes, practice based strategies are offered to improve outcomes and reduce readmissions	Aside from facilitating communication between patients and healthcare providers, medical interpreters can also serve as cultural brokers. The medical interpreter helps bridge the cultural divide between patients and clinicians.	N/A	The evidence-based tips for bridging language barriers between nurses and patients with LEP will help nurses provide optimal patient care. They can apply to nearly every healthcare deliv- ery setting, with some modification.
MONROY,MARIANNE/ 2015	US	N/A	health care providers (clinicians and physicians)	The article offers guidelines on how health care providers can develop protocols to help limited-English proficient patients understand medical treatment and advice as mandated by the U.S. Office of Civil Rights.	N/A	Best Practices: 1. Determine language preferences 2. Ensure understanding 3. Inform patients of their rights 4. Use qualified interpreters 5. Use caution with staff and family 6. Use video if appropriate 7. Don't forget written documents 8. Consider culture 9. Never refuse	N/A

Moch,Renae/ 2014	US	N/A	health care providers (clinicians and physicians)	There are five main steps practices should take to develop a strategy to overcome language barriers and improve the quality of care for LEP and hearing-impaired patients	N/A	1. Determine the need for services in your practice 2. Develop a policy 3. Determine the method of communication to be used during the patient encounter 4. Seek financial support for medical interpretation 5. Provide language-appropriate patient forms and educational resources	N/A
Juckett,Gregory/2014	US	N/A	health care providers (clinicians and physicians)	The use of professional interpreters (in person or via telephone) increases patient satisfaction, improves adherence and outcomes, and reduces adverse events, thus limiting malpractice risk	Best use of Trained Medical Interpreter: 1) Fewer errors in communication, 2) Improved patient satisfaction, 3) Interpreter may act as a cultural liaison, 4) Interpreter may clarify patient meaning beyond language, 5) Interpreter may function as a link between patients and the health system, 6) Lower malpractice risk, 7) Use of a trained interpreter is associated with significantly shorter hospital stays and 8) Use of a trained interpreter meets Title VI of the Civil Rights Act	Best Practices: Use of a trained interpreter meets the legal requirements of Title VI of the Civil Rights Act and should be offered to patients with limited English proficiency	

Table 5: Literature Evidence Table: Quality Improvement

Author/ Year	Location	Study Design	Sample Characteristics	Purpose Statement	Results of Interest	Recommendations	Outcome
Bull,J./2018	Denver, Colorado	QI study	n=2 family physicians, n=1 pediatrician, n=1 registered nurse (RN) and n=1 Bhutanese Nepali interpreter (cultural broker),n= 68 patients	Aims: 1) creation of a patient registry with RN care coordination; 2) development of a manual with guidelines and a care pathway to educate clinic providers, including residents; and 3) design and imple- mentation of a series of culturally-adapted group visits (GV) for patients and families with the same primary language	For all Failure to thrive (FTT) patients combined, there was a statistically significant increase in the number of clinic visits over what is typically expected for age-appropriate well-child checks comparing pre- and post-intervention (p=.002). In 2014, prior to the intervention, 50% of the SC cohort and 75% of the GV cohort had increased clinic visit numbers above what was expected for their age, and post-intervention in 2015 this increased to 75% and 100%, respectively.	Future research is needed with a larger numbers of patients to investigate why foreign-born children of immigrant and refugee parents are presenting with what appear to be elevated rates of FTT, and what primary care interventions are most effective. Failure to thrive seems to be a common issue among some immigrant and refugee children, a fact that deserves greater attention in the primary care setting.	The project created new opportunities for involvement and education of family medicine residents, including orientation to the educational manual and direct participation in GV facilitation. The curriculum was designed for reuse in future GVs for other language/ethnic groups. Given the low rates of parental health literacy, the GV model afforded more time for the education of parents collectively, with less repetition of the same clinical information to individual patients and families.

Intervention Articles

Interventions for Refugee Target Populations

Two articles in this review were focused on interventions for refugee populations. These interventions were targeted to overcome healthcare related challenges such as behaviors or perceptions based on previous experiences, as well as cultural expectations or differences. An intervention study in New England conducted a longitudinal outcome assessment of the project SHIFA (Supporting the Health of Immigrant Families and Adolescents) (Ellis et al., 2013). SHIFA is a prevention and community resilience program developed to provide targeted stress reduction intervention to mitigate psychological distress (Ellis et al., 2013). A multi-tiered intervention where participants received increasing levels of treatment based on the severity of their screening score. Participants enrolled in Tiers 1 and 2 did not receive direct services but instead focused on programs that engaged the community as a whole. Tiers 3 and 4 offered direct additional services and mental health care (Ellis et al., 2013). In addition, the screening tools used to categorize participants into the four tiers of treatment were specifically tailored to the participants and listened to community feedback (Ellis et al., 2013). The study population included 30 participants. Sixty percent (n=18) were Somali ethnicity and 40% (n=12) were Somali Bantu ethnicity. The mean age of participants was 13.0 years (SD 0.96), with a range of 11 to 15 years (Ellis et al., 2013). The objective of this study was to evaluate the effectiveness of project SHIFA by assessing appropriate levels of treatment engagement, improvements in mental health symptoms, and changes in resource hardships following the intervention (Ellis et al., 2013). Researchers conducted a series of surveys to measure the effectiveness of project SHIFA using the Adolescent Post-War Adversities Scale-Somali version, War Trauma Screening Scale, UCLA PTSD Reaction Index for DSM–IV, Depression Self-Rating Scale, and others (Ellis et al.,

2013). Participants in the study demonstrated an improvement of their mental health across all levels of treatment. Resource hardships (personal, social, or material) were significantly associated with having more symptoms of post-traumatic stress disorder (Ellis et al., 2013). The stabilization of resources (e.g., lack of resource hardship) yielded an improvement in symptoms of depression and post-traumatic stress disorder for participants in the top tiers of treatment (Ellis et al., 2013). Fidelity (adherence) to treatment was at 87.87% (Ellis et al., 2013). An important component of Project SHIFA, which may have contributed to the success of the intervention, was the use of cultural brokers in the development of the intervention as well as administration of screening tools and at-home treatments. The cultural brokers were individuals living within the community who had an extensive understanding of cultural values and community dynamics, as well as a working knowledge of mental health treatment systems, ethical norms, goals, and expectations (Ellis et al., 2013). Furthermore, cultural brokers were on hand to answer any questions that participants had regarding the study process, language translation, and relevance of the study. The authors of the study attributed high engagement and retention to cultural ties, resources, and collective community support (Ellis et al., 2013).

Another study that focused on community-based engagement implemented the Immigrant and Refugee Health Education Program in Buffalo, New York. This single-session, evidence-based breast health education program aimed to inform, increase awareness, and encourage mammography completion among medically underprivileged refugee women (Gondek et al., 2015). The program's major purpose was to raise breast health education and comprehension among immigrant and refugee women (Gondek et al., 2015). The Social Cognitive Theory was used as the program's framework (Gondek et al., 2015). The study population included women from Burma or Thailand (n=27); Nepal (n=38); Somalia, Angola, Congo, Ethiopia, or Eritrea

(n=7); Spain, the Dominican Republic, Puerto Rico, Panama, or Brazil (n=2); and Yemen, Iraq, Iran, Afghanistan, Lebanon, or other Middle Eastern nations (n= 26). Approximately 51 % of the participants were over age 40 years.(Gondek et al., 2015). After the intervention, mammography screening was completed by approximately 65% (n = 19) of eligible Burmese/Thai women and 43% (n = 12) of eligible African women, which was significantly higher compared to other races/ethnicities in the study (Gondek et al., 2015). The 14 community-based breast health education events in the intervention had a total of 348 participants (Gondek et al., 2015). Significant improvements were made in the knowledge-based pre and post-test evaluations. At the beginning of the study, participants identified a median of two correct answers, and in the post-test, they identified a median of four correct answers ($p<0.001$) (Gondek et al., 2015). A total of n=60 women (33%) completed mammograms following the program, included 20 who had never had a mammography prior to the intervention (Gondek et al., 2015). Of the 60 women who completed mammograms following the program, 70% had $\leq$ 6 years of formal schooling and 90% were between the ages of 40 and 59 (Gondek et al., 2015). Language interpreters were a valuable part of the intervention as they provided translation services during the enrollment of the program, while collecting key demographic information, throughout the educational sessions, during mammography screening, and while conducting the intervention post assessment (Gondek et al., 2015). In addition, the educational materials and PowerPoint slides were also available in the participants' native languages. Interpreters were present during the mammogram screening to enhance participant understanding about the procedure (Gondek et al., 2015). Furthermore, the educational sessions were conducted by a program director and/or a health educator who had expertise working with immigrant and refugee populations in community-based initiatives (Gondek et al., 2015). These interventions conducted successful

health education programs using a community-based approach, and were successful because interpreters were able to increase participant's knowledge and minimize language barriers for refugees.

Interventions for Provider Target Populations

Four articles in this review were focused on interventions for Provider Target Populations. These interventions were aimed at health care professionals to provide training for culturally competent treatment, how to utilize skilled interpreters, and increase understanding of unique cultural needs of refugees. An intervention study in Minnesota conducted a qualitative assessment utilizing a constructivist paradigm and a grounded-theory technique (Paetow et al., 2023). The purpose of this study was to determine if a brief cultural immersion experience (in which medical residents would share a meal with Somali interpreters at a Somali restaurant) would alter medical residents' knowledge, attitudes, and behaviors toward Somali refugees (Paetow et al., 2023). The study population included 20 E.R. medical residents, 1 faculty physician, 1 Somali interpreter (Paetow et al., 2023). Six meals were held with 2-4 residents in each group. Of the total n=20 residents in the study, n=17 (85%) participated in the assessment, survey and qualitative interview following the dinner (Paetow et al., 2023). According to the quantitative survey data, 100% of medical residents agreed or strongly agreed that this experience was beneficial, that they would suggest it to coworkers, and that it increased their knowledge of Somali culture. The post assessment found that 59% of medical residents agreed or strongly agreed that the cultural immersion experience impacted their views toward Somali patients, and 88% agreed or strongly agreed that it changed their behaviors while treating Somali patients. The qualitative interviews yielded four themes from the medical residents, information

gain, attitude changes, behavioral changes, and experience of sharing a meal. (Paetow et al., 2023). This study is significant to the literature review because medical residents were able to closely interact with Somali interpreters who were part of the local community. This study also used an interpreter as a cultural broker, who served as an ambassador and guide, not just for translation but also for cultural guidance, which was a crucial reason for the success of the intervention (Paetow et al., 2023). The cultural broker also provided context and helped medical residents develop a greater understanding of historical trauma, the struggle of migration, and the experience of being a refugee (Paetow et al., 2023).

An intervention study in Buffalo, NY, conducted an interprofessional education program (IPE) by utilizing a flipped classroom setting (Griswold et al., 2021). The flipped classroom concept works by issuing self-study materials to students prior to a live learning session. The objective of the study was to address the gap in education for interprofessional students regarding interactions with interpreters and gain a better understanding of refugee patient needs (Griswold et al., 2021). The study population included interprofessional student participants (n=28) and patient participants (PPs). The PPs were Iraqi (n = 3) and Burmese (n = 3) refugees living in resettled local refugee communities, individuals from the Iraqi American Society, and the Burmese Community Support Group (Griswold et al., 2021). According to instructors, peers, interpreters, and patient participants, 80-92% of students were proficient in the skills necessary to use an interpreter (Griswold et al., 2021). During the intervention debriefing, students discussed the importance of interprofessional collaboration and case management, especially communication among teams, in providing quality care to refugees with limited English proficiency (Griswold et al., 2021). The feedback from the student participants was categorized into four major themes, 1) interviewing P.P.s was essential in learning about cultural and

interprofessional communication, 2) interpreters have an essential and unique role for feedback during patient interactions, 3) the program was a productive opportunity for cultural competency training, and 4) cultural identity of patients and providers are a fundamental part of patient encounters (Griswold et al., 2021). The P.P.s provided the following feedback 1) maintaining confidentiality is important 2) interpreters who speak the same language as patients may come from a different culture, 3) it is essential for patients and interpreters to be comfortable with one another (Griswold et al., 2021). This intervention is significant to the literature because it provided an opportunity to train healthcare professionals on the skills necessary to engage with resettled refugees and proper use of interpreters. The P.P.s offered valuable information on how to work with an interpreter, discussed their own cultural experiences, and gave health care students a practical opportunity to develop their cultural competency skills. (Griswold et al., 2021).

Another intervention that utilized an interprofessional approach to healthcare training was the Refugee Health Partnership (RHP) conducted in Baltimore. In 2011, students and staff from the Johns Hopkins University School of Medicine created the RHP at a nearby refugee resettlement organization. In this program, teams of preclinical medical students were matched with newly relocated refugees or asylees who required specialized medical care (Bernhardt et al., 2019). Following training, students assisted patients in navigating the healthcare system for a year by making monthly home visits and accompanying them to appointments (Bernhardt et al., 2019). Students took part in monthly seminars led by knowledgeable academics and visitors as well as attended monthly reflection activities to analyze experiences (Bernhardt et al., 2019). The intervention had a longitudinal experimental assessment approach (Bernhardt et al., 2019). The study population was an executive board that consisted of student leaders, affiliated faculty,

agency staff, and selected cohorts of preclinical medical students (15 per year) (Bernhardt et al., 2019). The RHP provided services to 20 families from 15 different countries of origin, with Sudan and Bhutan having the highest representation (Bernhardt et al., 2019). Of the 20 families, 17 (85.0%) were from the Middle East or Africa, however, only 1 (5%) of the families was a refugee family (Bernhardt et al., 2019). The intervention created four cohorts from 2012 to 2016 consisting of 20 refugee families and 60 students across all cohorts (Bernhardt et al., 2019). Cohort assignment was based on student and participant language proficiency, access to transportation, prior experience, and, if relevant, gender preferences (Bernhardt et al., 2019). The intervention was determined to be successful and measured mean differences in attitudes and awareness on a Likert scale of 1 to 5. Understanding of various patient viewpoints had a mean difference increase of 1.21, comfort in talking with patients across cultural and linguistic barriers increased by 1.11 and 1.82 respectively (Bernhardt et al., 2019). During the intervention students learned about the use of interpreters, intercultural communication, and refugee/asylee mental health (trauma-informed care) as part of their monthly curriculum (Bernhardt et al., 2019). While interacting with program refugee/asylee families, students had the opportunity to practice interpreter-assisted communication, as interpreters were readily available over the phone or in person (Bernhardt et al., 2019). Students credited the RHP for improvements in their communication skills across cultural and linguistic boundaries as well as their comprehension of refugee/asylee patient viewpoints (Bernhardt et al., 2019).

An intervention that utilized interprofessional approach to healthcare training conducted in San Antonio. The San Antonio Refugee Health Clinic (SARHC) is a dental clinic operated and led by students and faculty (Farokh et al., 2014). Participants in the study included 32 dental, 83 medical, and 118 nursing students (Farokh et al., 2014). The objective of the program was to

mentor students while promoting oral health awareness among recently resettled refugees in San Antonio. The goal of this dental clinic was to enhance oral health, expand access to dental treatment for refugees, and give dentistry students a chance to hone their diagnostic abilities (Farokh et al., 2014). Refugees from Nepal, Burma, Iraq, Iran, Congo, Burundi, and Thailand made up the majority of the clinic's patients. Results from the study confirmed that offering individualized oral health and nutrition education, counseling for quitting smoking, and teaching on cultural competence, the intervention improved access to dental treatment (Farokh et al., 2014). The outcomes of the initiative have been concentrated on educating the participants who are refugees about access to oral health care by offering nutritional advice related to oral health, oral cancer screenings, and thorough head and neck exams as a part of an overall oral health screening (Farokh et al., 2014). This introspective, mentor-led community service experience helped student participants develop their skills and knowledge regarding providing care to U.S. refugees. Authors stated that it was difficult to discern who benefited the most from this intervention; the health care student participants gained knowledge and the refugee patients gained improved care (Farokh et al., 2014). Dental students in this clinic continue to participate in this ongoing program that has been successful due to the long-standing relationships between this academic institution and key community organizations (Farokh et al., 2014). This intervention is an excellent example of the benefits of community engagement in healthcare program offerings.

Interventions for Combined Refugee and Provider Target Populations

There was a single article in this review focused on multiple interventions for provider and refugee target populations, conducted in the Midwest, called the Congolese Health

Partnership (CHP) (Ajjarapu,et al., 2021). The CHP was established by a university in the Midwest,an academic hospital, and the Congolese community (Ajjarapu,et al., 2021). The target population included the department of Obstetrics and Gynecology (OBGYN) (n=30) health care providers and Congolese adults in the community (n=N/A) (Ajjarapu,et al., 2021). The aim of the CHP program was to increase access to proper healthcare for pregnant Congolese women and their families. The intervention had two overarching objectives to 1) promote understanding among Congolese refugees about healthcare throughout pregnancy and delivery and 2) foster trust between Congolese families and healthcare professionals (Ajjarapu,et al., 2021). In the Congolese group discussion, concerns such as community mistrust in medical providers, concern over misjudgment and the overuse of C-sections and, uncertainty of health insurance coverage throughout pregnancy and childbirth were all highlighted during group discussion (Ajjarapu,et al., 2021). In the healthcare professionals discussion group, these participants expressed worry about language barriers, a lack of understanding of culturally specific preferences for obstetric care in the community, and insufficient awareness of legal policy regarding insurance for Congolese mothers (Ajjarapu,et al., 2021). Outcomes from this intervention were the development of four educational sessions on prenatal care, delivery (including C-sections), postnatal care right after childbirth, and health insurance (with an emphasis on Medicaid) (Ajjarapu,et al., 2021). The material for the educational sessions was developed by a team of healthcare experts, educators, and students alongside community involvement (Ajjarapu,et al., 2021). The educational content for the sessions was translated into the local languages of the Congolese population, Lingala and Swahili. Additionally, a training session on the history of the conflict in the Democratic Republic of the Congo was developed for healthcare providers. Experiences of Congolese refugees were also shared with healthcare providers including,

receiving medical care at home and in the U.S., and the cultural expectations of Congolese families regarding pregnancy and childbirth (Ajjarapu,et al., 2021). The authors mention that one way to address health inequalities in the refugee community was to build capacity within residency education programs; the purpose being to provide care for patients from communities that are different from the standard biomedicine practiced in the U.S. (Ajjarapu,et al., 2021). The CHP offered significant insight into the need for greater culturally competent treatment within this community and can serve as a case study for initiatives aimed at reducing health inequalities among refugees in the United States (Ajjarapu,et al., 2021).

Practice Guideline Articles

Four articles in this review were focused on practice guidelines for healthcare providers. These articles provide a list of guidance for healthcare providers and physicians that are meant to improve the treatment of patients and language access in the United States. The first practice guideline article focused on evidence-based methods for removing language barriers (Squires, 2017). This article offered an overview of language barriers that might exist between patients and nurses, as well as potential solutions. Practice-based recommendations were suggested to enhance health outcomes and decrease readmissions after describing how the lack of medically trained interpreters can impact patient outcomes (Squires, 2017). This guideline describes the role of medical interpreters as not only helping patients and healthcare professionals communicate, but also acting as cultural brokers (Squires, 2017). The article mentions that cultural gaps between patient and healthcare professional are reduced when using medical interpreters (Squires, 2017). This practice guideline is important because it highlights how nurses can organize their care more effectively by using these evidence-based practices: 1) Utilize the interpreting services provided by the organization, 2) exercise caution if employees who are not

medically trained interpreters provide interpretation, 3) Provide proof when utilizing medically trained interpreters, 4) Use medically trained interpreters (at admission, during patient education, and at discharge), 5) Place a high priority on patient medication adherence understanding and 6) health care providers and nurses should be vocal about the importance of limiting linguistic barriers for patients (Squires, 2017). These guidelines can also be implemented in variety of different healthcare settings with minor changes (Squires, 2017). The author mentions that these evidence-based practice guidelines will assist nurses in overcoming language barriers and providing appropriate treatment for their patients.

The second practice guideline article focused on procedures that healthcare professionals should implement in clinical settings to assist LEP patients in understanding their medical care as required by the U.S. Office of Civil Rights (Monroy, 2015). All LEP patients who are receiving governmental financial assistance need to offer interpretation services, excluding patients who are on Medicare Part B, per Title VI of the Civil Rights Act (Juckett & Unger 2014; Monroy, 2015). The following guidelines have been identified by the author as best practices. 1) Find out the patient's native language, both spoken and written. 2) Establish whether the patient needs an interpreter. Health care professionals must not presume that a patient who speaks more than one language understands them. Ask patients to repeat vital information regarding their treatment and follow up before discharge. 3) Explain to the patient that they have a right to a professional interpreter at no cost. 4) It is important to use a trained interpreter during treatment, discussing patient follow up and, when obtaining a patient's medical background and consent. Throughout examinations and assessments, interpreters are required to respect their duties, preserve objectivity, and maintain privacy. 5) Although it could be acceptable in some instances to depend on bilingual employees, doing so could be harmful if the employee does not have a strong

understanding of healthcare terms in both languages. Utilizing family members as translators should be avoided since they frequently lack the necessary medical term comprehension skills and may have ulterior motives at odds with the patient's best interests. Additionally, it could cause issues with patient privacy. 6) Despite the fact that in person interpreters are frequently advised, the Department of Health and Human Services (HHS) is aware that over-the-phone or virtual interpretation could be needed. 7) Clinics and Hospitals should offer written documents that have been translated into the patient's native language. Translations of significant documents are required. 8) Culture and language are not the same. Health care professionals and interpreters ought to be mindful that culture affects ways of communicating as well as knowledge and conduct related to health. 9) More importantly, healthcare professionals never decline to offer language access services, charge LEP patients for these services, or postpone critical or urgent medical treatment (Monroy, 2015).

The third practice guideline article also developed a best practices for health care professionals with the objective to limit language barriers and improve the quality of care for LEP patients (Moch,et al., 2014). The following guidelines were developed as best practices. 1) Evaluate if interpretation services are a necessity (look at HHS mandates and guidelines), 2) Create guidelines (For LEP patients and personnel, a documented policy adhering to Title VI of the Civil Rights Act of 1964 should be prepared. When creating policies for interpretation, healthcare practitioners should also be included), 3) Decide on the patient communication approach to be implemented (in order to evaluate whether interpretation is required in person or over the phone, it is critical to gather data about patient's native language), 4) Enlist financial support for medical interpretation (The District of Columbia and 13 states currently cover interpreters for Medicaid/SCHIP plans: Hawaii, Iowa, Idaho, Kansas, Maine, Minnesota,

Montana, New Hampshire, Utah, Vermont, Virginia, Washington, and Wyoming), 5) Provide patient documentation and instructional resources in the patient's native language. (Moch,et al., 2014).

The final practice guideline article also highlights the importance of having a professional interpreter whether in-person or over the phone as doing so will lower the risk of malpractice by improving patient adherence and poor outcomes (Juckett & Unger 2014). The following guidelines have been identified by the authors as best practices.1) LEP patients should be given the option to use a qualified interpreter as it satisfies the legal requirements of Title VI of the Civil Rights Act. 2) Health care professionals should speak to the patient in the first person while utilizing an interpreter 3) Better communication is facilitated when the interpreter is seated next to or slightly behind the patient. 4) Healthcare professionals should articulate the importance of sentence-by-sentence interpretation when utilizing an interpreter. 5) For LEP patients, a qualified interpreter should be utilized to enhance communication (leading to fewer mistakes), clinical results, and contentment with treatment (Juckett & Unger 2014). This practice guideline also highlights the significance of the four CLAS standard requirements: (1) Linguistic support for LEP patients should be provided at no charge; (2) patients need to be informed of the accessibility of interpretation services in the language of their choice, both written and spoken (3) It is crucial to use qualified interpreters, and 4) the use of unqualified interpreters or minors as interpreters ought to be prevented (Juckett & Unger 2014). The CLAS standards serve as a guide for healthcare professionals and practices to enhance the delivery of treatments that are both culturally as well as linguistically suitable. They provide healthcare institutions with a number of guidelines in order meet the requirements of LEP refugee patients with backgrounds that are culturally and linguistically diverse.

Quality Improvement Articles

A single study in this review used a quality improvement approach to conduct an intervention in Denver, Colorado (Bull,et al., 2018). This study sought to improve primary care for immigrant and refugee children with failure to thrive (FTT) in a clinic were increased rates of FTT were observed (Bull,et al., 2018). The objective was to improve assistance for healthcare professionals caring for these high-risk patients, standardize patient education delivered with cultural sensitivity, and eventually boost retention and follow-up of FTT patients inside the clinic to enhance their nutritional status and development (Bull,et al., 2018). The intervention had three main components 1) the development of a patient registry with registered nurse (R.N.) care coordination 2) a manual with instructions and a care pathway to instruct clinic staff, including residents, and 3) several culturally appropriate group visits (G.V.) for clients and families speaking the same native tongue (Bull,et al., 2018). There were 68 total participants including, (n=2) family physicians, (n=1) pediatrician, (n=1) registered nurse (RN), (n=1) Bhutanese Nepali interpreter (cultural broker), and (n= 68) pediatric patients with FTT (Bull,et al., 2018). Of the 68 pediatric patients, (n=56) were categorized into the standard of care (S.C.) group, while n=(12) patients from Bhutan categorized in the group visits(G.V.) group (Bull,et al., 2018). The G.V. group was the intervention component of the study and included additional time to the existing standard clinical visit, provided an educational setting for the medical team and families, facilitated conversations in the primary language of the refugee families and allowed for sharing, communication, and support among parents (Bull,et al., 2018).

In the overall cohort, 88.2% of the 60 children with FTT were born in the United States to immigrants or refugees, and 11.8% of them were born abroad to immigrants or refugees (Bull,et al., 2018). Comparing the number of pre- and post-intervention clinic visits for all FTT

patients, there was a statistically significant increase (p=.002) in the G.V. group compared to the S.C. group (Bull,et al., 2018). Post-intervention, providers (n=16) reported increased satisfaction and confidence when treating FTT in pediatric refugee populations (t-value=8.43, p< .0001) (Bull,et al., 2018). The availability of clinical resources like the FTT treatment guide and flowchart, as well as improved support provided by a multidisciplinary team like R.N. care coordination with the FTT registry and patient access to G.V.s, have all been cited by providers as factors that have increased confidence and satisfaction in caring for children with FTT (Bull,et al., 2018). This intervention is relevant as it demonstrates the necessary interprofessional collaboration of healthcare professionals when providing care to refugee populations. Similar to other articles in this review the involvement of cultural broker and interpreter contributed to the success of the intervention. In the intervention, the interpreter was able to explain many cultural distinctions and beliefs to health care professionals. In the G.V. group, the cultural broker provided program development guidance on customary dining habits, normal diets within and outside of refugee camps, and culturally appropriate teaching strategies. Although all clinic visits included counseling for FTT, such as behavior modification and increasing caloric intake, consecutive G.V.s allowed the researchers to analyze and alter each subsequent clinic visits based on cultural needs. This intervention improved the quality of treatment for immigrant and refugee children with FTT and is a successful example of a multidisciplinary, primary care-based Q.I. project (Bull,et al., 2018).

Discussion

The purpose of this systematic review was to identify practices in the last 10 years that have improved healthcare and language access services for LEP refugees living in the U.S. Overall, the results of the literature found that successful interventions involved cultural brokers and medically trained interpreters, and reinforced the importance of language access practice guidelines for healthcare professionals. In these interventions, high levels of involvement and retention were linked to available resources, community support, and cultural awareness. Additionally, successful interventions utilized qualified interpreters at multiple stages of the intervention including during the design, recruitment and implementation, as well as the evaluation stage. Accurate and effective translation of educational materials was another key feature in the success of the interventions in this review. Furthermore, collaboration of community partners who have first-hand knowledge in working with immigrant and refugee groups is essential for long-term change. This literature review also identified language access practice guidelines aimed at meeting the needs of LEP refugee patients. These practice guidelines provide detailed steps for health care providers and institutions on how they can meet the needs of LEP refugee patients with backgrounds that are culturally and linguistically diverse.

Cultural brokers and community advocates serve as ambassadors and guides, not just for translation services but also for cultural guidance. These individuals provide context for health care workers regarding refugee concerns stemming from historical trauma, migration challenges and the overall refugee experience. These results are consistent with previous literature in that cultural brokers provide a unique opportunity to enhance communication and trust between patients and clinicians from varying cultural backgrounds (DiMeo, 2023). Previous research has identified cultural brokers as individuals who can assist in developing culturally and linguistically competent practices and educational materials (Brar-Josan, 2019; DiMeo, 2023;

NCCC, 2023). A cultural broker is a trained representative who can bridge the gap between an individual or groups of different cultures with the purpose of improving communication (Brar-Josan, 2019; Jezewski & Sotnik, 2001). Healthcare institutions have an opportunity to prioritize access to cultural brokers and community advocates when developing these interventions.

Another important finding in this literature review is the utilization of qualified medical interpreters when caring for LEP refugees. Trained medical interpreters were a crucial component of the interventions as they provided language translation services at multiple stages. Medical translators not only facilitate communication between patients and healthcare professionals but also serve as liaisons between cultures; bridging cultural divides between patients and healthcare providers. Results from this literature review are in agreement with previous research in that qualified interpreters enhance the course of treatment and increase clinical outcomes (Fennig & Denov, 2021). Prior research indicates the use of skilled interpreters and cultural brokers to bridge the cultural and linguistic barriers that exist between health professionals and their refugee patients (Fennig & Denov, 2021; Kirmayer et al., 2011). Engaging qualified medical interpreters to reduce linguistic barriers lowers health risks, decreases costs, promotes patient satisfaction, and improves the standard of healthcare delivery (Bauer & Alegría, 2010; Fennig & Denov, 2021; Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007). Health care facilities should hire qualified and medically trained interpreters for all patient interactions involving LEP refugees.

Results from this review found that healthcare providers require extensive health education on how to communicate with refugees, proper utilization of translators, demonstrate cultural understanding, and cultivating cultural humility. These results are consistent with previous research that found structured and ongoing training programs in refugee health were not

historically offered to healthcare professionals (Asgary & Jacobson 2013; Rashid, Cervantes, & Goez, 2020; Toole & Waldman, 1997). Healthcare professionals who treat refugee patients have reported infrequent training lacking a focus on global health and practice-based learning (Asgary & Jacobson, 2013; Rashid, Cervantes, & Goez, 2020). Although the quantity of health care professional training curriculum has increased in recent years, these sessions are often delivered on a one-time basis and lack the longitudinal integration necessary for permanent change (Mohamed-Ahmed et al., 2016; Murphy-Shigematsu & Grainger-Monsen, 2010; Rashid, Cervantes, & Goez, 2020). Medical students who participate in education electives on refugee health report successful patient interactions while demonstrating cultural humility (Bernhardt et al., 2019; Dussán, et al., 2009; Rashid, Cervantes, & Goez, 2020). Health care professionals also report an increase in communication skills due to the incorporation of practice guidelines and a patient centered approach. An increase in knowledge regarding refugee health care related challenges was associated with an improvement in provider comprehension of obstacles to care accessibility and navigating the healthcare system (Bernhardt et al., 2019; Dussán, et al., 2009; Rashid, Cervantes, & Goez, 2020). Healthcare professionals should acquire the skills necessary to communicate with their refugee patients using an interpreter, while understanding the cultural experiences of refugees, and practicing cultural humility and competence skills. It is essential to provide comprehensive training and education for healthcare providers who work with refugee patients to improve healthcare outcomes.

Implications from this literature review may provide guidance on future research and practice interventions. Health care organizations should recognize the multifaceted role that cultural brokers play when serving LEP refugee populations. In healthcare, cultural brokers serve as interpreters, advocates, educators and assist with developing practice and training guidelines

for healthcare facilities. Cultural brokers should be recruited to serve as permanent staff members to serve in health care organizations and be involved in the design and implementation of language access interventions.

A practice implication from this study is that healthcare facilities would benefit from hiring qualified, medically trained interpreters for LEP refugee populations. Interpreters improve medical care by reducing cultural divides between patients and their physicians, enhance communication between patients and healthcare professionals, and improve treatment outcomes. As a result, interpreters should be hired on a part-time or full-time basis to assist healthcare institutions as well as be involved in interventions designed for LEP refugee populations. Health care professionals require comprehensive education on how to interact with refugees and the appropriate use of interpreters. Interprofessional education initiatives and long-term connections between academic institutions and community groups have been credited with the success of interventions for health care professionals. Qualified medical interpreters are an essential part in improving LEP refugee medical care.

Another implication for healthcare facilities is the development of guidelines and practices to educate providers and clinic staff on the needs of LEP refugees. The development of comprehensive refugee guidelines should be done by refugee resettlement agencies in partnership with health care providers. These trainings could include education regarding the refugee experience, cultural humility, cultural competency, proper utilization of interpreter services. Building a relationship between providers and the refugee communities they serve is an important part in reducing stigma and improving treatment outcomes. Resettlement agencies should work with community stakeholders to create a coalition aimed at strengthening the relationship between providers and refugee patients through improved cultural understanding.

A potential limitation of this systematic review was selection bias. Selection bias may have occurred while screening and reviewing articles based on the inclusion and exclusion criteria. For example, articles were excluded if they failed to state if participants involved in the research had refugee status or stratify how many refugee participants were in a study population. Another possible limitation was the exclusion of articles published outside of the US. These articles were excluded due to the difference in the U.S. healthcare system and heath care systems in other countries. In addition, another limitation could be the exclusion of studies published prior to 2013 based on the review parameters. This may have limited the number of articles eligible for the review. However, 10 years was considered appropriate due to relevance in the research field. A final limitation could be the generalizability of study results to the larger LEP refugee population living in the U.S. Studies in this review were often specific to certain racial or ethnic refugee populations. Therefore, further exploratory research is needed to make generalizations to the entire refugee LEP population in the U.S.

Conclusion

Healthcare providers encounter significant obstacles while delivering treatment to U.S. refugees due to misunderstandings, a limitation of resources and knowledge, language barriers, and cultural differences. The purpose of this review was to identify healthcare practices and interventions that improve health care or language access services for LEP refugees in the U.S. Results from this literature review found that engaging cultural brokers, hiring qualified medically trained interpreters, and developing guidelines and practices for providers is an essential part of improving refugee healthcare in the U.S. Implications for future research include identification of alternative methods to engage cultural brokers, recruitment of qualified medical interpreters, and training medical providers on cultural awareness and competency. Another practice implication would be the development of training programs to recruit formerly resettled refugees with English language skills or medical backgrounds to act as cultural brokers and liaisons within their own communities.

There are several areas of future research that should be explored further. Future research should focus on identifying best practices for building long-term partnerships between medical providers and refugee communities. One way to build these partnerships is to incorporate the use of cultural brokers. Researchers should explore alternative recruitment options to incorporate resettled refugees into culture broker roles. Engaging refugee community members as cultural brokers may significantly improve refugee patient care, reduce language barriers, and enhance health outcomes by facilitating improved patient-provider relationships. Additional research should also focus on identifying effective methods to recruit qualified interpreters through engaging cultural brokers or training members of refugee communities to serve as medical interpreters. Finally, interventions should develop regular cultural humility and competency training for medical providers committed to serving refugee populations. In conclusion, this

literature review contributes to the overall knowledge of the patient-provider relationship for LEP refugee population in the U.S.

References

Asgary, R., & Jacobson, K. (2013). Comprehensive on-site medical and public health training for local medical practitioners in a refugee setting. Disaster medicine and public health preparedness, 7(1), 82-88.

Ajjarapu, A., Story, W. T., & Haugsdal, M. (2021). Addressing obstetric health disparities among refugee populations: Training the next generation of culturally humble OB/GYN medical providers. Teaching and learning in medicine, 33(3), 326-333.

Bang, S. H., Huang, Y. C., Kuo, H. J., Cho, E. S., & García, A. A. (2023). Health status and Healthcare Access of Southeast Asian refugees in the United States: An integrative review. *Public health nursing (Boston, Mass.).* https://doi.org/10.1111/phn.13167

Barksdale, C. L., Rodick, W. H., Hopson, R., Kenyon, J., Green, K., & Jacobs, C. G. (2017). Literature review of the national CLAS standards: Policy and practical implications in reducing health disparities. *Journal of racial and ethnic health disparities*, *4*, 632-647.

Bauer, A. M., & Alegría, M. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: a systematic review. Psychiatric Services, 61(8), 765-773.

Bernhardt, L. J., Lin, S., Swegman, C., Sellke, R., Vu, A., Solomon, B. S., & Cuneo, C. N. (2019). The refugee health partnership: A longitudinal experiential medical student curriculum in refugee/asylee health. Academic medicine, 94(4), 544-549.

Brar-Josan, N., & Yohani, S. C. (2019). Cultural brokers' role in facilitating informal and formal mental health supports for refugee youth in school and community context: a Canadian case study. British Journal of Guidance & Counselling, 47(4), 512-523.

Bull, J., Cabral, K., & Kvach, E. (2018). Failure to thrive among immigrant and refugee children: a quality improvement project to innovate a primary care approach. Journal of Health Care for the Poor and Underserved, 29(4), 1319-13

Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work, 18*(4), 410-430.

Department of Homeland Security.(2022). *Annual flow report March 2022 - refugees and asylees: 2020.* Retrieved from https://www.dhs.gov/sites/default/files/2022-03/22_0308_plcy_refugees_and_asylees_fy2020_1.pdf

DiMeo, A., Karlage, A., Schoenherr, K., Spigel, L., Chakraborty, S., Bazan, M., & Molina, R. L. (2023). Cultural brokering in pregnancy care: A critical review. International Journal of Gynecology & Obstetrics.

Dussán, K. B., Galbraith, E. M., Grzybowski, M., Vautaw, B. M., Murray, L., & Eagle, K. A. (2009). Effects of a refugee elective on medical student perceptions. BMC medical education, 9(1), 1-8.

Eckstain, B. (2011). Primary care for refugees. American Family Physician, 1–9.

Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., Blood, E. A., & Betancourt, T. S. (2013). Multi-tier mental health program for refugee youth. Journal of consulting and clinical psychology, 81(1), 129.

Farokhi, M. R., Glass, B. J., & Gureckis, K. M. (2014). A student operated, faculty mentored dental clinic service experience at the University of Texas Health Science Center at San Antonio for the underserved refugee community: an interprofessional approach. Texas dental journal, 131(1), 27-33.

Feinberg, I., O'Connor, M. H., Owen-Smith, A., Ogrodnick, M. M., & Rothenberg, R. (2020). The relationship between refugee health status and language, literacy, and time spent in the United States. HLRP: Health Literacy Research and Practice, 4(4), e230-e236. https://doi.org/10.3928/24748307-20201109-01

Fennelly. (2006). Listening to the experts: provider recommendations on the health needs of immigrants and refugees. Journal of Cultural Diversity, 13(4), 190–201.

Fennig, M., & Denov, M. (2021). Interpreters working in mental health settings with refugees: An interdisciplinary scoping review. American Journal of Orthopsychiatry, 91(1), 50.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. Medical care research and review, 62(3), 255-299.

Frequently asked questions on legal requirements to provide language access services. Migrationpolicy.org. (2014, February 18). From https://www.migrationpolicy.org/programs/language%C2%A0access-translation-and-interpretation-policies-and-practices/frequently-asked

Gondek, M., Shogan, M., Saad-Harfouche, F. G., Rodriguez, E. M., Erwin, D. O., Griswold, K., & Mahoney, M. C. (2015). Engaging immigrant and refugee women in breast health education. Journal of cancer education, 30, 593-598.

Griswold, K. S., Kim, I., McGuigan, D., Shogan, M., Zinnerstrom, K., Lie, D., & Ohtake, P. J. (2021). Interpreted encounters for interprofessional training in cultural competency. Journal of Interprofessional Education & Practice, 24, 100435.

Jacobs, E. A., Shepard, D. S., Suaya, J. A., & Stone, E. L. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. American journal of public health, 94(5), 866-869.

Jezewski, M. A., & Sotnik, P. Culture Brokering: Providing culturally competent rehabilitation services to foreign-born persons [Internet]. Buffalo: Center for International Rehabilitation Research Information and Exchange. CIRRIE Monograph Series; 2001 [cited 2012 Jun 10].

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health services research, 42(2), 727-754.

Khullar, D., & Chokshi, D. A. (2019). Challenges for immigrant health in the USA—the road to crisis. *The Lancet*, *393*(10186), 2168-2174. https://doi.org/10.1016/S0140-6736(19)30035-2

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., ... & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. Cmaj, 183(12), E959-E967.

Lenderts, Hoffman, S. J., & Stitch, J. (2021). The Role of Culture in Shaping Health Perceptions and Behaviors of Resettled Karen Refugees. Journal of Transcultural Nursing, 32(2), 145–152. https://doi.org/10.1177/1043659620902836

Le, & Kato, T. (2006). The role of peer, parent, and culture in risky sexual behavior for Cambodian and Lao/Mien adolescents. Journal of Adolescent Health, 38(3), 288–296. https://doi.org/10.1016/j.jadohealth.2004.12.005

Matlin, S. A., Depoux, A., Schütte, S., Flahault, A., & Saso, L. (2018). Migrants' and refugees' health: towards an agenda of solutions. *Public Health Reviews*, *39*(1), 1-55. https://doi.org/10.1186/s40985-018-0104-9

Moch, R., Nassery, H. G., & Fareed, M. T. (2014). Incorporating medical interpretation into your practice. Family Practice Management, 21(2), 16-21.

Mohamed-Ahmed, R., Daniels, A., Goodall, J., O'Kelly, E., & Fisher, J. (2016). 'Disaster day': global health simulation teaching. The Clinical Teacher, 13(1), 18-22.

Monroy, M. (2015). Patient language services: your responsibilities: why your practice needs to develop protocols and procedures. Contemporary OB/GYN, 60(9), 38-40.

Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). Healthcare barriers of refugees post-resettlement. *Journal of community health*, *34*, 529-538.

Murphy-Shigematsu, S., & Grainger-Monsen, M. (2010). The impact of film in teaching cultural medicine. Fam Med, 42(3), 170-172.

National Center for Cultural Competence n.d. Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs. Accessed March 12, 2023. https://nccc.georg etown.edu/culturalbroker/2_role/2_role.html

Office of Refugee Resettlement -An Office of the Administration for Children & Families. (2021). Retrieved from https://www.acf.hhs.gov/orr/about/history

Office of Refugee Resettlement- Refugee Health Promotion. Office of Refugee Resettlement - The Administration for Children and Families. (2023).Retrieved from https://www.acf.hhs.gov/orr/programs/refugees/rhp

Office Of The United Nations High Commissioner For Refugees. (2020) United Nations High Commissioner for Refugees UNHCR . International Organizations. [Web Archive] Retrieved from https://www.unhcr.org/us/what-we-do/build-better-futures/long-term-solutions/resettlement

History. Office Of Refugee Resettlement: An Office of the Administration for Children & Families. (2021). https://www.acf.hhs.gov/orr/about/history

Office Of The United Nations High Commissioner For Refugees. (2022) United Nations High Commissioner for Refugees UNHCR. International Organizations. [Web Archive] Retrieved from https://www.unhcr.org/us/news/news-releases/unhcr-global-displacement-hits-another-record-capping-decade-long-rising-trend.

Office Of The United Nations High Commissioner For Refugees. (n.d.) United Nations High Commissioner for Refugees UNHCR . International Organizations. [Web Archive] Retrieved from https://www.unrefugees.org/refugee-facts/usa/

Omenka, O. I., Watson, D. P., & Hendrie, H. C. (2020). Understanding the healthcare experiences and needs of African immigrants in the United States: A scoping review. *BMC Public Health*, *20*(1). https://doi.org/10.1186/s12889-019-8127-9

Paasche-Orlow, M. K., & Wolf, M. S. (2007). The causal pathways linking health literacy to health outcomes. American Journal of Health Be-havior, 31(Suppl. 1), S19-S26. https://doi.org/10.5993/AJHB.31.s1.4 PMID:17931132

Paetow, G., Scott, N., Panning, A., Hopkins, J., Aden, M., & Hart, D. (2023). Culinary cultural immersion: A qualitative analysis of resident knowledge, attitudes, and behavioral changes following a brief Somali cultural immersion experience. AEM Education and Training, 7(1), e10844.

Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Rashid, M., Cervantes, A. D., & Goez, H. (2020). Refugee health curriculum in undergraduate medical education (UME): a scoping review. Teaching and Learning in Medicine, 32(5), 476-485.

Reception and Placement - United States Department of State. (2023, February 15). United States Department of State. https://www.state.gov/refugee-admissions/reception-and-placement/#:~:text=The%20resettlement%20agencies%20assist%20refugees,necessary%20social%20or%20language%20services.

Squires, A. (2017). Evidence-based approaches to breaking down language barriers. Nursing, 47(9), 34.

Terasaki, Genji, MD, Ahrenholz, Nicole Chow, MD, & Haider, Mahri Z., MD, MPH. (2015). Care of Adult Refugees with Chronic Conditions. The Medical Clinics of North America, 99(5), 1039–1058. https://doi.org/10.1016/j.mcna.2015.05.006

Toole, M. J., & Waldman, R. J. (1997). The public health aspects of complex emergencies and refugee situations. Annual review of public health, 18(1), 283-312.

U.S. Department of State. (2023). United States Department of State- Reception and placement . U.S. Department of State. https://www.state.gov/refugee-admissions/reception-and-placement/#:~:text=The%20resettlement%20agencies%20assist%20refugees,necessary%20social%20or%20language%20services.

United States Department of Health & Human Services Office of Minority Health (OMH) (n.d.). AANHPI Language Access Resource Guide. https://www.minorityhealth.hhs.gov/assets/pdf/AANHPI-Language-Access-Resource-Guide_Final_508c_-6.14.23.pdf

Warden, J., Vadman, O., Michori, R., & Carlough, M. (2017). Building capacity to care for refugees. Family Medicine, 22–26.

Curriculum Vitae

Curriculum Vitae
Bemnet Kebede, BS

Department of Epidemiology and Biostatistics

University of Nevada Las Vegas, NV

Email: bkebede240@gmail.com

Education

University of Nevada Las Vegas

MPH, 2023 (Expected)

BS, 2016

Public Health Experience

February 2017- Present

Catholic Charities of Southern Nevada - Migration and Refugee Services (Health Promoter)

Las Vegas, NV

Duties - Assist clients with all doctor's appointments, referrals, and health insurance inquiries; Assist in conducting educational health workshops for clients.