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Hiwet Weldeselase

ASSESSING THE ROLE AND INTEGRATION OF COMMUNITY-ENGAGED RESEARCH (CEnR) IN ADDRESSING HEALTH CARE ACCESS FOR MIGRANTS IN THE UNITED STATES

A QUALITATIVE SYSTEMATIC REVIEW

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An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
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Abstract

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Migrants in the United States are faced with several health care utilization and access challenges, including language barriers and a lack of sensitivity towards differences in cultural health beliefs. A qualitative systematic review was conducted to understand the current role and integration of community-engaged research (CEnR) as a key strategy in the improvement of healthcare access for migrant populations in the United States. The Cochran method for qualitative systematic reviews was carefully followed, with data extraction using the Cochrane Public Health Group method of data extraction and data eligibility. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) was used to assess and organize findings throughout the data retrieval process. A total of 905 documents were identified, with only 10 records meeting the inclusion criteria for the qualitative systematic review. The level of CEnR integration into Implementation Science significantly increased within the last decade and is seen as a tool for better engagement with migrants and for improvements to their health care experiences. Yet, community engagement in all areas of the research process is not being practiced as it should. Ultimately, this review showed that the current integration of CEnR approaches to the research addressing health care experiences of migrants in the United States does not necessarily imply that community engagement is happening in all stages of research. The reviewed publications show that CEnR can positively impact the health of migrant communities through increasing awareness of intercultural dynamics and creating genuine, trustworthy relationships with stakeholders. There is also a need to further understand how CEnR strategies are being implemented and to continue researching the effectiveness of CEnR in general. The reviewed publications stated that when migrants are put in the position to spearhead the conversations surrounding their own health service utilization concerns, the ethics in research are at their best.

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LIST OF ABBREVIATIONS

CEnR	Community-Engaged Research
CBPR	Community-Based Participatory Research

INTRODUCTION

The United Nations Commissioner stated that 70 million people have been displaced worldwide from their home countries due to excessive violence, religious persecution, and other direct human rights violations (UNCR, 2015). According to the International Organization of Migration (2009), displacement is a determinant of health from a human rights perspective. Migrants face specific difficulties concerning their right to health. For example, traveling conditions and limited access to proper healthcare are aspects of displacement that can increase vulnerability to disease (Davies et. al., 2009).

Displaced people who've migrated to the United States are faced with numerous barriers to accessing consistent and attainable healthcare for a variety of reasons. One important reason is the lack of culturally sensitive healthcare services, which can often be expressed through conflict in patient-physician communication, inadequate treatment plans with no respect to cultural beliefs, and difficulties accessing information for health services due to language barriers (Anand & Lahiri, 2009).

Immigrants living in the United States are faced with several challenges with utilizing and accessing healthcare services. Those challenges may include language barriers, lack of sensitivity around differences in cultural beliefs, and navigating the complex structure of insurance plans (Anand & Lahiri, 2009). There are also countless eligibility requirements that immigrants must meet to even qualify for medical insurance in the United States (Prentice et. al., 2011). Navigating eligibility requirements, coupled with the utilization challenges mentioned above, has created a health care system that is almost impossible for immigrants living in the United States to positively engage. Thus, examining issues of accessibility to health care among immigrant populations in the United States is an important and timely research issue.

While the United States is perceived to be extremely appealing for migration, there are issues that migrants face, including social interactions that lack intercultural engagement, which is defined as intentional and deep engagement between people of different cultures (The United Church of Canada, 2011). The United States has historically practiced a multicultural approach to social engagement with migrants - one that applies the notion of living alongside each other but not intentionally engaging in each other's cultural backgrounds (Arasaratnam et. al., 2011). In contrast, the intercultural engagement paradigm has the distinctive feature to promote engagement of individuals from different ethnic backgrounds at the local level and pushes that level of engagement mainstream, a contacts-based approach that drives socialization processes and culture-making (Zapata-Barrero, 2017). In other words, the intercultural engagement paradigm promotes living *in* diversity, and not just *with* diversity. (Zapata-Barrero, 2017).

Community-Engaged Research (CEnR) emphasizes the importance of partnership with communities throughout research development, implementation, and dissemination of results. Given the highly multicultural characteristics of the United States population, an intercultural engagement paradigm is arguably key to implementing CEnR in public health. CEnR and intercultural engagement both prioritize consistent collaboration and deep relationships between members of the interacting communities. Using the intercultural paradigm and CEnR as key strategies in the improvement of the quality of healthcare for migrant populations prioritizes effective and respectful forms of care as they relate to people's cultural health beliefs and practices (Anand & Lahiri., 2009).

Through the guise of a qualitative systematic review, this thesis will explore the level of integration of CEnR and intercultural engagement in health care access and quality improvement research (Implementation Sciences research) as it relates to the health and health care experiences of migrants in the United States. The systematic review will also seek to identify promising practices for the integration of CEnR and intercultural engagement in Implementation Sciences research. Theoretical frameworks on intercultural engagement and CEnR will frame the review while serving as a call to action on prioritizing this level of engagement as an important approach for success.

CHAPTER 1

LITERATURE REVIEW

Migrant Population in the United States

As we discuss health care access and implementation science research for migrant populations in the United States, it's important to establish a foundational understanding of how large the migrant population is. The United States has a long history of resettlement and is considered the largest refugee resettlement location in the world (United Nations High Commissioner for Refugees, 2020). More than 40 million people living in the United States were born in another country, which accounts for about 1/5th of the world's migrants (United Nations High Commissioner for Refugees, 2020). Since 1965, when the United States immigration laws were politically represented in our national quota system, the number of displaced individuals has tripled in size and now represents about 14% of the United States population (Pew Research Center, 2020).

As of 2018, the top five countries of birth for migrants in the United States were Mexico, China, India, the Philippines, and El Salvador. About 11.2 million immigrants living in the United States were from Mexico and accounted for 25% of the migrant population (Budiman, 2020). 2.9 million migrated from China, 2.6 million migrated from India, 2 million migrated from the Philippines, and 1.4 migrated from El Salvador. These numbers increase by a minimum of 150,000 per region each year (Budiman, 2020). The Pew Research Center projected that by 2065, immigrants and their descendants will account for 88% of the United States population increase, given the consistency in growth and representation from various regions (Pew Research Center, 2020).

There are many reasons why people migrate to the United States. Some emphasize the importance of individual decision-making when describing the reasons behind migration, and others emphasize the importance of broader structural forces that cannot be controlled by individual decision-making. There are "push and pull" factors that researchers discuss when describing the process behind migration – the notion that the living conditions of one's home country are no longer considered livable and can be improved in a different environment (United Nations High Commissioner for Refugees, 2015). This does not always include choice, and mostly leads to forced displacement if unlivable conditions are a matter of safety. Some reasons for migration include quality of life, work opportunities, escaping religious prosecution, environmental factors, access to health care, access to education, etc. These are all considered social, political, and environmental factors that stimulate the need for migration.

Barriers in Access to Health Care for Migrant Populations in the United States

Migrants not only have a higher burden of disease but also compromised access to health care, as they face many barriers to access and quality of care. Research suggests that migrant families often forgo needed health care services because they fear interactions and lack of respect within these spaces (Derose et al., 2007). Many factors affect displaced individuals' vulnerability to inadequate health care in the United States. Those factors include socioeconomic status, language barriers, federal/state/local health care policies, geographic location, lack of cultural awareness and cultural sensitivity from health care workers, stigma, inaccessible health insurance policies, and marginalization in the health care system. Migrants have lower rates of usage of health insurance, statistically use fewer health care services, and receive a lower quality of care than the United States born populations due to those inaccessibility issues and societal factors mentioned above (Beck, 2019).

Social determinants of health refer to non-biological factors determined by social systems and inequalities that have important effects on health outcomes. They are the conditions in which people are born, grow, live, work, and age and are mostly responsible for health inequities. Migrants are at great risk of suffering from health disparities due to societal factors that impact their lives. Social determinants of health are often described as living and working conditions, physical and social environment, education, gender, and social cohesion and integration. Migrants face specific difficulties concerning their right to health (Castañeda, 2015) Their right to quality health care services may be inadequately covered by state health systems and unaffordable health insurance, cultural barriers, or difficulties accessing the information on health services and health-related issues. Undocumented migrants are also often denied access to public health services. Even migrants with legal immigration status face various obstacles to utilizing health care services due to cultural differences (Castañeda, 2015). There is a distinct relationship between migration and health from a human rights and social equity-based perspective that needs to be further understood. According to the International Organization for Migration Health Department, the barriers to health care access for migrants have led to migration and displacement being seen as a determinant of migrants' health (Davies, 2009).

Health care access from the policy perspective is one of the major barriers that contribute to health disparities in migrant populations in the United States. In 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law and provided insurance to millions of people, but explicitly excluded undocumented immigrants from enrolling in health coverage programs (USAgov, 2021). Undocumented immigrants are also not allowed to buy marketplace health coverage or obtain other savings on marketplace plans in different regions across the United States (USAgov, 2021). Without federal and state subsidies, buying health care insurance becomes cost-prohibitive for migrants and creates financial barriers to practicing their right to health care. There is detriment in explicitly excluding migrants from health care coverage based on legal status, especially when there are unexplainable loopholes and regulations that migrants must work through to even begin the process of obtaining legal status in the United States. Given the difficulties of obtaining public health insurance, many migrants rely on employer-based insurance or go to community health clinics, free clinics, and emergency departments to access medical care. In cases of needing emergent medical care, many migrants apply for Emergency Medicaid coverage if they are in a Medicaid-eligible category such as children, pregnant women, families with dependent children, and elderly or disabled individuals (DuBard & Massing, 2007).

Cultural and linguistic differences also become barriers and play a huge role in migrant access to quality health care in the United States. Patient satisfaction, community support, patients' willingness to seek treatment, and patient outcomes are all dependent on culturally appropriate care and communication (Anand & Lahiri, 2009). Nearly 55 million individuals (19.7%) in the United States speak over 30 languages other than English at home (U.S. Census Bureau, 2006). Cultural and linguistic barriers in the health care system place migrants at a higher risk of mismanagement of their medical conditions and are a huge concern for patient safety. There is a much higher chance of adverse medication reactions when patients receive instructions in a language they don't speak or read fluently (Wilson et. al., 2005). Over 50% of migrants in the United States report not preferring English when discussing health care needs and medical instruction of treatment plans (Wallace, 2016).

"African Americans, Asian Americans, and Hispanics are more likely than whites to experience difficulty communicating with physician(s), feel they are treated with disrespect when receiving health care services, and experience barriers to care like lack of insurance or a regular doctor. Minorities feel they would receive better care if they were a different race or ethnicity" (Collins et. al., 2002). While health systems work to respond to the shifting populations among communities they serve, there is not a big enough shift happening in the need for more culturally sensitive and responsive care for migrant populations in the United States.

The impact of culture on patient comfort with practitioners is often another very important social determinant of health among migrant populations in the United States when utilizing health care services (Health and Medicine Division, 2017). There is cultural context to differences in understanding the roles and functions of health care systems and providers in the United States vs. other countries, and the lack of understanding of these differences from a provider's perspective leads to barriers in communication and ignoring health beliefs. Immigrants may face providers that don't respect other cultures' health and wellness beliefs and may challenge those beliefs when providing health treatment plans (Holmes, 2006). Many health and wellness beliefs are rooted in patients' spiritual traditions and cultural orientation.

The dismissal of those health and wellness beliefs leads to misunderstood expectations on patients' ability to choose treatments. Providers may layout choices for the patient, and if the patient sees the provider as an authority, having choices may be strange or unsettling. The health of migrant communities in the United States is largely equated to the availability, accessibility, acceptability, and quality of services in the environment around them. Migrants should have a right to access socially, culturally, and language-appropriate health care services without putting their cultural beliefs at risk.

Multicultural vs. Cross-Cultural vs. Intercultural Approach to Engagement with Immigrants

In general, engagement with immigrants to the United States, who represent a myriad of cultural backgrounds, is approached from multicultural and cross-cultural strategies. The multicultural approach to engagement is one in which people are living alongside one another, but the different cultural groups within a single region don't intentionally engage with each other (The United Church of Canada, 2011).

The Cross-cultural approach to engagement considers one culture the norm or standard in a particular region in comparison to all other cultures in that same region (The United Church of Canada, 2011). Given the implicit identification of a dominant culture for comparison, the lack of addressing power differentials, and limited and superficial interactions, learning and exchange resulting from the cross-cultural approach to engagement is often constrained. In other words, although a cross-cultural approach can sometimes bring induvial change, it does not facilitate a collective transformation that leads to improvements for all (The United Church of Canada, 2011).

Intercultural engagement is understood as an involved and very intentional form of interaction between people of different cultural backgrounds, allowing for a deep understanding and respect for all cultures in a community (The United Church of Canada, 2011). This type of engagement is also characterized by a mutual exchange of ideas, the development of deep relationships, and the addressing of power imbalances impacting relationships. Everyone is constantly learning from each other and grows together through intentional engagement with one another.

Intercultural interaction in the context of health care is defined as the ability to deliver "effective, understandable, and respectful care that is provided in a manner compatible with patients' cultural health beliefs, practices, and preferred language" (Office of Minority Services, 2000). Providing training on specific cultures can be somewhat helpful but will backfire if the information is offered in a one-dimensional manner or if it is used to stereotype individuals. Intercultural engagement in health care access goes beyond the assumption that a few pieces of training will suffice and somehow create "mastery" or "competency" in cultural understanding – that level of "mastery" simply does not exist in the context of understanding the complexity of culture. Using an intercultural approach in health care for migrant populations means understanding that providing quality care to all cultural backgrounds lays in the development of respectful skills in the learning about cultural and personal beliefs and the questioning of all aspects of what it means to be a health care provider. Intercultural engagement being at the forefront of addressing health care access for migrant populations will equalize power dynamics in medicine and continue to put the needs of the communities first (Anand & Lahiri, 2009).

The intercultural approach to engagement in health care also addresses the issue of medical ethnocentrism, which can often explain health care quality, utilization, and access due to lack of cultural humility and cultural awareness (Anand & Lahiri, 2009). Medical ethnocentrism impacts inaccurate diagnosis and treatment, exacerbated illnesses, and noncompliance in the health care field (Institute of Medicine, 2002). Unaddressed medical ethnocentrism becomes a barrier to accessing health care as it inhibits a healthcare worker's understanding of the patient's beliefs and behaviors (Anand & Lahiri, 2009). Cultural humility in health care, defined as the process of ongoing self-reflection and self-critique through which power imbalances are brought into check (Tervalon & Murray-Garcia, 1988), is key to intercultural engagement given its critical role in effective and appropriate communication in multicultural situations. Quality of communication and the relationship between a patient and provider are key predictors of positive or negative health outcomes. Lack of trust, understanding and loyalty in patient-physician relationships are due largely to ignored cultural differences between health care providers and patients and the main contributing factor to the lack of access and quality of health care for migrant communities within the United States (Fredericks et. al., 2006).

Intercultural Engagement, CEnR, and Implementation Sciences

The intercultural engagement paradigm promotes intentional, genuine, and respectful engagement of all cultural backgrounds with respect to shared geographic location (Zapata-Barrero, 2017). It has been shown that there is a need to push this level of engagement into mainstream implementation research and strategies, especially when addressing health care access and quality of health care services for migrants in the United States - "Intercultural health care is arguably one of the most commonly conjured pathways and the best practices to robust health care delivery ..." (Gyasi, 2018). Intercultural engagement encompasses all that leads to a healthy population (Gyasi, 2018). For intercultural engagement to be implemented in research strategies for improvements in health care quality and access for the USA migrant community, it is critical to understand how to improve intercultural awareness and cultivate cultural humility. Using intercultural awareness and sensitivity as strategies for CEnR is key to the implementation sciences and health outcomes of migrant populations in the United States (Secor-Turner et. al., 2010). Without intercultural awareness and sensitivity paradigms, we cannot be successful or create effective health outcomes in the work that's done within implementation (Secor-Turner et. al., 2010).

CEnR in health care utilizes community engagement in the process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their health and well-being. In practice, community engagement is a blend of science and art as it relates to the health outcomes of a specific community or communities working together to incite change (Michener et. al., 2012). Adoption and implementation of health care recommendations set by the community remain a challenge. The gaps and barriers that exist for the quality and efficiency of United States health care for migrant communities can benefit from a CEnR approach to improvement. Researchers must actively engage stakeholders in all stages of research (Wallerstein et. al., 2010).

The clearest and current roadmap for researchers to accomplish such a task in a conscientious, mutualistic manner is through research that is genuine community engagement. Institutional complexities in infrastructure, policy, curriculum, and other support mechanisms limit researchers' capacity to be dedicated to such efforts (Wallerstein et. al., 2010). CEnR and intercultural engagement both prioritize consistent collaboration and long-term, deep relationships between members of the interacting communities. Using the intercultural paradigm and CEnR as key strategies in the improvement of quality of healthcare for migrant populations prioritizes effective and respectful forms of care as they relate to people's cultural health beliefs and practices (Anand & Lahiri, 2009).

Implementation sciences refer to the gap between research and practice/policy and CEnR and intercultural engagement are key approaches to improving the quality of improvement research (implementation sciences) as it relates to the health and health care experiences of migrant populations in the United States. There is a built-in assumption that if you can build out and publish writing on a certain program or policy, it will be implemented within a certain time frame. The reality of this assumption is just not true and does not address the real-world application process of these published findings (Bauer & Kirchner, 2020). Implementation sciences address the dismissal of that assumption and bring awareness to getting practices and policies into the hands of those that need it. How can we accelerate the process of implementation while being intentional about its impact and contribution to health outcomes? There is a strong emphasis on the ability to address the "how" in implementation sciences and improvement research, such as the how in ensuring that evidence-based policy and programs have an impact on the health outcomes of our communities and health inequalities. (Bauer & Kirchner, 2020)

With the knowledge we have on barriers in access to quality and culturally sensitive health care services for migrant populations in the United States, it is important to consider the benefits of the intersection of the intercultural paradigm and CEnR for sustainable improvements to those barriers. Community-engaged research and improvements in implementation are key frameworks to the outcome of quality health care for migrant populations that can prioritize effective and respectful care as they relate to people's cultural health beliefs and practices.

CHAPTER 2

METHODS

This thesis was completed as a qualitative systematic review that generally relied on the Cochran method for systematic reviews (Higgins et. al., 2021). It also relied on the CEnR and intercultural engagement in health care frameworks. Secondary sources were systematically compiled using three different social and health sciences-centered search engines. These search engines were used to locate academic articles that assessed the level of integration of CEnR and intercultural engagement in health care access and in Implementation Science. The systematic review related those experiences to the role of intercultural engagement and CEnR in the improvement of health care access for migrants in the United States. In this review, we did not perform any statistical analysis of the results of relevant studies.

The goal of this systematic review was to explore the level of integration of CEnR and intercultural engagement in health care access and Implementation Science research as it relates to the health and health care experiences of migrants in the United States. The objective of this review was to identify promising practices for the integration of CEnR and intercultural engagement in Implementation Sciences research. Additionally, it is hoped that the results can serve as a call to action on prioritizing intercultural engagement as an important approach for success

Search Criteria and Strategies

This systematic review of the literature was completed using a variety of articles and documents that reported information, from both broader and narrower perspectives, on CEnR and intercultural approaches to addressing the health care needs of migrants in the United States. The articles and documents identified also reported information from different migrant groups in the United States.

Lastly, articles and documents used in this systematic review of the literature reported issues that migrants face in terms of quality of health care in the United States. The publication types used when searching for published literature included the following: literature reviews, systematic reviews, lectures, peer reviewed academic articles, book chapters, and news articles. Table 1 provides justifications for using each of the publication types.

Table 1: Publication Types

Publication Type	**Justification**
Literature reviews	▪ Literature reviews written by a variety of authors (students, professors, researchers, physicians, etc.) were used to gain an understanding of CEnR and intercultural engagement. Also, to gain an understanding of promising practices for the integration of those two farmworkers in relation to improving health care access and quality for migrants in the United States. ▪ Literature reviews were used to explore a variety of health outcomes from different migrant groups as they relate to their experiences with quality and access of health care services in the United States
Systematic reviews	▪ Systematic reviews written by a variety of authors (students, professors, researchers, physicians, etc.) were used to explore research questions on the importance and integration of CEnR and intercultural engagement either in the United States or on a global level ▪ Systematic reviews were used to explore research questions on a variety of health outcomes from different migrant groups as they relate to their experiences with quality and access of health care services in the United States
PhD, MD, and MPH degree level lectures	▪ Lectures were used to hear public health professions speak on their experiences with and interpretations of CEnR and intercultural engagement in the work they've done with different communities in the United States, as well as their experiences in addressing quality and access of health care services in the United States.
Book chapters	▪ Book chapters were used to explore research on intercultural engagement in the health care system in the United States, or lack thereof. These chapters were also used to explore the lived experiences of the term "migrants" being applied to the theory of social determinant of health. ▪ Book chapters were used to explore language and trust as prominent indicators of intercultural engagement and CEnR being implemented in different forms of service throughout the United States.
News articles	▪ News articles were used to explore personal anecdotes of migrant families, physicians, and nurses who have expressed their experiences navigating the United States health care system and the role that intercultural engagement played in those experiences.

Database Types and Search Domains

Three databases were chosen after discussions with the thesis chair and an Emory University librarian about the relevance and appropriateness of the databases based on the systematic review's goal and objectives. After initial testing of search returns, the following health and social sciences search databases were chosen: MEDLINE – PubMed, SCOPUS, and AnthroPLUS. Four different domains were identified to facilitate and categorize the search of publications in the chosen databases: Cultural Engagement, Displacement, Health Care System, and Implementation Sciences. Table 2 lists the keywords labeled as "domains" that were used to facilitate the search of full-text documents and publications within those three databases.

Table 2: Search Domains

1	Cultural Engagement
2	Displacement
3	Health Care System
4	Implementation Research

Search Terms

The four domains listed above were used to categorize the search terms used to complete multiple rounds of searches for publications. Table 3 shows a list of the 38 search terms used in this systematic review. The search terms were organized with respect to a specific domain.

Table 3: Search Terms

Domain Name	Search Terms
Cultural Engagement	Intercultur* Multicultur* Cross-Cultur* Sensitivity Insensitivity Competence Incompetence Awareness Communication Community Language Cultur* Humility Engagement Diversity
Displacement	Migrant* Immigrant* Vulnerable Migrant (and) health (and) outcome* Language ^ Trust ^
Health Care System (United States)	Health Delivery (and) of (and) health (and) care Attitude (and) to (and) health Western (and) medicine Traditional (and) medicine Social (and) determinant* (and) or (and) health Health (and) care (and) quality Health (and) care (and) access Language ^ Trust ^
Implementation Research	Knowledge (and) research Knowledge (and) translation Implementation (and) research Implementation (and) outcomes Community (and) engaged (and) research Capacity (and) building Public (and) health Global (and) health

* Spelling used to include all word formats in database search (ex: Intercultur* will include interculture, intercultural, etc.)
(and) -All words in sequence will be searched as a statement or pair
^ Search terms repeat in another domain

DATA COLLECTION

Publication Selection Process

A search strategy was established to identify specific areas in all searched publications and used to label each piece of writing as eligible or not in accordance with the goal of the systematic review. This selection strategy was created to establish a uniform process of inclusion and exclusion criteria and was recorded using a *document eligibility form* and a *data extraction form*, as shown in Appendices A and B. These forms were created for this review by using and adapting the Cochrane Public Health Group method of data extraction (Higgins et. al., 2021). A variety of Canva design software form creation tools were used for the graphic design of the forms. Specific inclusion and exclusion criteria used for each search are described below.

Inclusion Criteria

During the first stage of searching and screening publications, there was a heavy focus on screening titles and abstracts of each piece of writing. Publications that were written in English and discussed CEnR, intercultural engagement, migrant experiences in accessing health care, and implementation sciences/research were included in a first search. During the second stage of searching and pre-screening publications, there was a heavy focus on the full text of each publication, with tighter screening restrictions. The following were the inclusion criteria used for the second round of searching: discussion of CEnR and migrant experiences in the context of the United States; discussion or appraisal of CEnR and implementation sciences/research in the form of teaching or training; discussion of the development of training programs with CEnR, intercultural engagement, and/or implementation research as a foundation to their teachings. Articles that discussed successful examples of the integration of CEnR in health services for migrant populations outside of the Unites States were also included. Articles were not restricted based on their methodological focus.

Exclusion Criteria

Publications that were not written in English were excluded from the search. Publications that were written before 2014 were excluded from the search as a form of keeping the systematic review as recent as possible. Book reviews and conference posters/presentations (outside of PhD, MD, and MPH degree level lectures on relevant topics listed in inclusion criteria) were excluded from the search. Articles that discussed training and teaching forums outside of health care and health care access were excluded from the search if there were no elements of CEnR or implementation research.

Document Eligibility and Data Extraction

Document Eligibly Form

The document eligibility screening form (Appendix A) was used to create an organized and uniform list of information extracted from each publication that was chosen after the first and second rounds of searches. The form extracted general information from each publication and additional information that coincided with the inclusion and exclusion criteria to label the publication as eligible or not to the systematic review. Each study was labeled using the last name of the first author and publication year when included in the document eligibility form (example: Neima1999) for organizational purposes.

The document eligibility screening form included the following sections:

1. Study Characteristics
    a. Publication label (example: Neima1999)
    b. Publication title
    c. All authors included in publication
    d. Database where publication was found
    e. Type of study (example: cross-sectional, cohort or case-control, etc.)
2. Review of Inclusion Criteria
    a. Article language
    b. Article publication year
    c. Article study population
    d. Location/area of interest (example: Location in which the study is conducted)
    e. Topics mentioned in article (example: Mention of CEnR, intercultural engagement, migrant experiences in accessing health care, and/or implementation sciences/research were included)
3. Eligibility Decision
    a. Answered with a simple "yes", "no", or "maybe" based off information gathered from sections 1 and 2 of document eligibility screening form

Data Extraction

If the publication was given a "yes" as its eligibility decision at the end of the document eligibility screening form, then it was moved to the data extraction process. The data extraction form (Appendix B) is a standardized form using the Cochrane Public Health Group method of data extraction (Higgins et. al., 2021) to help synthesize data. The data extraction form included the following sections:

1. General Information
    a. Publication label (example: Neima1999)
    b. Date that data extraction form was completed
    c. Publication title and hyperlink to publication
    d. All authors included in publication
    e. Database where publication was found
    f. Additional notes (Is this article a duplicate? Possible conflicts?)
2. Population and Setting
    a. Study population and population description
    b. Location/area of interest (Location in which the study is conducted)
    c. Description of setting (Any additional context necessary to understand study/publication)
3. Methods
    a. Type of study (example: cross-sectional, cohort or case-control, etc.) or type of publication
    b. Aim/objective of study
    c. Duration of study
    d. Sampling technique(s)
4. Outcomes
    a. Specific outcome(s)
    b. How outcome(s) were measured (Self-reported questionnaires, surveys, interviews, etc.)
    c. Description of outcome(s)
5. Results, Analysis, Strengths, and Limitations
    a. Reported results of each publication
    b. Notes on analysis of each publication
    c. Publication strengths
    d. Publication limitations (strategies to overcome limitations if mentioned)
    e. Key conclusions

CHAPTER 3

RESULTS

After going through two rounds of database searches a total of 904 publications, as highlighted in the flow chart created in Figure 4. Additionally, a book chapter was identified outside of the database searches and included in the review due to its relevance and eligibility. After the removal of duplicates from all database searches and block search formats, 246 articles underwent title and abstract review. The purpose of the title and abstract review was to gauge whether the purpose, discussion, and overall goal of each article would fit the inclusion criteria of this systemic review.

Figure 4: PRISMA Flowchart, Database Searches, Inclusion Criteria

Database Searches

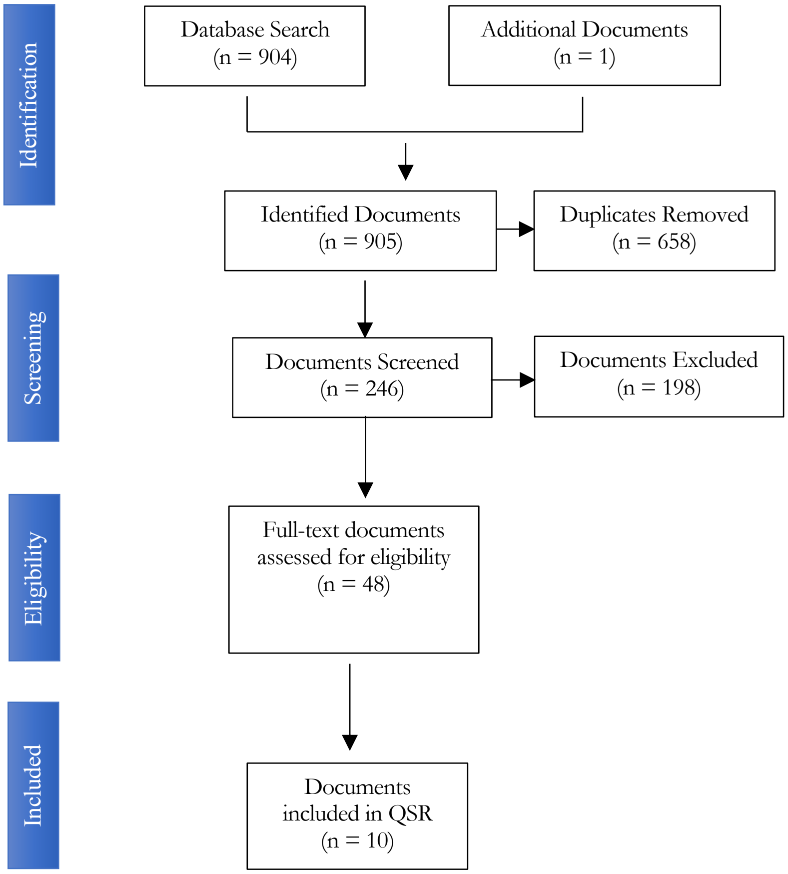
- PubMed (n = 370)
- SCOPUS (n = 509)
- AnthroPLUS (n = 25)

Block Search Formats

- (Migrant AND Healthcare AND (Intercultur* OR Multicultur* OR Cross-Cultur* OR Sensitivity OR Insensitivity OR Competence OR Incompetence OR Awareness OR Communication OR Community OR Language OR Cultur* OR Humility OR Engagement OR Diversity OR Immigrant OR Refugee OR Vulnerable OR Trust OR Language OR Medicine OR Health OR Western OR Traditional OR "Community Engaged Research" OR Implementation OR "Community-based participatory research" OR CBPAR OR CENR))
- (Migrant AND Healthcare AND Cultur* AND (Intercultur* OR Multicultur* OR Cross-Cultur* OR Sensitivity OR Insensitivity OR Competence OR Incompetence OR Awareness OR Communication OR Community OR Language OR Humility OR Engagement OR Diversity OR Immigrant OR Refugee OR Vulnerable OR Trust OR Language OR Medicine OR Health OR Western OR Traditional OR "Community Engaged Research" OR Implementation OR "Community-based participatory research" OR CBPAR OR CENR))
- (Migrant AND Healthcare AND Cultur* AND ("Community Engaged Research" OR Implementation OR "Community-based participatory research" OR CBPAR OR CENR OR Language OR Trust OR Immigrant OR Refugee))

Inclusion Criteria

- Year of publication (2014 – present)
- Publication language: English
- CEnR/CBPR focus with mention of community-engaged approach to research
- Migrant experiences and barriers when accessing health care
- Examples of implementation and/or recommendations of research usage



Among the 246 screened articles, 98 articles were excluded because they did not use a healthcare setting as their area of focus. Many of those excluded articles used education and academia as their focus. 61 articles were excluded because they did not provide examples or recommendations of how their CEnR based findings can be implemented for the specific communities used in the study. It was important to include articles that went beyond simply expressing their findings and incorporate some sort of implementation plan of their findings. 39 articles were excluded because they did not include the necessary population of interest. A total of 198 articles were excluded during the screening process, and 48 articles underwent full-text review for eligibility.

During the document screening process, it became evident that authors were using community-based participatory research (CBPR) and CEnR interchangeably in the context of community-engaged research in public health practice. While both CEnR and CBPR share similarities in its definitions, CEnR is commonly understood as an umbrella term for methodologies and frameworks that utilize community partnerships in all aspects of research, whereas CBPR is sometimes used to name the more specific method used in the respective study (Whitley, 2022). Given the number of articles using both frameworks interchangeably, this resulted in including publications that mentioned CBPR in their findings, while still discussing and focusing on CEnR in the description of their frameworks. A total of 9 studies were included after meeting all inclusion criteria and surpassing the data eligibility form. An additional book chapter was found as an external resource and included in the final list of publications to review, making 10 the total number of included documents. The following sections discuss characteristics and findings from the final list of 10 resources.

Figure 5: Eligible Documents Retrieved from Database Search (n = 10)

Document Number	Author(s) / Publication Year	Title	Type of Study	Database
1	Ming Tai-Seale, Greer Sullivan, Ann Cheney, Kathleen Thomas, and Dominick Frosch 2016	The Language of Engagement: "Aha!" Moments from Engaging Patients and Community Partners in Two Pilot Projects of the Patient-Centered Outcomes Research Institute	Qualitative Research Case Study	PubMed
2	Tanvir Chowdhury Turin, Nashit Chowdhury, Sarika Haque, Nahid Rumana, Nafiza Rahman, and Mohammad A Lasker 2021	Involving im/migrant community members for knowledge co-creation: the greater the desired involvement, the greater the need for capacity building	Qualitative Research Case Study	PubMed
3	Tanvir Chowdhury Turin, Nashit Chowdhury, Sarika Haque, Nahid Rumana, Nafiza Rahman, and Mohammad A A Lasker 2021	Meaningful and deep community engagement efforts for pragmatic research and beyond: engaging with an immigrant/racialized community on equitable access to care	Qualitative Research Case Study	PubMed
4	Lidia Horvat, Dell Horey, Panayiota Romios, and John Kis-Rigo 2014	Cultural competence education for health professionals	Qualitative Systematic Review	PubMed
5	Georgina Perez, Pamela Della Valle, Sarah Paraghamian, Rachel Page, Janet Ochoa, Emilia Suarez, Angela Thrasher, and Giselle Corbie-Smith 2016	A Community-Engaged Research Approach to Improve Mental Health Among Latina Immigrants	Qualitative Cross-sectional study	SCOPUS
6	Tali Filler, Pardeep Kaur Benipal, Nazi Torabi, and Ripudaman Singh Minhas 2021	A chair at the table: a scoping review of the participation of refugees in community-based research in healthcare	Qualitative Systematic Review	PubMed
7	Theresa S Betancourt, Rochelle Frounfelker, Tej Mishra, Aweis Hussein, and Rita Falzarano 2015	Addressing health disparities in the mental health of refugee children through community-based participatory research	Qualitative Cross-sectional study	PubMed
8	Lisa M. Vaughn, Farrah Jacquez, Robin Lindquist-Grantz, Allison Parsons and Katie Melink 2017	Immigrants as Research Partners: A Review of Immigrants in Community-Based Participatory Research	Qualitative Systematic Review	PubMed
9	Crista E Johnson, Sagal A Ali, and Michèle P-L Shipp 2019	Building community-based participatory research partnerships with a Somali refugee community	Qualitative Mixed Methods Study	PubMed
10	Rohini Anand and Indra Lahir 2004	Intercultural Competence in Health Care - Developing Skills for Interculturally Competent Care	Book Chapter	Book Chapter

Publications' Characteristics

The geographic distribution of the studies included in the systematic review covers research that took place exclusively in the United States, specifically in the Arkansas Delta Region, North Carolina, and Massachusetts (5 articles), in the United States among other regions (3 articles), and in Canada (2 articles). The articles that discussed the application of CEnR in regions outside the United States were included in the review because they served as comparable examples of the integration of CEnR and or intercultural engagement in health services for migrant populations. The articles that took place in the United States among other regions, include experiences that also took place in Western Europe, Australia, the Middle East, the Netherlands, Sub-Saharan Africa, and Southeast Asia. The race/ethnicity of study populations in the publications identified included Sub-Saharan African migrants, Bangladeshi migrants, Latinx immigrants, Somali Bantus immigrants, Bhutanese refugees, and Black Americans. In terms of the age range of studies' populations, the most common age group amongst all articles ranged between 18 and 49.

Of the ten articles that were included in the final analysis, seven articles (70%) focused specifically on the experiences and health care barriers of migrant, immigrant, and/or refugee communities. The other three articles (30%) focused on the experiences and health care barriers for migrant, immigrant, and/or refugee communities, as well as on low-income multilingual and culturally and linguistically diverse communities. Even though these three articles (30%) did not focus solely on migrant, immigrant, and/or refugee communities, they were included in the final analysis due to their inclusion of migrant, immigrant, and/or refugee communities and of communities that have strong similarities with migrants regarding the barriers they face when accessing health care. More specifically, these articles discussed language barriers, mistrust in health care, dismissal of cultural beliefs in treatment plans, and systematic racism/prejudice among marginalized communities that were not characterized as just migrant, immigrant, and/or refugee communities.

Purpose, Role, and Effects of the CEnR Approach in Health Care

There was a variety of reasonings behind how CEnR can be useful to addressing health care access and outcomes amongst all articles used in the analysis. Of the reviewed publications, three articles (30%)

focused on the importance of intercultural awareness and sensitivity as a means of bettering health care experiences and outcomes in the given region; two articles (20%) focused on the negative effects of not properly engaging community members and prioritizing their expressed needs like negative mental health outcomes and chronic stress; two articles (20%) focused on the positive statistics associated with improvements in research and intervention participation when community engagement is at the forefront of research; and three articles (30%) focused on holding researchers, primary care physicians, nurses, and others in positions of power to properly implement a community-engaged approach to care and research efforts. It's important to note that none of the publications focused on health policy while addressing health care intervention or improving access to health care.

All articles provided examples of how CEnR could be used in the context of their specified populations and regions, and further expressed the importance of implementing research findings into the real world. Most articles had more than one recommendation for implementing their research into the real world when looking at the percentages of reoccurring themes. Four articles (40%) created a recommendations list of how language sensitivity could be incorporated into health care settings and health improvement research. Using common language was a recurring theme in most publications, but only four (40%) explicitly stated using common and engaging language as a recommendation for implementation. Two articles (20%) used real-world examples of capacity building being implemented in migrant communities across Canada to demonstrate that this form of community-engaged research is not only possible but also positive and impactful. One article (10%) provided an example of how primary health care barriers were addressed in Bangladeshi immigrant communities in Canada through comprehensive community-engaged research and stated that this is the only "ethical way to tackle lack of access to primary care." (Turin et. al., 2021). One article (10%) was a cross-sectional study that showed how collaborating with a community-led organization like *Amigas Latinas Motivando el Alma* would significantly improve the health and wellness of Latina immigrant communities in North Carolina. This article provided positive examples of how collaboration with community partners and genuine relationships with community members can lead to long-standing positive changes (Perez et. al., 2016).

Community Involvement, Representation, and Gaps

When discussing the involvement of immigrants and other communities that face barriers when accessing health care services, there was a common theme among all publications about the importance of pursuing community engagement in all stages of research and implementation. Six publications (60%) discussed the importance of involvement in both the inception of research and dissemination of resources or intervention, while the other four (40%) included examples of community engagement, as well as the importance of involving community members in obtaining funding and transparency of funding in general. All four articles (40%) argued that the lack of involvement in funding stages when trying to use community engagement approaches to research makes the research unfair, unjust, and unethical (Filler et. al., 2021). They stated that issues around trust must be addressed for genuine involvement and representation to occur, and without that level of transparency, there is no purpose in pursuing community-engaged approaches to research. (Filler et. al., 2021).

CHAPTER 4

DISCUSSION

The scholarly publications included in this systematic review attempted to analyze and assess the role, effectiveness, and integration of CEnR and intercultural engagement approaches in the provision of health care for migrants in the United States. The results of this review a) casted light on the current level of integration of CEnR as it relates to the improvement of health care experiences for migrant populations, b) emphasized the importance of creating genuine partnerships with migrant communities when practicing CEnR, c) highlighted the role of CEnR in facilitating trust-building, and d) reiterated the overall advantage of the CEnR approach to improving health care outcomes and experiences of migrant populations.

Current Level of Community-Engaged Research (CEnR) Integration

Most reviewed publications (80%) identified it was important to assess the current level of CEnR integration in their respective locations before diving into their own research, while also stating that the use of CEnR has significantly increased within the last decade and that there is an overall understanding that engagement strategies are necessary in examining and improving the health care experiences of migrants (Betancourt et. al., 2015; Perez et. al., 2016; Seale et. al., 2016; Vaughn et. al., 2017; Johnson et. al., 2019; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021). However, the current level of CEnR integration in health care research and interventions was also described as lacking community accessibility and collaboration in all research areas (Betancourt et. al., 2015; Perez et. al., 2016; Seale et. al., 2016; Vaughn et. al., 2017; Johnson et. al., 2019; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021). The argument that these articles posed was that even though CEnR is being utilized more often as a strategy to examine and improve the health care experiences of migrants in the United States, the level of engagement and integration in all areas of the research process is not being practiced as it should.

Based on the information gathered from all reviewed documents (n=10), the steps in the research process of CEnR strategies are (1) inception of issue or need (2) acquiring and outsourcing funding (3) development of the study design (4) engaging community and community leaders (5) collecting data (6) analyzing data (7) dissemination of knowledge. The articles also argue that because migrant communities are so diverse and can have a plethora of important ideas and perspectives during collaboration, they must be included in all stages of the research process, from inception to dissemination (Betancourt et. al., 2015; Perez et. al., 2016; Seale et. al., 2016; Vaughn et. al., 2017; Johnson et. al., 2019; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021). Also, the reviewed articles make clear that to have an equitable and ethical approach to examining and improving the health care outcomes and experiences of migrants in the United States, there must be genuine involvement in all aspects of the research process. Ultimately, this review showed that current implementation of CEnR approaches to address health care outcomes and experiences of migrants in the United States does not necessarily imply that community engagement is happening in all stages of research.

Genuine and Meaningful Partnerships with Migrant Communities

Seven of the reviewed publications (n=10) discussed the importance of creating genuine and meaningful partnerships with migrant communities as it relates to collaborative efforts of CEnR strategies (Anand & Lahir, 2004; Perez et. al., 2016; Seale et. al., 2016; Johnson et. al., 2019; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021;). Creating genuine and meaningful partnerships was summarized into 3 categories: (1) Practicing intercultural engagement approaches to partnerships (cultural humility and intercultural awareness and sensitivity as a means of bettering health care experiences in the United States), (2) joining forces with community leaders and organizations (applying CEnR to project through partnering with community-based organizations to properly address lack of mental health services in the community), and (3) building trust throughout all stages of research and collaboration (importance of trust-based partnerships when understanding health disparities if the researchers claim to have a genuine solutions-based approach).

As discussed in the thesis literature review chapter, an intercultural engagement approach to partnerships and overall communication is needed to attain improvements in access and quality of health care for migrants in the United States. This approach fosters deep understanding and respect for all groups involved (Seale et. al., 2016; Johnson et. al., 2019; Filler et. al., 2021; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b). The reviewed articles argued that being intentional about our communication efforts and using respectful language with the communities we are engaging with is necessary to create meaningful partnerships (Anand & Lahir, 2004; Seale et. al., 2016; Johnson et. al., 2019; Filler et. al., 2021; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b;). One of the reviewed articles stated that to fully understand the health care needs of any community, including migrant communities, you must approach the partnership through an intercultural engagement lens and engage in intercultural communication efforts to understand key aspects such as patients' viewpoints and existing health beliefs (Anand & Lahir, 2014).

In addition to having an intercultural engagement approach to partnerships, some articles in the review also argued that joining forces with community leaders and organizations can aid in building genuine and meaningful partnerships with community members during the CEnR process (Horvat et. al., 2014; Betancourt et. al., 2015; Perez et. al., 2016; Seale et. al., 2016; Filler et. al., 2021;). Building relationships with trusted community leaders amongst migrant populations can ensure language barriers are addressed, health needs are fully understood from the perspective of community members, social networks are accessed properly, and collaborative partnerships are sustained (Horvat et. al., 2014; Perez et. al., 2016; Seale et. al., 2016;). Building genuine partnerships with community leaders and organizations connects groups that are trying to bring attention to health challenges faced in their communities (Perez et. al., 2016). Creating alignment in the goal to examine and improve the health care experiences of migrants only strengthens the outcome.

It is important to note that a few articles (n=9) expressed the potential danger of practicing tokenism in partnerships, stating that community-based and community-engaged research strategies must involve participants and community members meaningfully and utilize an ethical and pragmatic purpose and approach when establishing these relationships (Perez et. al., 2016; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b). To ensure tokenism is not at the root of these relationships, the reviewed articles suggest that community leaders not be the only individuals included in engagement, but multiple community members (Perez et. al., 2016; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b). They all must have the opportunity to hold leadership positions and access the same amount of information when it comes to creating and implementing potential programs or addressing health care needs. The idea of only "selecting community champions" can be extremely problematic and lead to disingenuous feelings and mistrust (Chowdhury et. al., 2021a; Chowdhury et. al., 2021b), becoming impossible for meaningful relationships to be built once that trust is broken (Chowdhury et. al., 2021a).

The Advantage of the CEnR Approach

A bit over half of the publications (n=10) provided details on how having a community-engaged and community-based approach to addressing health care access and outcomes in migrant communities can benefit community members, researchers, and the overall quality of research (Anand & Lahir, 2004;

Perez et. al., 2016; Seale et. al., 2016; Vaughn et. al., 2017; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021). In terms of benefitting the community members, two articles in the review stated that having a community-engaged and community-based approach leads to long-term sustainability of the implemented programs, higher rates of empowerment, higher rates of trust within the community, and more capacity building (Chowdhury et. al., 2021a; Chowdhury et. al., 2021b). In terms of benefitting the researchers and quality of research, four articles in the review (40%) stated that implementing a community-engaged approach leads to better and more intentional recruitment of research participants as well as a more culturally relevant approach to the research question at hand (Perez et. al., 2016; Seale et. al., 2016; Vaughn et. al., 2017; Filler et. al., 2021).

The reviewed publications (n=10) clearly show that CEnR can positively impact migrant communities in both the short term and long term. Increasing awareness and creating genuine relationships with stakeholders, all while discussing health concerns through the lens of CEnR is discussed as an integral part of influencing change and integrating research into true action and implementation (Seale et. al., 2016; Johnson et. al., 2019; Chowdhury et. al., 2021a; Chowdhury et. al., 2021b; Filler et. al., 2021). The close involvement of community members in research implementation was another CEnR advantage identified by two of the articles in the review (20%). These articles stated that when migrants are put in the position to spearhead the conversations surrounding their own health concerns, the intention and overall quality of research is at its highest (Chowdhury et. al., 2021a; Chowdhury et. al., 2021b). Being able to enrich the research question through personal experience and personal perception can ultimately shift the research strategy in the right direction.

Limitations

A few factors limited the consistency of this systemic review. One limitation was the use of language and jargon by the different publications, which became difficult to decipher during the database search and data extraction process. For example, most articles used migrant, immigrant, and refugee interchangeably, without explicitly defining the terms as different from each other. This situation made it difficult to define the type of migrant population during the systemic review process. Another example of limitations in terms of language and jargon was the use of CBPR and CEnR. Community-based participatory research (CBPR) and community-engaged research (CEnR) were used interchangeably throughout many articles found during the database searches. CBPR falls under the rubric of action research – actively involving members of the community, their leaders, and creating other partnerships. Whereas CEnR is used as the umbrella term that encompasses similar approaches to community engagement in research (Whitely, 2022). Both frameworks possess similarities in their advocacy for community engagement, but they are not the same. Given the number of articles using both labels interchangeably, this review included publications that mentioned CBPR in their findings, while still implicitly discussing and focusing on CEnR in the description of their frameworks.

Lastly, another limitation was that most articles concluded that more evidence is needed to make a definitive statement about the use of CEnR as an effective strategy to address the health care experiences of migrant communities in the United States. This is viewed as a limitation because it shows that at this time it is not possible to properly assess the utilization, integration, and effectiveness of community-engaged and community-based strategies in addressing health care for migrant communities in the United States.

CHAPTER 5

CONCLUSION AND PUBLIC HEALTH IMPLICATIONS

Through the information collected as part of this qualitative systematic review, there is evidence to assert that CEnR has strong potential to be an effective strategy in understanding and improving the health care experiences of migrants in the United States. There is also evidence that intercultural engagement strategies coupled with CEnR allow for power dynamics to equalize in the health care experiences of migrants in the United States. However, it is also evident that there is a need to further understand how CEnR strategies are being implemented and to continue researching the effectiveness of CEnR in general.

The level of CEnR integration into Implementation Science has significantly increased within the last decade and is perceived as a tool for better engagement and improvements to the health care experiences of migrants. Yet, community engagement in all areas of the research process is not being practiced as it should. This review continues to highlight the importance of trust and genuine partnership as an integral part of establishing research strategies that effectively and appropriately address the health care needs of migrant communities in the United States.

Identifying effective and appropriate cultural engagement strategies in the health care experiences of migrants in the United States can significantly contribute to equalizing the power dynamics that commonly exist in health care and research strategies, and therefore, has important public health implications. Power dynamics are often evident in minority communities, specifically migrant communities, and manifest in experiencing a lower quality of health care and less or no community agency in health research activities. Without balancing the power dynamics that exist in these spaces of medicine and research, we can’t address the larger, more complex health care needs of the communities around us. As public health practitioners, it’s our responsibility to ensure that all communities, including minority and migrant communities, are supported in addressing the power imbalances that exist around them. It’s also our responsibility to practice genuine engagement, meaningful partnerships, and providing support for self-empowerment as foundational aspects in this process toward health equity.

APPENDIX A

DOCUMENT ELIGIBILITY FORM

Study Characteristics		**Review Inclusion Criteria**		**Eligibility Decision**
Publication Label		**Article language**		
Publication Title		**Publication year**		
Author(s)		**Study population**		
Database		**Location/Area of interest**		
Type of study		**Topics mentioned**		

APPENDIX B

DATA EXTRACTION FORM

GENERAL INFORMATION	
Publication Label	
Date Data Extraction Form was Completed	
Publication Title and Hyperlink	
Authors	
Database	
POPULATION AND SETTING	
Study Population and Population Description	
Location/Area of Interest	
Description of Setting	
METHODS	
Type of Study	
Aim/Objective(s)	
Duration of Study	
Sampling Techniques	
OUTCOMES	
Specific Outcome(s)	
How Outcome(s) were Measures	
Description of Outcome(s)	
RESULTS, ANALYSIS, STRENGTHS, LIMITATIONS	
Reported Results	
Notes on Analysis	
Publication Strengths	
Publication Limitations	
Key Conclusions	

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