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Refugee Health in the United States: A Socio-Cultural Perspective

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Refugee Health in the United States: A Socio-cultural Perspective

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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

Refugee Health in the United States: A Socio-cultural Perspective

By Doris K. Mukangu

Problem/Background: Very few studies have addressed priority health issues affecting refugee health post-resettlement, especially from a socio-cultural perspective. Herein lies a gap regarding how to adequately address barriers that this unique population encounters in being able to fully utilize the healthcare resources available to them. The uniqueness of this population can be attributed to the fact that they are represented by different ethnicities, languages, literacy levels, educational backgrounds, and sub cultures, to name a few. The United Nations (UN) states the world refugee situation as the worst migration crisis since World War II. "Refugee crisis: More than 200 migrants drown and freeze to death as first fortnight of 2017 sets new record" Dearden, L. (2017, January) *The Independent*; "Tens of thousands of migrants and refugees are working their way north through the Balkans" Reid. S (2017, July) *The Daily Mail*…these are examples of many of the headlines that plague the news almost every day. Once these refugees flee their countries, they are typically housed in refugee resettlement camps. Due to limited resources in the camps, refugees have numerous acute and chronic health issues that are not attended to and may often persist post-resettlement. During resettlement, a lot of attention is given to infectious diseases, but very little attention is given to chronic illnesses. Moreover, post-resettlement, follow up for identified diseases may prove to be a challenge due to a myriad of barriers in accessing healthcare. One of the barriers being navigating the medical system in their new home country.

Key Aims: The purpose of this study is to use secondary data to explore refugee health in the United States post-resettlement from a socio-cultural perspective. The second purpose is to examine how the public health community can better deliver healthcare to the thousands of refugees that are resettled in the United States every year. Lastly, this study will explore the various themes that have emerged from various research studies conducted in refugee communities using a SEM theoretical construct.

Methods: A total of 1515 peer reviewed articles with 51 core articles regarding the subject of resettlement and public health are included in this systematic literature review. The aim of this study is to explore priority health issues in the refugee community in the United States post-resettlement and to suggest how service providers can best serve this unique population.

Conclusion: Three themes emerged from the literature related to refugee health issues post-resettlement that pointed to socio-cultural barriers. The results suggest that the public health community should re-evaluate the current methods of providing health care to the refugee community and implement evidence-based interventions from a socio-cultural perspective. A

social-ecological model construct is recommended to unearth underlying healthcare challenges in this unique population.

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Editor's Note: For confidentiality reasons, the names of individuals in vignettes have been changed to protect the privacy of individuals. The author of this paper is a co-founder and president of Amani Women Center, a 501c 3 non-profit serving the refugee community in Clarkston, Georgia, founded in 2006.

ACKNOWLEDGEMENTS

I would like to thank my thesis committee chair, Dr. Kathleen R. Miner, for her support and guidance throughout this process.

Thank you to Jaqueline Walker, Reggie Erawoc, Joanna Angel, Dr. Vuvu Manseka, and Kotouc family for their support and encouragement through this process.

Thank you to the many refugee women, whose voices are rarely heard, for lending me their stories.

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Refugee Health in the United States: A Socio-cultural Perspective

Everyone has the right to seek and to enjoy in other countries asylum from persecution." Universal Declaration of Human Rights, Article 14 (1)

Chapter 1- Introduction

Background

According to the Office of the United Nations High Commissioner for Refugees (UNHCR), there are an unprecedented 65 million displaced people in the world today, of whom 21. 3 million are refugees (United Nations High Commissioner for Refugees [UNHCR], n.d.a). UNHCR further states that the number of displaced people is at its highest ever and far beyond post-World War II numbers (UNHCR, n.d.a.). In other words, UNHCR reports that worldwide, an average of 24 people per minute are newly displaced (UNHCR, 2015). The office of the UNHCR was created in 1950, after World War II, in order to help millions of Europeans who had fled their countries and homes. The main functions of the UNHCR are to offer refugees international protection, to seek lasting solutions to their problems, and to provide them with material assistance in the form of food, shelter, medical assistance, education, and other social services. The UNHCR defines a refugee as a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality

and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (United Nations High Commissioner for Refugees [UNHCR], 2017). The Pew Research Center informs us that over half of the world's refugee population comes from three countries: Syria, Afghanistan, and Somalia.

The Pew Research Center is a nonpartisan fact tank that informs the public about the issues, attitudes and trends shaping America and the world (Pew Research Center, 2010). The Pew (2010) further states that most of these refugees are hosted in countries that border their home countries from which they are fleeing conflicts and persecution. With over 2.5 million people, Turkey hosts the largest number of refugees worldwide, followed by Pakistan and Lebanon, with 1.6 million and 1.1 million, respectively (UNHCR, 2015). The United States Committee for Refugees and Immigrants (USCRI) reports that UNHCR refers refugees for resettlement to a third country when all efforts to either help refugees return home or settle permanently in the country of asylum have failed (USCRI, n.d.c.). Only about 1 percent of all refugees are resettled in a third country (USCRI, n.d.c.). Resettlement is the transfer of refugees from an asylum country to another State that has agreed to admit them and ultimately grant them permanent settlement (UNHCR, nd.c). Of all the member-countries of the U.N., only the following countries have resettlement programs: Australia, Canada, Denmark, Finland, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United States. Other countries accept individual refugees on an ad hoc basis (USCRI, n.d.c.). Family ties, trade skills, professional abilities, language facility, and various other factors are considered by UNHCR when matching a refugee with a resettlement country (USCRI, n.d.c.). The figure below shows the number of refugees resettled worldwide by country of origin (U.S. Committee for Refugees and Immigrants, 2017).

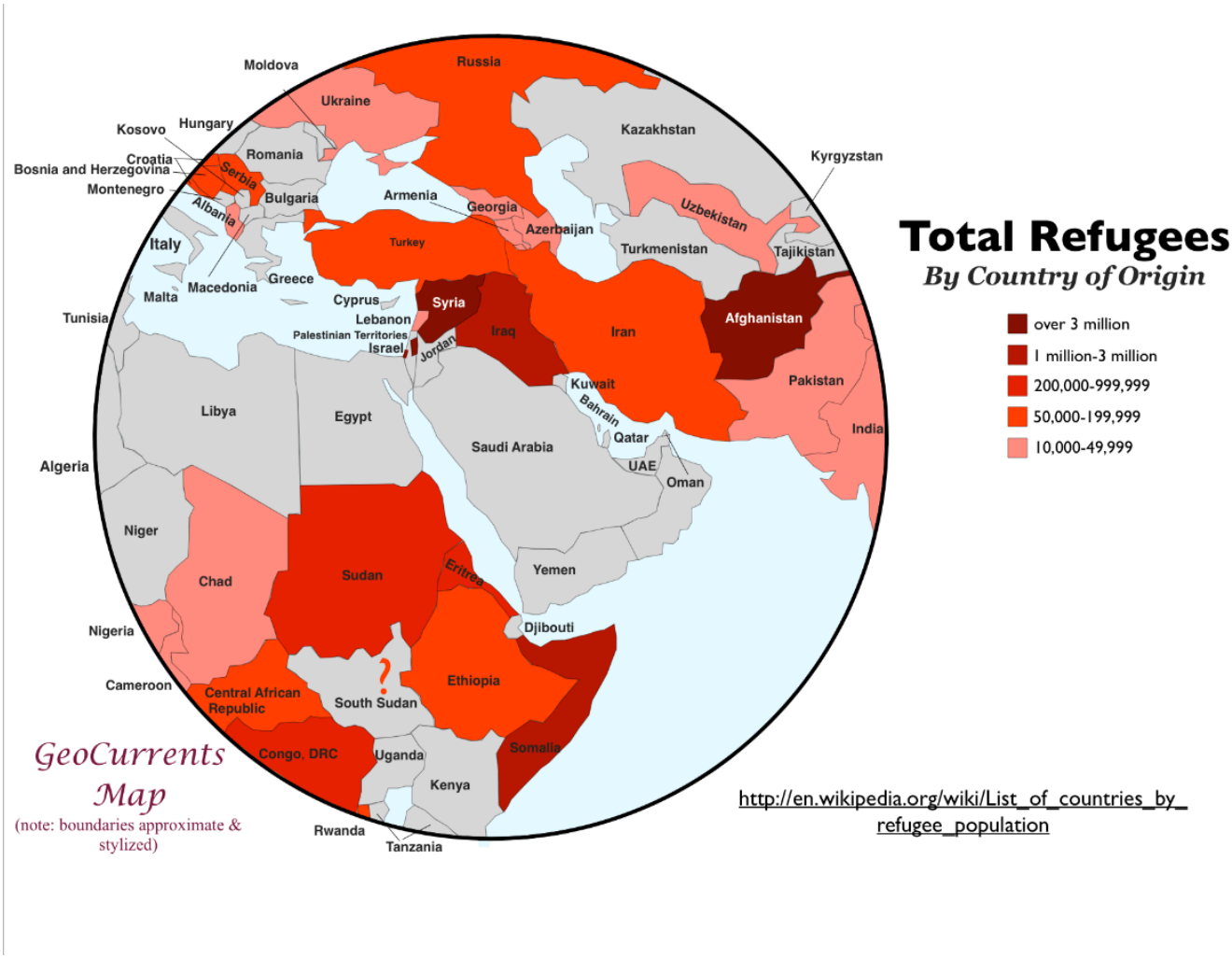

Figure 1 Refugee resettlement worldwide by country of origin

Global forced displacement of people has been on the rise over the last three decades due to armed conflicts and other forms of human rights violations in many regions around the world (UNHRC, 2015). The resulting humanitarian crises are borne by some of the least economically affluent countries (UNHRC, 2015). The situation usually unfold as follows:

1. Refugee flees war.
2. Refugee flees into country of asylum.
3. Refugee registers with UNHCR and moves into camp or private lodging.

4. UNHCR refers refugee to third country for possible resettlement.

5. Refugee then goes to U.S. refugee processing center for eligibility screening.

6. Refugee paperwork and bio-data goes to U.S. for allocation to volunteer agencies (VOLAGs).

7. INS interview is scheduled.

8. International Organization for Migration (IOM) schedules medical screening, provides treatment, arranges travel loan, and arranges flight.

9. Refugee departs for the U.S. and arrives at the prearranged resettlement site (UNHRC, 2015).

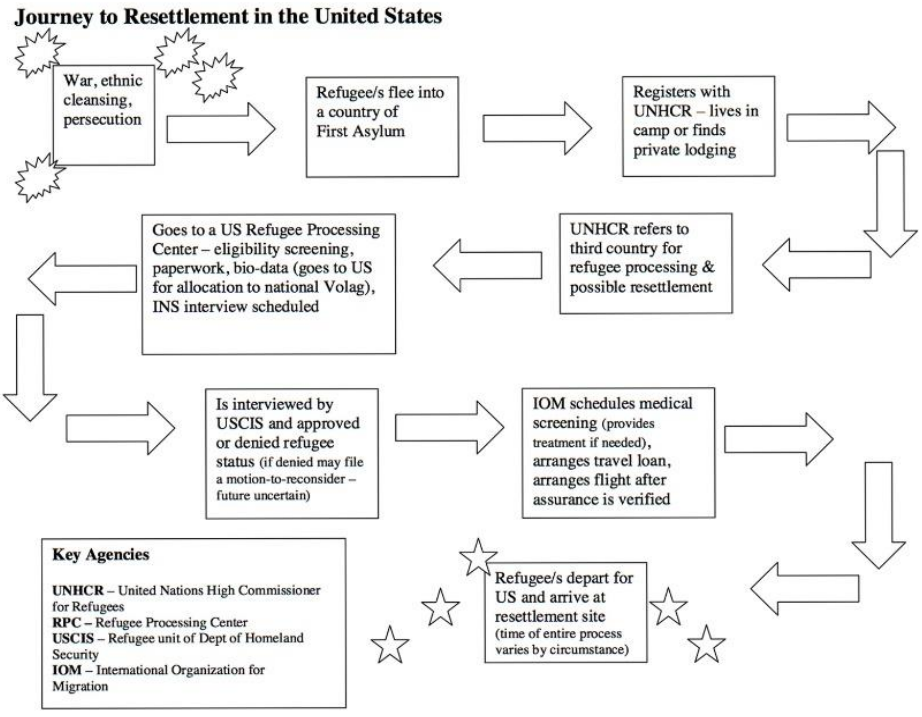

Figure 2. Refugee resettlement process to the United States. Reprinted from *Journey to Resettlement in the United States Flowchart*, by Office of Refugee Resettlement (ORR). Retrieved from https://www.acf.hhs.gov/orr/resource/journey-to-resettlement-in-the-united-states-flowchart, 2014.

The Global Trends report by UNHCR, reveals that more than 85% of refugees are hosted by low- to middle-income countries, while fewer than 5% are hosted by countries in the developed regions of the world (UNHCR, 2015). The unwillingness and incapability of more developed countries to host refugees has led to some dire circumstances as presented almost daily in the media.

"The first half of 2016 saw a 37 percent increase in the number of recorded deaths and disappearances across the Mediterranean Sea, compared to the same period in 2015," an IOM study said"(Frej, 2016).

"Fire destroys Syrian refugee camp in Lebanon, kills one" (Reuters, 2017).

"The UN Refugee Agency (UNHCR) has recorded at least 1,073 people dead or missing on the treacherous passage between Libya and Italy" (Independent, 2017).

The global refugee predicament will require a collaborative effort on the part of all nations, not only to ensure the safety of refugees but also to address the underlying causes of the crisis. According to the UN (2015), the US contributes significantly to the resettlement of refugees and has a proven record of resettling more refugees than any other country in the world. It is among the four most successful countries for refugee resettlement.

REFUGEE RESETTLEMENT IN THE UNITED STATES OF AMERICA

According to the U.S. Office of Refugee Resettlement (ORR) (2012), every year, thousands of refugees who are fleeing war and persecution are resettled to cities across the United States to rebuild their lives. About three million refugees have been resettled in the U.S. since Congress passed the Refugee Act of 1980, which created the Federal Refugee Resettlement Program and the current national standard for the screening and admission of refugees into the country (Office of Refugee Resettlement [ORR], 2012). "The goal of the federal Refugee Resettlement Program is to provide for the resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible after arrival in the United States." (OOR, 2012). Title IV, chapter 2 of the Immigration and Nationality Act (INA) contains the provisions of the Refugee Act (ORR, 2012). It is important to note that ORR is an office of the Administration of Children and Families (ACF).

Security and Safety Concerns

Recent claims in the media that refugees are terrorists or likely to engage in criminal activities are unfounded.

"They are being released by the tens of thousands into our communities with no regard for the impact on public safety or resources…We are going to build a great border wall to stop illegal immigration, to stop the gangs and the violence, and to stop the drugs from pouring into our communities."– President Donald Trump (Kubrin, Ousey, Reid, & Adelman, 2017).

No refugees have carried out major fatal terrorist attacks in the U.S. since the Refugee Act of 1980 (Levenson, 2017). According to experts like Stanford Law Professor David Alan Schlansky, there is no evidence that refugees contribute to any significant level of crime in

America. He argues that “refugees have always been screened more carefully than other immigrants” (Sklansky, 2017).

According to the highly structured United States Refugee Admissions Program (USRA), refugees undergo a rigorous screening process before entering the U.S. (U.S. Department of State, 2017). The first step for most refugees who come to the U.S. is to register with the U.N. Refugee Agency, which makes the initial referral to the resettlement country (U.S. Department of State, 2017). Registration involves collecting documents including biometric data, date of birth, place of birth, and an iris scan. The U.N. then conducts interviews to the make sure applicants are bona fide refugees and the biometric data are rechecked. The UNHCR also considers criteria like medical needs and whether there are family or friends in a certain country to help determine where refugees should be placed (U.S. Department of State, 2017). Once the U.N. refers a refugee, a U.S. government-funded refugee support center receives the person’s application. At the center, a file is created and information is collected to begin background checks that independently ensure that the refugee is genuinely fleeing persecution or harm (U.S. Department of State, 2017). The screening process looks for indicators such as: the individual is a security risk, connections to known bad actors, outstanding warrants/immigration, or criminal violations (Pope, 2015). The U.S. government takes referrals from UNHCR and then screens and decides which refugees are admitted to the U.S. At this point in the process, less than 1 percent of the global refugee population is eligible to progress for further assessment by the U.S. government, according to an infographic created by the White House on the refugee-screening process. Around 56,000, or 80 percent, of the 70,000 refugees who are resettled annually in the U.S. arrive after being referred through the UNHCR (U.S. Department of State, 2017).

The Departments of State, Homeland Security (DHS), and Health and Human Services (HHS) work together to uphold America's humanitarian response to refugees through the U.S. Resettlement Program (USRP). Once the United Nations and U.S. embassies refer refugee cases for resettlement consideration, U.S. Citizenship and Immigration Services (USCIS) officers at DHS conduct individual interviews, grant clearances, and make final determinations for admission (U.S. Department of Health and Human Services, Administration for Children & Families, Office of Refugee Resettlement [HHS], 2015).

Here is an overview of what the vetting process looks like (Waldman, 2017).

- Eight government agencies – including the National Counterterrorism Center, FBI, Department of Homeland Security, and State Department
- Six security databases
- Five separate background checks
- Four biometric security checks – including fingerprints, checked against databases
- Three separate, in-person interviews
- Two interagency security checks running data against criminal, intelligence, and terrorism databases

Volunteer Agencies

The State Department's Bureau for Population, Refugees and Migration (PRM) coordinates admissions and allocations to specific cities and resettlement agencies, in conjunction with nine national volunteer agencies (VOLAGS) that oversee a network of some 250 affiliates in 49 states plus the District of Columbia through the Reception & Placement Program (U.S. Department of State, n.d.). When refugees arrive at their destination, these local affiliates greet them at the airport and help them with housing and access to other resources (U.S. Department of State, n.d.). Upon arrival, the refugees receive support from the Office of Refugee Resettlement (ORR) at HHS in the form of short-term cash, medical assistance, English as a Foreign Language classes (ESL), job preparation, and employment services, as well as case managers to facilitate the process of attaining self-sufficiency (HHS, 2016).

Resettlement Agencies or Volunteer Agencies (VOLAGs) are organizations working in partnership with the Office of Refugee Resettlement with the common mission of providing refugees with resources to become integrated into American society (HHS, 2012). VOLAGs have multiple streams of funding: State Department's Bureau of Population, Refugees, and Migration (PRM); self-generated resources; and the Office of Refugee Resettlement (part of the U.S. Department of Health and Human Services). Funding is used to provide a range of services, including sponsorship, initial housing, food and clothing, orientation and counseling, job placement, ESL, and other necessary social services (HHS, 2012).

There are a total of nine major resettlement agencies: Church World Service, Episcopal Migration Ministries, Ethiopian Community Development Council, HIAS - The Global Jewish Non-profit, International Rescue Committee, Lutheran Immigration and Refugee Service, U.S.

Committee for Refugees and Immigrants, United States Conference of Catholic Bishops, and World Relief (OOR, n.d.b.).

Figure 4 below provides a step-by-step breakdown of the resettlement process of refugees upon arrival to the United States as provided by the Office of Refugee Resettlement (ORR). This process involves the Department of Homeland Security: U.S. Citizen and Immigration Services, the State Department: Bureau of Population, Refugees and Migration, and the Department of Health and Human Services: Office of Refugee Resettlement.

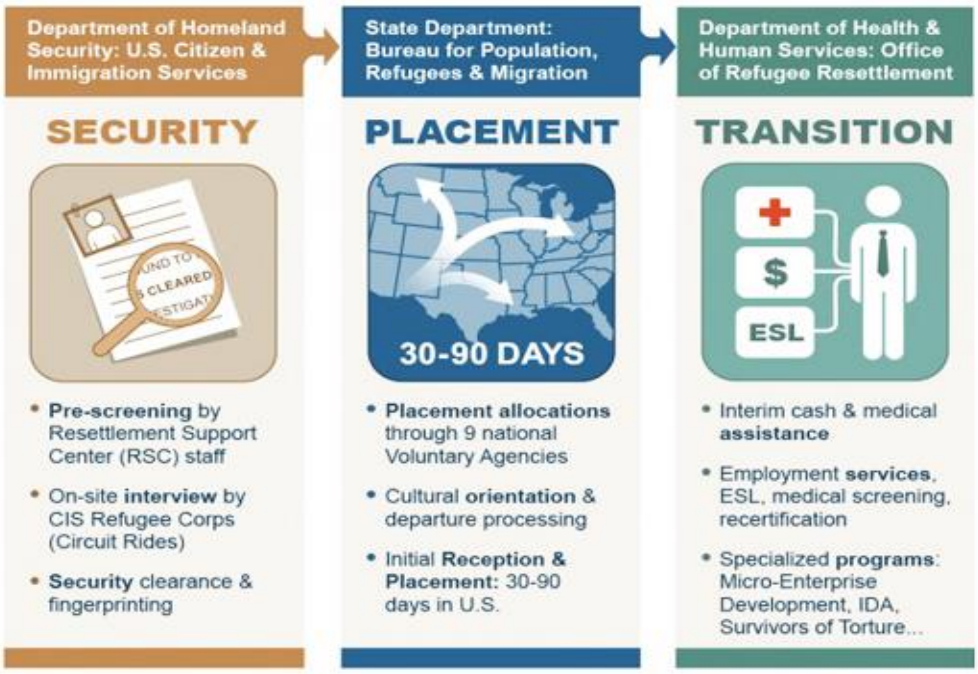

Figure 3. Refugee resettlement process upon arrival to the United States. Reprinted from *The U.S. Refugee Resettlement Program – an Overview,* by Office of Refugee Resettlement (ORR). Retrieved from https://www.acf.hhs.gov/orr/resource/the-us-refugee-resettlement-program-an-overview

VOLAG's play a significant role in the resettlement process for refugees upon arrival to the United States. VOLAG's can either enhance the likelihood of successful acculturation of

refugees or delay the integration process, depending on how effectively they can meet needs of the newly arrived refugees. For more information on VOLAG's please visit https://www.acf.hhs.gov/orr/resource/voluntary-agencies.

REFUGEE RESETTLEMENT IN CLARKSTON, GEORGIA

When a city is welcoming to refugees, it empowers them to thrive. Clarkston, Georgia is such a city. Its slogan "small city, big heart" expresses it well. According to the ORR, hundreds of refugees are resettled in Clarkston, Georgia every year. The refugee population was 7,554 as of the 2010 census (City of Clarkston, n.d.). The city is noted for its ethnic diversity, and is often referred to as "the most diverse square mile in America," also earning the name "Ellis Island of the South" (City of Clarkston, n.d.), In the 1990s, refugee resettlement programs identified Clarkston as a good solution for displaced persons of many backgrounds. The rental market was open, residents were moving farther out from the Atlanta urban core, and Clarkston was the last stop on a transit line into the city of Atlanta. (City of Clarkston, n.d.).

Clarkston is home to a local mosque with 800 worshipers. By some estimates, half the population of the city is from outside the U.S. and, 60 languages are spoken in this 1.4 square mile space. (See Figure 4).

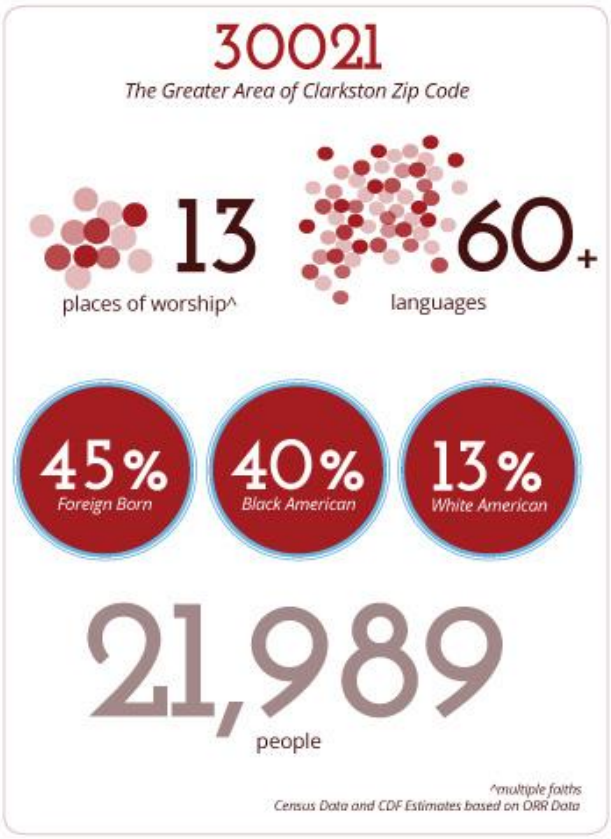

Figure 4. Clarkston residents and its population of refugees and immigrants from around the world. Reprinted from *Where We Work*, by CDF: Collective Action Initiative. Retrieved from http://cdfaction.org/where-we-work/

The experiences that bring each refugee to the US are varied and unique. The common denominator for all refugees is that they qualify under the UNHCR definition of what a refugee is: "a person who flees to a foreign country or power to escape danger or persecution." *The story of Aphia, a 32-year-old woman, is typical. Aphia has recently resettled in Clarkston, Georgia. When asked what country she comes from, she hesitates. "I am originally from Congo but I have lived in Uganda most of my life." Aphia's parents fled the war in Congo and migrated by foot to Uganda in search of a safe space. They resettled in a refugee camp in Uganda, where she spent 10 years of her life and whilst there applied to come and live in the U.S.*

Education

Clarkston High School, a public high school, is located in Clarkston, Georgia, in central DeKalb County. This school is very diverse with a student body representing 54 countries, reflective of the growing ethnically and culturally diverse community (Clarkston High School, n.d). Refugee children are increasingly graduating and applying to universities, which reflects the strong family values that encourage a good education. Georgia State University, Clarkston Campus, formerly known as Georgia Perimeter College, is one of the most culturally diverse in the University System of Georgia, with students from more than 150 countries (Georgia State University [GSU], n.d.).

Employment and Businesses

Refugees are productive and hardworking people (Coalition of Refugee Resettlement Agencies) (CRSA) (n.d.). On one end of the spectrum, refugees are still in competition for entry-level jobs with many unemployed Americans. Temporary, part-time, and seasonal jobs tend to be the first forms of employment throughout the country for refugees. Refugees in many states still have to wait longer to get jobs, often work fewer hours than full-time, or travel long distances to acquire full-time employment. Many refugees work in jobs that are not typically appealing to Americans. Many are employed in meatpacking factories that are situated many miles away from their homes. The factories often have extremely cold temperatures and require laborious and taxing work.

Harlan (2016, May 24), tells the heart-wrenching story a refugee, Ahmed. For Ahmed, the job at National Beef meant butchering parts of 3,000 cows per eight-hour shift, a supervisor standing right behind him, using the knife so furiously that he would sometimes feel like his ribs were shaking loose. But the job was also a test of the limits in America for a largely destitute,

unskilled and growing influx of Somali refugees, a group that was now prevailing in the competition for grueling jobs because of the very desperation they were trying to escape.

Refugees are contributing greatly to the economies of states that they are resettled in, as reported by the local Coalition of Refugee Service Agencies (CRSA)(n.d.) In DeKalb County, DeKalb Farmers Market has employed nearly 500 refugees from 38 different countries, reflecting the industrious and productive nature of refugees (CRSA, n.d.) .

On the other end of the spectrum, many refugees are entrepreneurs. According to the Georgia Budget and Policy Institute (2016), about 26 out of every 1,000 Burmese in the U.S. and 22 out of every 1,000 Hmong are business owners, compared to 31 out of every 1,000 U.S.-born people (GBPI, 2016). Take a stroll around the small city of Clarkston, GA, and you will come across several refugee-owned businesses: *Lambadina restaurant, Market Street, is owned by a lady, who came to the United States as a refugee from Eritrea. She says that her passion for cooking and her love for her ethnic food motivated her to start her business. Right across from the city hall is "Merhaba Shawarma," another hole in the wall, a favorite of Clarkston residents and workers. The owner from Eritrea, has owned and run this business for over seven years.*

Aforementioned, are stories that speak of the resilience and hardworking nature of refugees when given the opportunity, contrary to what is consistently portrayed in the media.

Theoretical Framework- The Social Ecological Model (SEM)

Very few studies currently exist on best practices for promoting and providing healthcare for refugees resettled in the united states using a theoretical framework. The Social Ecological Model (SEM) provided the theoretical framework for the discussion of the findings of the literature review for this paper. The ultimate goal of the SEM is to break down the cause and effect of health determinants so that individuals, societies, and organizations can effectively promote healthy behaviors through multi-level interventions. The multiple levels of influence for health-related behaviors and conditions according to the ecological model are five: (1) *intrapersonal* or *individual* factors; (2) *interpersonal* factors; (3) *institutional* or *organizational* factors; (4) *community* factors; and (5) *public policy* factors (McLeroy, Bibeau, Steckler, & Glanz, 1988).

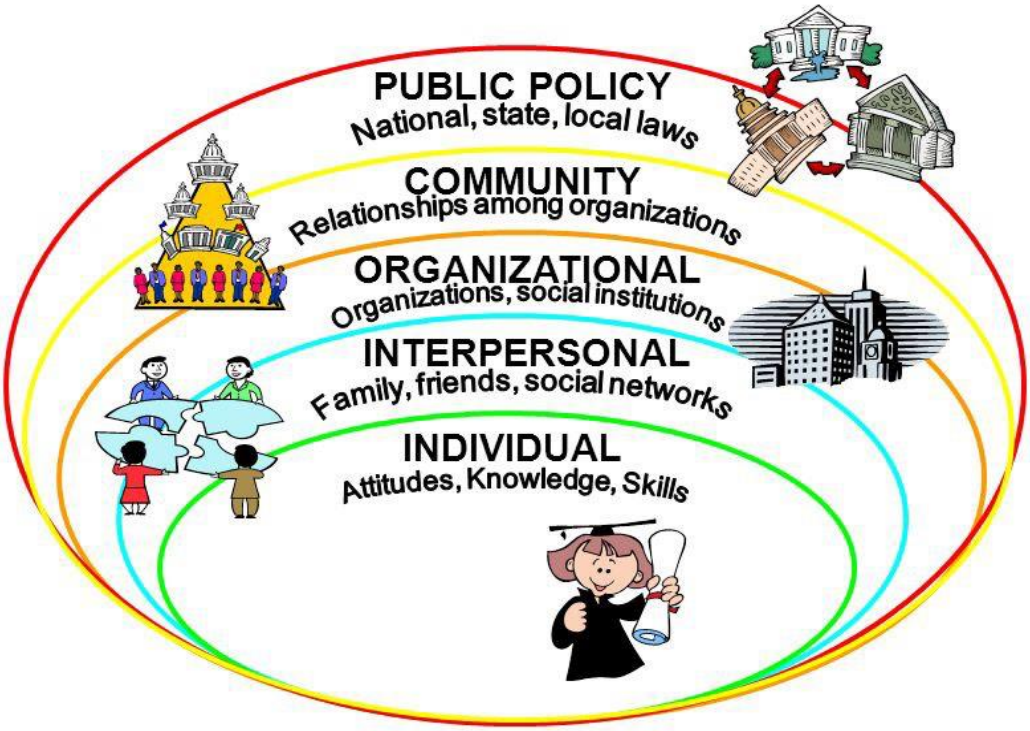

Figure 5. Social Ecological Model. Retrieved from http://www.balancedweightmanagement.com/TheSocio-EcologicalModel.htm, 2014.

Purpose Statement

The purpose of this study is to utilize secondary data from other research sources to explore refugee health in the United States post-resettlement from a socio-cultural perspective. Secondly, to determine ways in which public health can better serve the thousands of refugees that are resettled in the United States every year. Lastly, this study will explore the application of evidence-based theories to examine key themes identified in delivering health services effectively in the refugee community.

Research Question:

What are the most efficient methods of delivering healthcare to refugees in the United States post-resettlement? What are the most effective methods of delivering healthcare to refugees in the United Sates post-resettlement?

Significance Statement

Refugees are a unique population with unique health care needs. Refugees originate from varied backgrounds therefore presenting different health issues. Using a single template to meet the needs of the refugee community has proven to be inefficient and ineffectual. Identifying and addressing socio-cultural characteristics which are unique to this population is necessary to increase accessibility to much needed healthcare.

Addressing refugee health issues from a socio-culturalperspective can provide insight and rationale for targeted program planning, allocation of funding, and policy making that can be beneficial to the public health community as whole.

Engaging various stakeholders to elucidate what works and what doesn't can provide insight to the various communities to enhance and inform health providers on how to better address the needs which exist in the refugee community. Lastly, applying evidence based methods in addressing healthcare challenges is necessary for effective and efficient delivery of healthcare to this unique community.

Definition of terms

The following phrases and terms are used throughout the paper and are associated with refugee health and refugee resettlement.

Acculturation – is defined as the process by which a newcomer adopts the cultural behaviors common in the host country, which may lead to changes in diet, physical activity level, and environmental exposures.

Evidence-based public health - is defined as the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models (Brownson et. al, 2003).

Health - a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Public health – Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases.

Refugee – a refugee is a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

Refugee camp – is a temporary settlement built to receive refugees and people in refugee-like situations. Refugee camps usually accommodate displaced persons who have fled their home country, but they are also available for internally displaced persons.

Resettlement - according to UNHCR, resettlement is the transfer of refugees from an asylum country to another State that has agreed to admit them and ultimately grant them permanent settlement.

Refugee Health - The Journal of Immigrant Health defines refugee health (also referred to as immigrant health), as the field of study on the health effects experienced by people who have moved to another area of the world, either by choice or as a result of unsafe circumstances such as war (Palinkas et al. 2003).

Socio-cultural perspective- "Socio-cultural perspective: A perspective describing people's behavior and mental processes as shaped in part by their social and/or cultural contact, including race, gender, and nationality (Catherine A. Sanderson, 2010).

Acronyms

The following acronyms are used throughout this paper and associated with refugee health and refugee resettlement.

ACA – Affordable Care Act

ASD – Autism Spectrum Disorder

CDC- Centers for Disease Control

CLAS – Culturally and Linguistically Appropriate Services

CRSA – Coalition of Refugee Service Agencies

DCBOH –DeKalb County Board of Health

DGMQ- Division of Global Migration and Quarantine

DHS- Departments of Homeland Security

DHHS- Department of Health and Human Services

DPH – Department of Public Health Refugee Health Program

DRHP-Domestic Refugee Health Program

EBCOs- Ethnically based community organizations

EDN- Electronic Disease Notification System

FGM - Female Genital Mutilation

GATE – Georgia Team Empowerment

GSU – Georgia State University

HBV- Hepatitis B Virus

HHS- State and**?** Health and Human Services

IOM- International Organization of Migration

IRMH -Immigrant, Refugee and Migrant Health

LEP – Limited English proficiency

LTBI – Latent Tuberculosis infection

NCEZID – National Center for Emerging and Zoonotic Infectious Diseases

NCDs – Non-communicable diseases

NCHS – National Center for Health Statistics

NGO's - Non-Government Organizations

OMH – Office of Minority Health

ORR-Office of Refugee Resettlement

PPACA – Patient Protection and Affordable Care Act

PTSD – Post Traumatic Stress Syndrome

PRM- Bureau for Population, Refugees and Migration

RHP – Refugee Health Program

RHTAC – Refugee Health and Technical Assistance Center

SEM- Social Ecological Model

UNDP – United Nations Developmental Program

UNHCR – United Nations High Commissioner for Refugees

USRP- U.S. Resettlement Program

USCIS- U.S. Citizenship and Immigration Services

USCRI – United States Committee for Refugee and Immigrants

USRA – United States Refugee Admissions Program

VOLAGS – Volunteer Agencies

WHO- World Health Organization

Chapter 2 – Literature Review

Introduction

The Journal of Immigrant Health defines refugee health (also referred to as immigrant health) as the field of study of the health effects experienced by people who have moved to another area of the world, either by choice or as a result of unsafe circumstances such as war (Palinkas et al. 2003).

The health of refugees is strongly influenced by their migration history therefore, causing higher rates of mood disorders, post-traumatic stress disorder, and anxiety than the general population (Mishori, Aleinikoff, & Davis, 2017). Mishori et al. (2017) further discuss that chronic non-communicable diseases, such as diabetes mellitus and hypertension, are prevalent among refugees and that many of them may be missing routine immunizations and screenings for cancer and chronic diseases. In the US, the Office of Refugee Resettlement (2017) recognizes that refugee health is affected by many compounding factors including geographic origin and refugee camp conditions. The ORR has further identified that refugees face a wide variety of acute or chronic health issues, infectious diseases such as tuberculosis or intestinal parasites, chronic illnesses such as diabetes or hypertension, and mental health issues such as post-traumatic stress disorder or depression. Refugees and new immigrants arriving in the United States often encounter a multitude of stressors adjusting to a new country and potentially coping with past traumas (Hartwig & Mason, 2016). It is therefore necessary to identify what the major health issues are in the various groups of refugees post-resettlement and the most efficient and effective way to provide them with healthcare. Moreover, it is important to determine what barriers refugees face while attempting to get their healthcare needs met. According to the 1990 US Census, almost 14 million people living in the United States do not

have good English language skills (Woloshin et al., 1995). Language being the most important factor in effective doctor-patient communication can translate into many refugees not adequately receiving much needed healthcare. Research has identified multiple layers of barriers other than language. This section of the paper will focus on identifying priority health issues affecting various ethnicities in the refugee community as well as challenges that refugees face in accessing health services. Lastly a conclusion on the relevance of exploring these challenges for the public health community.

Background

Health Care in Refugee Camps

Non-governmental organizations in refugee camps provide in-patient and outpatient healthcare, including: paediatrics and integrated management of childhood illness: reproductive health: psychiatric consultations: emergency medical services: basic laboratories: tuberculosis management; and voluntary testing and counselling for HIV (CDC, 2014c). Depending on one's ethnicity and the camp in which one resides, vaccinations are administered in accordance with the World Health Organizations (WHO) Expanded Program on Immunization. These records are then located in a health information packet provided by IOM and are in turn recorded in the CDC's Electronic Disease Notification system (WHO, 2017).

Pre-Departure Treatment

Refugees receive different types of pre-departure screening depending on country of origin and ethnicity. A medical examination is mandatory for all refugees coming to the U.S., and all applicants outside the U.S. applying for an immigrant visa must follow the CDC's Technical Instructions (CDC, 2014b). The examination is performed by a panel of physicians selected by US Department of State consular officials who have been trained by the CDC (CDC, 2014b). This vetting process is intended to identify applicants who have inadmissible health conditions. The health information acquired is registered by the Electronic Disease Notification System (EDN) and made available to the state refugee health programs (CDC, 2014b).

Post-Arrival Medical Screening

The approach to the refugee's health once in the United States has a multi-tiered, ranging from the local level to the state level. The Centers for Disease Control and Prevention (CDC), the U.S. agency charged with tracking and investigating public health trends as part of the U.S. Public Health Services (PHS) within the Department of Health and Human Services (HHS), is located in Atlanta, GA (CDC, n.d). Within the CDC is the Immigrant, Refugee and Migrant Health Branch (IRMH), which is part of the Division of Global Migration and Quarantine (CDC, Division of Global Migration and Quarantine [DGMQ], 2016). Its goals are to promote and improve the health of immigrants, refugees, and migrants and to prevent the importation of infectious diseases and other conditions of public health significance into the U.S. by these groups. (CDC, DGMQ, 2016). To accomplish its goals, the IRMH branch plays a significant role in refugee health, both overseas and domestically (CDC, DGMQ< 2016). The Domestic Refugee Health Program facilitates collaboration with state and local health department partners to improve healthcare and monitor medical conditions of refugees after their arrival

into the United States (CDC, 2016d.). IRMH also maintains the Electronic Disease Notification System (EDN), which notifies states and local health departments of the arrival of refugees to their jurisdictions. EDN provides states with overseas medical screening results and treatment follow-up information for each refugee (CDC, 2013). The goal of the Refugee Health Promotion (RHP) program is to incorporate a framework of health services from arrival to self-sufficiency, ranging from attending health orientation and education classes, to accessing health services, to obtaining affordable ongoing healthcare. Special emphases are placed on health literacy: access to health and emotional wellness services, and access to affordable healthcare beyond the initial services provided upon arrival into the United States (ORR, n.d.).

Major Health Challenges in Refugee Population in the United States

This section of the paper is an analysis of studies that have been done on major health concerns and challenges identified in the following largest groups of refugee populations that have resettled in the United States. These refugees are primarily from Myanmar, Dem. Rep. of Congo, Syria, Iraq, Somalia, and Bhutan. The focus is on three major sections: non-communicable disease/chronic diseases, infectious diseases, and mental health. In addition there will be a section giving special attention to Female Genital Mutilation, as it is a pervasive issue in some refugee communities.

According to the CDC (2014), the following health conditions are considered priority health issues when caring for or assisting Bhutanese refugees: anemia, vitamin B12 deficiency and mental health. The Congolese refugees have slightly different priority health conditions; parasitic infections, malaria, mental health and sex and gender based violence. Burmese refugees who are the largest number of refugees resettled in the US to date experience Hepatitis B and intestinal parasites as distinct health burdens. The Syrian refugee population is burdened

with the specific health conditions of anemia, diabetes, hypertension, and mental health. Diabetes mellitus, hypertension, and mental health conditions are considered to be high health priority areas for Iraqi refugees. Interestingly, even though Somalians are the fourth largest number of refugees resettled in the United States, there was no information provided by the CDC on what the highest priority health issues are in this community. However, a few studies have been conducted that are particular to this group and will be included in this analysis paper. This paper covers the six major groups resettled in the United States to date, so Syrian refugees will not be included in the discussion. Due to the myriad health challenges refugees face, it is very important that they have access to much needed healthcare.

Access to Healthcare

Yun, Fuentes & Desai, 2016 noted that rates of uninsured people were comparable among refugees and immigrants. The data showed the proportion as 49% and 47.4% respectively. However, further studies revealed that 46.5% with chronic conditions lack health insurance. The same study suggests that additional information on chronic disease and health insurance coverage would be useful to better inform primary care, preventive health and insurance outreach programs. Studies show that immigrants have lower rates of usage of health insurance, use less health care, and receive lower quality of care than U.S.-born populations due to various reasons: socioeconomic background; immigration status; limited English proficiency; federal, state, and local policies allowing access to publicly funded health care; residential location; and stigma and marginalization (Derose, Escarce, & Lurie, 2007).

The Patient Protection and Affordable Care Act (PPACA) which is generally known as the Affordable Care Act (ACA) or Obamacare, is the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The

legislation includes a comprehensive list of health-related provisions (Healthinsurance.org, n.d.). The key provisions are: to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions. Even though efforts have been made to provide refugees with education through the Affordable Care Act (ACA) and other forms of health insurance by Refugee Health Technical Assistance Centre (RHTAC) and U.S. Office of Refugee Resettlement, forty percent (40%) of refugees have resettled in states without Medicaid expansion (Agarwal & Venkatesh, 2016).

Non-Communicable Diseases and Chronic Diseases

The global rise in non-communicable diseases (NCD) suggests that US-based refugees are increasingly affected by chronic conditions. According to WHO, non-communicable diseases (NCDs), also known as chronic diseases, are not passed from person to person. They are of long duration and generally progress slowly. The four main types of non-communicable diseases are cardiovascular diseases (heart attacks and stroke), cancers, chronic respiratory diseases (chronic obstructive pulmonary disease and asthma) and diabetes (WHO, 2015).

A retrospective study conducted at a major medical health center found that during the first eight months of resettlement in the US, half of adult refugees were diagnosed or treated for at least one chronic NCD (51.1%). One in five adults had two or more chronic NCDs (Yun et al., 2013).

Furthermore, a study of pediatric refugees revealed that there is an increased risk of rapid weight gain after US immigration (Olson et al., 2017). According to the National Center for Health Statistics (NCHS), ambulatory care provided in a timely and appropriate manner may be able to prevent illness, control acute episodes and manage chronic conditions (NCHS, 2017).

It is therefore imperative that **a** conscientious effort be made to ensure that refugees are resettled in states where they have ACA coverage and moreover that refugees have access to ambulatory care to curb progression of chronic diseases.

Malnutrition

Refugees have very limited knowledge of what is deemed as "healthy" US foods and are also overwhelmed by the many choices available, making food selection and preparation a very daunting process for them (Willies & Buck, 2007).

In a study reviewing the medical records of all newly arriving pediatric refugees (0-18 years) entering DeKalb County, Georgia between October 2010 and July 2011 were, the data indicated that approximately one in five refugee children were anemic or malnourished. Refugee children were grouped as African, Bhutanese, or Burmese (resettling from either Thailand or Malaysia). Other studies have revealed that pediatric refugees are at an increased risk for growth and nutritional deficits (Shah et al. (2014). As more refugee children are resettled to the United States, it is important to screen appropriately in order to identify any growth or nutritional issues.

Vitamin Deficiency

Shah et al. (2014) in reviewing several studies concluded that there is widespread vitamin D deficiency among immigrants and refugees. Penrose, Adams, Nguyen, Cochran, and Geltman's research revealed that clinicians performing routine medical examinations in the United States reported high rates of hematologic and neurologic disorders caused by vitamin B12 deficiency in resettled Bhutanese refugees. Some of these studies indicate that malnutrition continues to be a major risk factor for refugee children. In order to address this issue, culturally

sensitive nutrition education and counseling should be provided after resettlement (Fabio, 2014).

Cancer

According to the CDC (2016), refugee populations are at a disproportionally increased risk for cancers that occur in the developing world, such as cancers of the liver, esophagus, and stomach. Moreover, there are no specific guidelines in the United States for screening for cancers that occur disproportionally in migrants from the developing world. Many refugees in the United States emigrated from countries where the incidence of cervical cancer is high. Refugee women are unlikely to have been screened for cervical cancer prior to resettlement in the U.S.

Refugee women face many barriers in accessing preventive services and screening. These include: fear of pain (the belief that mammograms are painful) and diagnosis (anxiety about what to do next if diagnosed with cancer), modesty (not wanting to expose oneself, especially to a male physician), and work and childcare commitments (the average family has 4-5 children) (Saadi, Bond, and Percac-Lima, (2015).

In addition, lack of the following facilitative factors may cause barriers to accessing preventive services and screening, such as outreach efforts (health education that is culturally appropriate), appointment reminders (reminders are overlooked if not in ethnic languages), and personal contact from health providers (prefer health providers that are culturally competent); perceptions of the American medical infrastructure compared with inadequacies in their home countries (lack of knowledge about navigating the medical system); and positive attitude toward U.S. health professionals (Percac-Lima et al., 2015).

Infectious Diseases

Refugees resettling in the United States carry a significant burden of infectious diseases because of exposures in their countries of origin and the circumstances of their migration.

Tuberculosis (TB)

When analyzing infectious diseases within the top 10 health conditions documented during screening assessments for refugees, exposure to tuberculosis and parasite infections were primary. Of those individuals diagnosed with latent tuberculosis infection (LTBI), 56% never received any treatment, and only 11% completed treatment (Holguin et al., 2017). Presence of latent Tuberculosis infection (LTBI) and parasite infections have been documented separately to be at high levels among newly arriving refugees, with rates of LTBI and pathogenic parasites as high as 64% and 40%, respectively (Board & Suzuki, 2016). This study also noted that poverty, crowded living conditions, and migration to be key risk factors for both TB and intestinal parasite infection. Additionally, the discordance in the classification of tuberculosis (TB) disease overseas compared to classification in the United States is problematic (Evans, Mador, Glick, & Ahmad, 2015). The data from the preceding report can be used to help state and local health departments provide prompt and effective follow-up, evaluation, and treatment to newly arriving immigrants and refugees. Timely follow-up might prevent additional spread of tuberculosis or other communicable diseases of public health significance into their communities. In addition, information from the EDN system allows health departments to use their resources as effectively as possible by providing clinical information that identifies the refugees and immigrants who should be prioritized for evaluation and treatment (Philen et al., 2014).

Human Immunodeficiency Virus (HIV)/AIDS

An article published by the U.S. Department of Health and Human Services (DHHS), CDC, and National Centre for Emerging and Zoonotic Infectious Diseases (NCEZID) states:

> beginning January 4th, 2010, refugees were no longer tested for HIV-infection prior to arrival in the U.S. "Current CDC guidelines for the United States recommend HIV screening in health-care settings for all persons 13-64 years of age. Screening of all refugees 13-64 years of age is recommended in accordance with this policy. Screening of all refugees on arrival, including those ≤12 years and ≥64 years of age, is also encouraged.

It should be noted that screening upon arrival to the U.S. is not mandatory and refugees choose not to participate. DHHS, NCEZID, & CDC, (2012), further reported that "multiple factors heighten the HIV risk for refugees; economic distress, conflict, sexual abuse and violence, oppression, discrimination, exploitation, gender bias, and sociopolitical marginalization". African-born immigrants and refugees have HIV infection rates six times higher than any other minority groups in the United States (Kingori et al., 2016). The authors continued by saying that the lack of aggregate HIV infection rates among African-born immigrants, for example, Somali refugees, is a cause for alarm and calls for more research to be conducted in this subgroup. Based on these studies, post- arrival HIV screening would reduce morbidity and decrease transmission.

Hepatitis B

According to WHO, infection with hepatitis B virus (HBV) is life threatening and may lead to acute and chronic liver diseases including cancer and cirrhosis. Approximately 248 million people are estimated to be infected worldwide (Chandrasekar et al., (2016). Most research on

hepatitis B virus (HBV) infection in the United States is limited to Asian populations, despite an equally high prevalence among African immigrants. The prevalence of HBV infection (current or past as determined by available titer levels) varied among refugees originating from different countries and, it was higher among Burmese refugees than among refugees from Bhutan or Iraq. Current or past HBV infection was also higher among adults (aged >18 years) and male refugees. These data might help inform planning by states and resettlement agencies, as well as screening decisions by health care providers (Chandrasekar et al., 2016). The CDC also recommends that family, sex partners, and household members be encouraged to get vaccinated in order to reduce transmission (CDC, 2015).

Mental Health

Johnson-Agbakwu et al. (2014), argues that post-traumatic stress disorder (PTSD), anxiety, and depression are common mental health disorders in the refugee population. The article further states that high rates of violence, trauma, and PTSD among refugee women remain unaddressed. According to WHO, mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2017).

Post- traumatic stress disorder (PTSD)

The study by Hollifield et al. (2002) reveals that, "depending on the sample, the rates of PTSD vary widely within any given refugee population, with prevalence rates ranging from 4% to 86% for PTSD and 5% to 31% for depression." According to Bolton (2002), although progress has been made in the development of culturally sensitive assessment measures, our ability to assess the mental health needs of individuals living as refugees is still limited, as is

our knowledge of effective psychological interventions for refugees. There has been major advancement in developing culturally sensitive assessment measures in PTSD in the refugee community. Examples of trauma screens include the Harvard Trauma Questionnaire, the Resettlement Stressor Scale, and the War Trauma Scale. Bolton further states that, very little progress has been achieved in assessing the mental health of refugees and effective psychological interventions. Possible variables suggested that contribute to this problem are limited funding for mental health programs, a shortage of bilingual mental health professionals, and a lack of cultural competence in mainstream service providers to respond to the needs of this population (Alegria, 2010).

Suicide

According to CDC (2013), more than 56,000 Bhutanese refugees have resettled in the United States since 2007. By early 2009, increasing numbers of suicides among them were reported. As of February 2012, 16 suicides among Bhutanese refugees in the United States were confirmed. To emphasis the seriousness of this matter, the author cites several instances of suicides in a short period of time as reported by the online newspaper – the Atlantic (2013). It says that Mishra's death is part of a troubling pattern among Bhutanese refugees resettled in the U.S. In August of 2010, about a month after Mishra's death, Dan Maya Gurung committed suicide in Buffalo, according to the Bhutan News Service. Gurung was in her late 30s and had been in the country just two weeks. The next month, Nirmala Niroula, 35, also living in Buffalo, hung herself in her apartment. Niroula had moved to the U.S. three months earlier. That December 20-year-old Menuka Poudel was found dead in her Phoenix apartment, hanging from a noose fashioned from the shawl Bhutanese women wear with their traditional clothing. She had been in the States just two months.

Regarding the phenomenon of suicides in this population, some suggestions that came up in a report by the Bhutanese community at the Georgia Coalition of Refugee Stakeholders (GCRS) meeting January 26, 2012 are: to include new families in social and education opportunities, the need for a system navigator (someone to help with all the processes and changes) and, the need to conduct training on how to address psychological distress on a community level. The report can be found at https://garefugees.files.wordpress.com/2010/07/georgia-coalition-of-refugee-stakeholders-january-26-2012.docx.

Disabilities

Mirza et al. (2014), notifies the urgency of, understanding healthcare needs and barriers faced by the growing numbers of disabled and chronically ill refugees in the U.S. signifies an important knowledge gap in the field of immigrant health. Mirza further states that filling this gap is an essential first step in eliminating disparities for this high need, high risk group. The disabled refugee population has unmet disability needs and limited resettlement resources due to numerous factors: limited awareness of disability rights and resources by service providers, narrow biomedical perspective or definition of disability, limited resources within agencies thus leading to a disconnect between refugees and disability service providers, mistrust between the different service providers, and lack of cultural competency among disability service organizations (Mirza & Heinemann, 2012).

Autism

There is statistical evidence indicating that Somali refugees and immigrants have high rates of autism spectrum disorder (ASD). Somalis in North America call autism the "Western disease" because there is no word for autism in the Somali language and because many believe it does not exist in Somalia (Decoteau, 2017).

It is important to note that there is significant reluctance among this population to address mental health issues due to the stigma that surrounds mental health and the lack of knowledge of the role mental health professionals play. Therefore, mental health concerns should begin by dealing within the family system and at the community level, especially in communities of faith (Piwowarczyk et al., 2014).

Based on research conducted by Vonnahme et al. (2015), delayed onset of poor emotional health may sometimes present itself as poor physical health. Hence, mental health screenings are recommended months after resettlement.

Female Genital Mutilation/Cutting

Female Genital Mutilation or Cutting (FGM/FGC) is common in many refugee populations, particularly those from East Africa such as Somalia, Ethiopia, and Sudan (WHO, 2017). It is important to note that these are areas from which some of largest refugee group resettled in the U.S migrate. According to the World Health Organization, more than 130 million women worldwide have undergone female genital cutting. This procedure has been declared a human right violation. The WHO definition: "female genital cutting refers to all procedures involving partial or total removal of female genitalia or other injury to female genital organs for any cultural, religious or otherwise nontherapeutic reasons." In the United States, the CDC requires that physicians who encounter mutilated refugee women complete a FGM record stating what type of procedure was done and that the woman has been educated that the procedure is illegal in the US (CDC, 2016). The following table presents the types of female genital mutation as defined by WHO.

Table 1 – Four Types of FGM

Type I	Partial or total removal of clitoris.
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or majora (infibulation), with or without excision of the clitoris.
Type IV	All other harmful procedures to the female genitalia for nonmedical purposes (e.g., piercing, incising, pricking, scraping, and cauterizating.

There are several cultural perceptions associated with the continuation of the practice of female genital mutation. Namely, rite of passage, preserving chastity, ensuring marriageability, religion, hygiene, improving fertility, and enhancing sexual pleasure for men (Nour, 2015). Even though it is not considered to be a priority health issue by the CDC, female genital mutilation (FGM) is rampant in some of the refugee communities and causes a barrier to women seeking health care for fear of stigmatization.

Conclusion

While the body of knowledge around refugee health post-resettlement continues to mature, additional studies are needed on how to more effectively and efficiently deliver healthcare to this unique population. This paper will attempt to build on the literature that is already available by extracting and compiling findings on what is working in providing health care to refugees

in the United States post-resettlement. Compiling emerging themes in the literature are likely to set the stage for future research. The next chapter will further provide a detailed description of the methodology applied to this study.

CHAPTER 3 – METHODOLOGY

Introduction

The purpose of this study is to utilize secondary data from other research sources to explore refugee health in the United States post-resettlement. Secondly, this study aims to determine ways in which public health can better serve the thousands of refugees that are resettled in the United States every year. Lastly, this study will explore the application of evidence based theories to examine key themes identified in delivering health services effectively in the refugee community.

Sources

The method of research used in this paper is literature reviews on refugee health in the United States from various sources. The review focused on health priority issues of refugees who have already resettled in the US. For the purpose of discussion, the articles were then systematically arranged into 3 main areas of interest: chronic diseases, infectious diseases, and mental health. The author used search strings such as infectious diseases, chronic diseases, and mental health. Studies conducted outside of the United States were excluded. Selection of sources was mainly related to the six major groups of refugees. These refugees primarily originate from Myanmar, Dem. Rep. of Congo, Syria, Iraq, Somalia, and Bhutan. The sources are primarily from PubMed, which sometimes would redirect, accessing full articles from the following: Ovid, Elsevier, Research gate, Sage, and PMC. Stories and experiences of refugees were sourced from online newspaper articles on various topics and personal encounters of the author.

Themes

The study examines key themes in delivering health services effectively in the refugee community in studies conducted on the highest health priority issues in the six major groups. The themes identified provide tools for service providers to more efficiently and effectively serve the refugee community. The themes were extracted from studies on the highest priority health issues in the largest number of refugee populations resettled in the US as provided by the CDC. The review was conducted on available studies on the specific topics of interest. Not much information has been published on these major groups especially on the highest priority health issues as per the CDC. Therefore, not all priority health issues in the largest number of refugees resettled in the US were covered in this paper. The following search terms were used separately or in combination: “refugee health”, “refugee health + United States”, “refugee health + infectious diseases”, refugee health + chronic diseases+ United States, “refugee health + mental health + united states” and “refugee post resettlement health issues.” The purpose of the themes is to gather recommendations of effective and efficient ways of serving the refugee population in the United States post-resettlement.

Chapter 4 – RESULTS

Study Selection

A total of 1,515 studies were selected using the following key phrases: “refugee health,” “refugee resettlement,” and “immigrant health”. After closer analysis, documents were narrowed down in relation to refugee health which left 225 studies eligible for study. This criterion was further narrowed down to refugee health as pertaining to the major groups resettled in the United States, which resulted in a total of 51 studies to be focused on in this paper. The main thrust of this research paper is to extract from these articles the most efficient and effective way to serve refugee populations and to organize these approaches into themes. All the themes of the selected studies were further analyzed to focus on effective and efficient ways of providing healthcare services to resettled refugee communities in the US.

Themes

This study examines themes extracted from research conducted on the highest health priority issues in the six major refugee groups. These refugees primarily originate from Myanmar, Dem. Rep. of Congo, Syria, Iraq, Somalia, and Bhutan. Identified themes provide tools for service providers to more efficiently and effectively serve the refugee community. The following are some of the themes from “findings” compiled from the studies.

Theme 1— Culturally and Linguistically Appropriate Services (CLAS)

According to the Office of Minority Health (OMH), CLAS are health care services that are respectful of and responsive to cultural and linguistic needs *(National Standards for Culturally and Linguistically Appropriate Services in Health Care, 2001).*

Special attention to culture and language and the influence of how healthcare services are received and delivered is necessary when providing healthcare to refugees. Studies have found that culturally appropriate education and linguistically appropriate education and counseling are most effective in addressing health issues in the refugee community (Fabio, 2014). In addition, studies have recommended using culturally appropriate validated tools for identifying mental health issues to aid in facilitating physicians/health care deliverers to better serve this community. Other studies reveal the effectiveness of interpreters and conducting health programs in community-based settings (Gondek et al., n.d). More studies reveal that understanding belief systems about affected communities impacts the test results, completion of immunizations, prevention strategies and long term follow-up (Jackson, Rhodes, Inui & Buchwald, 1997).

It has further been identified that training models that promote evidence-based psychological services offered with a culturally sensitive context are highly recommended when serving the refugee community (Fondacaro & Weinberg, 2002).

Other studies revealed that some ethnicities were gender specific when seeking healthcare. In one such example, Somali women prefer a female interpreter and provider for conducting the physical examination, particularly of the pelvic, breast, and abdominal examinations (Odunukan et al., 2014). Other studies revealed that health educators that are representative of the refugee communities and who speak the same language were the preferred method of information transfer (Haworth, Margalit, Ross, Nepal & Soliman, 2014).

Another study revealed that nutritional counselling and education provided in a culturally appropriate format should be provided to improve long-term health (Fabio, M., n.d.). Research on mental health service provision identified a shortage of bilingual mental health

professionals as one of the reasons for inconsistent and poorly integrated mental health services with other clinical services (Pollard et. al., 2014).

Little is written in the literature regarding Autism Spectrum Disorder (ASD) among the refugee population. Moreover, screening tools that are culturally adapted and translated to the appropriate languages are yet to be developed (McClure, Reines, & Suchdev, 2017). There exist screening tools that have been translated like the M-CHAT-R/F which has been translated into Bhutanese but is yet to be culturally adapted and translated to other languages (McClure, Reines, Suchdev, Oladele & Goodman, 2017).

Belief systems play a significant role when attempting to address health issues in the refugee community. Researchers have noted the importance of understanding belief systems while addressing health disparities (Saadi & Percac-Lima, 2012).

In addressing mental health issues, belief systems can influence seeking help when the topic is taboo. The lack of culturally appropriate questionnaires can add to the complexity of this issue as well. Many times, refugees are misdiagnosed with other ailments while in fact the real issue is one of mental health (Brink, Shannon, & Vinson, n.d.). Individual, family, and community perception regarding certain health conditions have a major impact in effectively addressing the issues. It is recommended that service providers understand the refugee's belief systems prior to setting up referral services (Piwowarczyk, Bishop, Yusuf, & Raj, n.d.).

National standards for CLAS as recommended by OMH can be found here https://www.thinkculturalhealth.hhs.gov/clas/standards. CLAS is therefore an integral part of providing health care services as it leads to improved access to care, improved quality of care, and improved health outcomes.

Theme 2 — Contextually Tailored Programs

Contextually tailored programs that consider each group as a separate entity are proven to be more effective in serving the refugee community. Additionally, studies have emphasized the importance of studying the different groups at the different times in their resettlement process.

Newly arrived refugees have different healthcare needs from those that have been resettled for years. Thus, prevention health strategies should differ from group to group. For example, for recently arrived refugees, some researchers have recommended the importance of addressing healthy eating habits and food preparation, tobacco cessation, and physical activity in community health education programs in order to address preventive measures for chronic diseases. This is an example of a program that is tailor-made to focus on a recently resettled group with the objective of addressing chronic disease awareness and education before the problem becomes unmanageable (Yun et al., 2012).

Forty percent of refugees have resettled to states without Medicaid expansion. A contextually appropriate solution to this would be for federal agencies to take into consideration ACA coverage when resettling refugees to ensure health coverage for this population (Agrawal & Venkatesh, n.d.). In addressing refugee health, consideration should also be taken about countries of origin. For example, some refugees migrating to the US come from countries where the rate of cervical cancer is high, and many of them have never received screening. In this context, US national organizations recommend screening for these populations upon arrival. Chronic illnesses are at an exponential growth rate in developing nations. However, initial refugee clinical visits do not address these issues. Researchers recommend that interventions

upon arrival during the resettlement process to prevent development of obesity and other related diseases.

Some findings suggest following a group over a period of time to determine how the acculturation process impacts their health. One such study encourages collecting data on changes in dietary habits and lifestyle and how it relates to long-term health of refugees. This information would be helpful in designing prevention strategies and programs. Moreover, this data could be used to design policies that provide healthier environments for refugees (Catherine, Zhou, Arnetz, & Jamil, 2015). The psychological impact of relocation may be particularly difficult for refugee youth. Some studies revealed the need for involving school nurses to serve in a supportive role in the transitioning process, improving their overall health and linking the youth to primary health care.

Theme 3 – Collaborative Approach

Several studies have identified the need for partnerships and collaboration in providing health care for refugees. This is especially important since refugees tend to be plagued with multiple chronic conditions due to underdeveloped or eroded health care systems in their countries of origin. Therefore, partnerships between refugee service organizations and clinical service providers, as well as implementation of community health worker models would improve health care efficiency especially for refugees with multiple chronic conditions (Yun, et al., 2012). A collaboration of clinical and public health interventions to prevent and mitigate chronic illnesses in the early resettlement process is recommended for refugees (Bhatta, Shakya, & Assad, 2015).

It is also important to note the necessity of a collaborative approach involving community leaders (parents, elders, religious leaders) and educational (schools), media, and healthcare settings (Kingori et al., 2016).

Refugees come from communities where there exists informal, cultural leadership. Engaging these community leaders impacts the success of providing healthcare to this population.

Some studies have found that interdisciplinary models of care are necessary for mental health in refugee communities. An integrated approach including sustainable multi-disciplinary health care providers as well as intensive care coordination and case management; trusted, gender-matched, patient health navigators and interpreters; as well as capacity building and empowerment are necessary. One such model that utilizes a collaborative approach is the Community-Based Collaborative-Action Research (CBCAR). This model entails a partnership between refugee women and researchers. An exchange of differing world views between the two factions provides insight that improves the health of the target community (Baird et al. n.d.).

Engaging policy makers who can be influential in the reviewing of state-level health reform policies is advisable in collaborative efforts. An example of this would be looking at health coverage of immigrants and refugees through an individual mandate, an employer mandate, an expansion of publicly funded insurance, or a combination of these (Derose, Escarce, & Lurie, 2007). Refugees who are resettled in states in which ACA has not been adopted have a difficult time accessing health care. Most refugees work for employers that do not provide medical insurance and many due to trauma have pre-existing conditions. Resettlement that is purposeful and strategic to ensure that the refugees are resettled in ACA friendly cities is strongly advised.

Table of Findings (Table 2)

Findings from the literature review of 51 articles are presented in the next table and are consistent with the three emerging themes discussed above.

Table 2.

		CULTURAL SENSITIVITY	
#	**ARTICLE**	**SOURCE**	**FINDINGS**
1	Understanding Bhutanese refugee suicide through the interpersonal-psychological theory of suicidal behavior.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4732867/ Ellis, B. H., Lankau, E. W., Ao, T., Benson, M. A., Miller, A. B., Shetty, S., … Cochran, J. (2015). Understanding Bhutanese Refugee Suicide Through the Interpersonal-Psychological Theory of Suicidal Behavior. *The American Journal of Orthopsychiatry*, *85*(1), 43–55. http://doi.org/10.1037/ort0000028	Attention to accessible and culturally sensitive health and mental health services for refugees is critical and primary care physicians may play an important role in identifying Bhutanese refugees at psychological risk. (Ellis et al pg. 11) Further understanding of what limits the availability or accessibility of health and mental health services for this community is needed (pg. 12). Bhutanese refugees had limited options for seeking help in refugee camps, but at least had access to community or sector heads, whereas in the United States many of these refugees may be unfamiliar with or unable to access services that can provide counseling or health support (T. Mishra, personal communication, December 18, 2013)..pg. 12
2	Connecting Cultures: A training model promoting evidence-based psychological services for refugees.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4266585/ Fondacaro, K. M., & Harder, V. S. (2014). Connecting Cultures: A training model promoting evidence-based psychological services for refugees. *Training and Education in Professional Psychology*, *8*(4), 320–327. http://doi.org/10.1037/tep0000071	A social justice framework (Fondacaro & Weinberg, 2002) emphasizes a social ecological epistemology and provides a culturally sensitive context in which graduate students can learn to engage with refugee communities at multiple levels and simultaneously utilize their clinical and scientific training. This framework emphasizes community voice, while acknowledging multi-agency professional expertise, and evidence-based prevention, intervention and evaluation strategies (pg. 2).
3	Provider and interpreter preferences among Somali women in a primary care setting.	http://journals.sagepub.com/doi/full/10.1177/2150131914552846 Olufunso W. Odunukan[1], Raolat M. Abdulai[2], Misbil F. Hagi Salaad[3], Brian D. Lahr[3], Priscilla M. Flynn[4], Mark L. Wieland[31]Mayo Clinic, Jacksonville, FL, USA[2]Brigham & Women's Hospital, Boston, MA, USA[3]Mayo Clinic, Rochester, MN, USA[4]University of Minnesota, Minneapolis, MN, USA	We found that Somali women generally preferred a female provider for conducting the physical examination, particularly for the pelvic, breast, and abdominal examinations. Likewise, Somali women strongly preferred female interpreters to be present during the physical examination. There was no stated preference for patient-provider racial concordance (pg. 109)
4	Knowledge, attitudes, and practices for cervical cancer screening among the Bhutanese refugee community in Omaha, Nebraska.	https://web-b-ebscohost-com.proxy.library.emory.edu/ehost/pdfviewer/pdfviewer?sid=25bc4211-b9e7-4557-baa9-58b4a6fb591c%40sessionmgr104&vid=1&hid=124 Haworth, R. J., Margalit, R., Ross, C., Nepal, T., & Soliman, A. S. (2014). Knowledge, Attitudes, and Practices for Cervical Cancer Screening Among the Bhutanese Refugee Community in Omaha, Nebraska. *Journal of Community Health*, *39*(5), 872–878. http://doi.org/10.1007/s10900-014-9906-y	Consistent with survey responses, the women all felt having someone who speaks their native language, from their community, and trained in health education topics was the preferable method of information transfer (pg. 7)
#	**ARTICLE**	**SOURCE**	**FINDINGS**
5	Nutrition for refugee children: risks, screening, and treatment.	https://www.ncbi.nlm.nih.gov/pubmed/25042431 Nutrition for Refugee Children: Risks, Screening, and Treatment *Current Problems in Pediatric and Adolescent Health Care*, Volume 44, Issue 7, Pages 188-195 Mary Fabio	Resettled refugee children continue to be at risk for both over- and undernutrition, therefore culturally appropriate education and counseling should be provided to improve long-term health. (pg.1)

6	Integrating primary care and behavioral health with four special populations: Children with special needs, people with serious mental illness, refugees, and deaf people.	https://www.ncbi.nlm.nih.gov/pubmed/24820687 Integrating primary care and behavioral health with four special populations: Children with special needs, people with serious mental illness, refugees, and deaf people. Robert Q. Pollard, Jr, William R. Betts, Jennifer K. Carroll, Jeanette A. Waxmonsky, Steven Barnett, Frank V. deGruy, 3rd, Laura L. Pickler, Yvonne Kellar-Guenther Am Psychol. 2014 May-Jun; 69(4): 377–387. doi: 10.1037/a0036220	Populations with special health and mental health care needs will benefit from closer integration between primary care and behavioral health service providers, as advocated in this special issue of the American Psychologist (pg. 386)
7	Adapting an Autism Screening Tool for Use in the DeKalb County Refugee Pediatric Clinic	https://www.ncbi.nlm.nih.gov/pubmed/?term=adopting+an+autism+screening+tool+for+use+in+deklab+county McClure, C., Reines, S., Suchdev, P.S. et al. J Immigrant Minority Health (2017). doi:10.1007/s10903-017-0553-0	Minimal literature exists regarding Autism Spectrum Disorder (ASD) among refugee children in the United States. Reliable ASD screening tools, such as the M-CHAT-R/F, have yet to be culturally adapted and translated into some languages spoken in the homes of these children (pg. 1)
8	High prevalence rates of diabetes and hypertension among refugee psychiatric patients.	https://www.ncbi.nlm.nih.gov/pubmed/18277218 Kinzie, J., Riley, C., McFarland, B., Hayes, M., Boehnlein, J., Leung, P., & Adams, G. (n.d.). High prevalence rates of diabetes and hypertension among refugee psychiatric patients. *The Journal of Nervous and Mental Disease., 196*(2), 108-112.	Clearly there is a need for combined psychiatric and medical programs where both physical and mental disorders are treated in a combined way with appropriate cultural and linguistic approaches (pg. 112)
9	Engaging Immigrant and Refugee Women in Breast Health Education.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497109/ Gondek, M., Shogan, M., Saad-Harfouche, F., Rodriguez, E., Erwin, D., Griswold, K., & Mahoney, M. (n.d.). Engaging Immigrant and Refugee Women in Breast Health Education. *Journal of Cancer Education., 30*(3), 593-598.	Our findings suggest that a health education program delivered in community-based settings and involving interpreters can enhance breast cancer knowledge (pg. 598)
10	Perspectives on preventive health care and barriers to breast cancer screening among Iraqi women refugees.	https://www.ncbi.nlm.nih.gov/pubmed/21901446 Saadi, A., Bond, B. & Percac-Lima, S. J Immigrant Minority Health (2012) 14: 633. doi:10.1007/s10903-011-9520-3	Our findings emphasize the importance of culturally appropriate education and outreach for engaging Iraqi women in health care, and of further community-level, targeted studies of underserved communities (pg. 638)
11	Perspectives of Somali Bantu refugee women living with circumcision in the United States: a focus group approach.	https://www.ncbi.nlm.nih.gov/pubmed/18550061 Upvall, M., Mohammed, K., & Dodge, P. (n.d.). Perspectives of Somali Bantu refugee women living with circumcision in the United States: A focus group approach. *International Journal of Nursing Studies., 46*(3), 360-368.	Facilitating communication and ultimately, trust of the women comes through appropriate use of interpreters, explaining all procedures even if the women do not question such procedures and appear compliant, and using only female providers if they are available (pg. 366)
#	**ARTICLE**	**SOURCE**	**FINDINGS**
12	Hepatitis B among the Khmer. Issues of translation and concepts of illness.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497109/ PMC4266585Hepatitis B Among the Khmer: Issues of Translation and Concepts of Illness. *Journal of General Internal Medicine, 12*(5), 292–298. http://doi.org/10.1046/j.1525-1497.1997.012005292.x	Optimum interpretation and patient education occurs when time and effort is spent on cultural mediation around critical concepts (pg. 295)

13	Validation of a brief mental health screener for Karen refugees in primary care.	https://academic.oup.com/fampra/article-lookup/doi/10.1093/fampra/cmv093 Darin R Brink, Patricia J Shannon, Gregory A Vinson; Validation of a brief mental health screener for Karen refugees in primary care. *Fam Pract* 2016; 33 (1): 107-111. doi: 10.1093/fampra/cmv093	The lack of brief, culturally appropriate, validated tools for assessing the mental health effects of refugee trauma has been identified by physicians as a barrier to screening the mental health of refugee trauma survivors (pg. 107) The development of validated, culturally appropriate questionnaires is necessary to accurately identify patients who suffer from mental health problems, many of whom have been misdiagnosed with another condition such as irritable bowel syndrome, migraine and vertigo (pg. 110)
14	Validation of a brief mental health screener for Karen refugees in primary care	https://academic.oup.com/fampra/article-lookup/doi/10.1093/fampra/cmv093 Brink, D., Shannon, P., & Vinson, G. (n.d.). Validation of a brief mental health screener for Karen refugees in primary care. *Family Practice., 33*(1), 107-111.	There is a lack of validated, brief screening tools to detect mental health disorders for use in primary care settings with Karen refugees. The development of validated, culturally appropriate questionnaires is necessary to accurately identify patients who suffer from mental health problems, many of whom have been misdiagnosed with another condition such as irritable bowel syndrome, migraine and vertigo (pg. 110)
15	The "Western disease": Autism and Somali parents' embodied health movements.	http://www.sciencedirect.com/science/article/pii/S0277953617300783 Decoteau, C. (n.d.). The "Western disease": Autism and Somali parents' embodied health movements. *Social Science*	There is some statistical evidence indicating that Somali refugees and immigrants have high rates of autism spectrum disorder (ASD). Somalis in North America call autism the “Western disease” because there is no word for autism in the Somali language and because many believe it does not exist in Somalia (pg. 169).
16	Female genital cutting: impact on women's health.	https://www.ncbi.nlm.nih.gov/pubmed/25565511 Nour, N. (n.d.). Female genital cutting: Impact on women's health. *Seminars in Reproductive Medicine, 33*(1), 41-46.	More than 130 million women worldwide have undergone female genital cutting (FGC). FGC is practiced in parts of Africa and Asia, in societies with various cultures and religions. Reasons for the continuing practice of FGC include rite of passage, preserving chastity, ensuring marriageability, and religion, hygiene, improving fertility, and enhancing sexual pleasure for men.
		CONTEXTUALLY TAILORED PROGRAMS	
#	**ARTICLE**	**SOURCE**	**FINDINGS**
1	Pre- and Post-displacement Stressors and Body Weight Development in Iraqi Refugees in Michigan.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4424180/ Catherine Jen, K.-L., Zhou, K., Arnetz, B., & Jamil, H. (2015). Pre- and Post-displacement Stressors and Body Weight Development in Iraqi Refugees in Michigan. *Journal of Immigrant and Minority Health / Center for Minority Public Health, 17*(5), 1468–1475. http://doi.org/10.1007/s10903-014-0127-3	It is therefore suggested that future studies follow refugees’ overtime and more in details assesses the relationship between possible changes in dietary habits and lifestyle as it relates to the acculturation process and long-term health and wellbeing. This would contribute to a better understanding of reasons behind the observed changes in body weight and chronic diseases. These data may shape strategies to prevent obesity and chronic diseases in refugees, such as developing nutritional education programs and providing easy access to exercise facilities, in order to promote healthy lifestyles. These data may also guide policies to establish healthy environments for refugees in general (pg. 9).

2	Factors Associated with Symptoms of Depression Among Bhutanese Refugees in the United States.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4631124/ Vonnahme, L. A., Lankau, E. W., Ao, T., Shetty, S., & Cardozo, B. L. (2015). Factors Associated with Symptoms of Depression among Bhutanese Refugees in the United States. *Journal of Immigrant and Minority Health / Center for Minority Public Health*, *17*(6), 1705–1714. http://doi.org/10.1007/s10903-014-0120-x	A mental health screening after resettlement could also be beneficial in this population, as a significant portion of refugees can have delayed onset of emotional distress [29].Onset of reportedly poor health or physical symptoms could be an indication for administering a mental health screening for refugees months or years after resettlement (pg. 8).
3	Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States.	https://www.ncbi.nlm.nih.gov/pubmed/?term=refugee+resettlement+patterns+and+state-level Agrawal, P., & Venkatesh, A. (n.d.). Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States. *American Journal of Public Health.*, *106*(4), 662-663.	The wide state-level variability in implementation of the ACA should be considered by federal agencies seeking to optimize access to health insurance coverage among refugees who have resettled to the United States (pg. 662)
4	The right to health of non-nationals and displaced persons in the sustainable development goals era: challenges for equity in universal health care.	https://www.ncbi.nlm.nih.gov/pubmed/28219374 The right to health of non-nationals and displaced persons in the sustainable development goals era: Challenges for equity in universal health care. (n.d.). *International Journal for Equity in Health.*, *16*(1), International journal for equity in health. , 2017, Vol.16(1).	Under the Millennium Development Goals (MDGs), United Nations (UN) Member States reported progress on the targets toward their general citizenry. This focus repeatedly excluded marginalized ethnic and linguistic minorities, including people of refugee backgrounds and other vulnerable non-nationals that resided within a States' borders. The inclusion of non-nationals and internally displaced persons in the post-2015 SDG framework must be anchored in the international human right to health (pg. 3)
#	**ARTICLE**	**SOURCE**	**FINDINGS**
5	Provider Perspectives on Promoting Cervical Cancer Screening Among Refugee Women.	https://link-springer-com.proxy.library.emory.edu/article/10.1007/s10900-016-0292-5 Zhang, Y., Ornelas, I., Do, H., Magarati, M., Jackson, J., & Taylor, V. (n.d.). Provider Perspectives on Promoting Cervical Cancer Screening Among Refugee Women. *Journal of Community Health.*, *42*(3), 583-590.	Many refugees in the United States emigrated from countries where the incidence of cervical cancer is high. Refugee women are unlikely to have been screened for cervical cancer prior to resettlement in the U.S. National organizations recommend cervical cancer screening for refugee women soon after resettlement (pg. 583)
6	Bosnian, Iraqi, and Somali Refugee Women Speak: A Comparative Qualitative Study of Refugee Health Beliefs on Preventive Health and Breast Cancer Screening.	https://www.ncbi.nlm.nih.gov/pubmed/?term=bosnia%2C+iraqi%2C+and+somali+refugee+women+speak Saadi, A., Bond, B., & Percac-Lima, S. (n.d.). Bosnian, Iraqi, and Somali Refugee Women Speak: A Comparative Qualitative Study of Refugee Health Beliefs on Preventive Health and Breast Cancer Screening. *Women's Health Issues.*, *25*(5), 501-508.	Understanding population-specific health beliefs, health information, and behavior are crucial for designing tailored prevention programs for refugee women (pg. 501)
7	Perceived barriers to success for resident physicians interested in immigrant and refugee health.	https://www.ncbi.nlm.nih.gov/pubmed/?term=to+success+for+resident+physicians+interested+in+immigrant+and+refugee+health. Alpern, J. D., Davey, C. S., & Song, J. (2016). Perceived barriers to success for resident physicians interested in immigrant and refugee health. *BMC Medical Education*, *16*, 178. http://doi.org/10.1186/s12909-016-0696-z	While the majority of respondents reported having already received training in immigrant and refugee health, most did not feel comfortable with their knowledge of immigrant and refugee health and would like more training. Importantly, most respondents wanted this training to be part of residency training (pg. 5)
8	Caring for Refugee Youth in the School Setting.	https://www.ncbi.nlm.nih.gov/pubmed/?term=Caring+for+Refugee+Youth+in+the+School+Setting Johnson, J., Beard, J., & Evans, D. (n.d.). Caring for Refugee Youth in the School Setting. *NASN School Nurse.*, *32*(2), 122-128.	The psychological impact of relocation and the stress of acculturation may perpetuate many of these existing challenges, particularly for refugee youth, with limited or underdeveloped coping skills. School nurses are uniquely poised to support refugee youth in the transition process, improve

			overall health, and facilitate access to primary health services (pg. 123)
9	Recommendations Diseases in African Refugees After Resettlement to United States.	https://www.ncbi.nlm.nih.gov/pubmed/?term=Development+of+Obesity+and+Related+Diseases+in+African+Refugees+After+Resettlement+to+United+States Rhodes, C., Chang, Y., & Percac-Lima, S. (2016). Development of Obesity and Related Diseases in African Refugees After Resettlement to United States. *Journal of Immigrant and Minority Health., 18*(6), 1386-1391	Despite increases in obesity and related diseases in developing nations, initial refugee clinical visits do not address these issues. Our findings emphasize the need for interventions during resettlement to prevent development of obesity and related disease in this vulnerable population (pg. 1386)
10	Tuberculosis misclassification among resettled refugees in Buffalo, New York, USA.	https://www.ncbi.nlm.nih.gov/pubmed/25574924 Evans, T., Mador, M., Glick, M., & Ahmad, I. (n.d.). Tuberculosis misclassification among resettled refugees in Buffalo, New York, USA. *The International Journal of Tuberculosis and Lung Disease : The Official Journal of the International Union against Tuberculosis and Lung Disease., 19*(2), 231-236.	Discordance in the classification of tuberculosis (TB) disease overseas compared to classification in the United States has been observed among immigrant populations (pg. 231)
#	**ARTICLE**	**SOURCE**	**FINDINGS**
11	Disease surveillance among newly arriving refugees and immigrants--Electronic Disease Notification System, United States, 2009.	https://www.ncbi.nlm.nih.gov/pubmed/24225411 Lee, D., Philen, R., Wang, Z., McSpadden, P., Posey, D., Ortega, L., . . . Painter, J. (2013). Disease surveillance among newly arriving refugees and immigrants--Electronic Disease Notification System, United States, 2009. *Morbidity and Mortality Weekly Report. MMWR., 62*(7), 1-20.	The data in this report can be used to help state and local health departments provide prompt and effective follow-up, evaluation, and treatment to newly arriving immigrants and refugees. Timely follow-up might prevent additional spread of tuberculosis or other communicable diseases of public health significance into their communities. In addition, information from the EDN system allows health departments to use their resources as effectively as possible by providing clinical information that identifies the refugees and immigrants who should be prioritized for evaluation and treatment (pg. 4)
12	Barriers to Healthcare Access Among Refugees with Disabilities and Chronic Health Conditions Resettled in the US Midwest.	https://SOURCE-springer-com.proxy.library.emory.edu/article/10.1007/s10903-013-9906-5 Mirza, M., Luna, R., Mathews, B., Hasnain, R., Hebert, E., Niebauer, A., & Mishra, U. (n.d.). Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. *Journal of Immigrant and Minority Health., 16*(4), 733-742.	Thus understanding healthcare needs and barriers faced by the growing numbers of disabled and chronically ill refugees in the U.S. signifies an important knowledge gap in the field of immigrant health. Filling this gap is an essential first step in eliminating disparities for this high need, high risk group (pg. 734)
13	Service needs and service gaps among refugees with disabilities resettled in the United States.	https://www.ncbi.nlm.nih.gov/pubmed/21981065 Mirza, M., & Heinemann, A. (2012). Service needs and service gaps among refugees with disabilities resettled in the United States. *Disability and Rehabilitation., 34*(7), 542-552.	Disabled refugee participants experienced several unmet disability-related needs and limited access to resettlement resources on account of their disability. These findings were associated with refugee service providers having limited awareness of disability rights and resources and a narrow biomedical perspective of disability. Additionally there was a disconnection between refugee and disability service systems resulting from resource limitations within agencies, mistrust between the different service entities, and a lack of cross-cultural nuance among disability service organizations (pg. 542)

14	Nutritional status of refugee children entering DeKalb County, Georgia.	https://www.ncbi.nlm.nih.gov/pubmed/23828627 Shah, A., Suchdev, P., Mitchell, T., Shetty, S., Warner, C., Oladele, A., & Reines, S. (2014). Nutritional status of refugee children entering DeKalb County, Georgia. *Journal of Immigrant and Minority Health., 16*(5), 959-967.	Clinicians caring for refugee children must be actively involved in referring these families to local WIC (special supplementation program for women, infants, and children) programs, monitor follow-up to ensure receipt of benefits, and coordinate with resettlement agency staff to ensure enrollment in the supplemental nutrition assistance program and Medicaid (pg. 966).
#	**ARTICLE**	**SOURCE**	**FINDINGS**
15	Vitamin D Deficiency Among Newly Resettled Refugees in Massachusetts	https://SOURCE-springer-com.proxy.library.emory.edu/article/10.1007/s10903-012-9603-9 Penrose, K., Hunter Adams, J., Nguyen, T., Cochran, J., & Geltman, P. (2012). Vitamin D deficiency among newly resettled refugees in Massachusetts. *Journal of Immigrant and Minority Health., 14*(6), 941-948.	Given the high prevalence of vitamin D deficiency and insufficiency documented in this study, empiric supplementation or treatment for newly-arrived refugees is likely to be preferable to targeted treatment based on screening results, both in terms of cost-effectiveness and health outcomes (pg. 946).
16	Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States	http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.303017?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed Agrawal, P., & Venkatesh, A. (n.d.). Refugee Resettlement Patterns and State-Level Health Care Insurance Access in the United States. *American Journal of Public Health., 106*(4), 662-663.	The wide state-level variability in implementation of the ACA should be considered by federal agencies seeking to optimize access to health insurance coverage among refugees who have resettled to the United States (pg. 662)
17	Immigrants and health care: sources of vulnerability.	https://www.ncbi.nlm.nih.gov/pubmed/17848435 Derose, K., Escarce, J., & Lurie, N. (n.d.). Immigrants and health care: Sources of vulnerability. *Health Affairs., 26*(5), 1258-1268.	State-level health reform policies—whether through an individual mandate, an employer mandate, expansion of publicly funded insurance, or a combination of these—provide a type of laboratory for understanding how different policies affect immigrants' health care experiences and, subsequently, their health status (pg. 1266)
18	High Prevalence of Chronic Non-Communicable Conditions Among Adult Refugees: Implications for Practice and	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3857959/ Yun, K., Hebrank, K., Graber, L. K., Sullivan, M.-C., Chen, I., & Gupta, J. (2012). High Prevalence of Chronic Non-Communicable Conditions Among Adult Refugees: Implications for Practice and Policy. *Journal of Community Health*, *37*(5), 10.1007/s10900–012–9552–1. http://doi.org/10.1007/s10900-012-9552-1	The global rise in non-communicable disease (NCD) suggests that US-based refugees are increasingly affected by chronic conditions. However, health services have focused on the detection of infectious disease, with relatively limited data on chronic NCDs gees would help prepare both clinicians and community-based organizations to better address the full range of health concerns impacting this population (pg. 1)

		COLLABORATIVE APPROACH	
#	**ARTICLE**	**SOURCE**	**FINDINGS**
1	Mental health screening among newly arrived refugees seeking routine obstetric and gynecologic care.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4228798/ Johnson-Agbakwu, C. E., Allen, J., Nizigiyimana, J. F., Ramirez, G., & Hollifield, M. (2014). Mental Health Screening Among Newly-Arrived Refugees Seeking Routine Obstetric and Gynecologic Care. *Psychological Services*, *11*(4), 470–476. http://doi.org/10.1037/a0036400	It is important to increase the awareness of potential mental disorders in the refugee community and connect identified individuals with available resources. Screening for mental disorders among refugee women will promote greater awareness and identify those individuals who would benefit from further mental health evaluation and treatment (pg.3) There is a need for community-partnered, culturally-tailored interventions to provide health promotion education, dispel myths and reduce the stigma of mental health, while accentuating asset-based, strength models of resiliency and community social support. Positive attributes such as strong family relations, community-centered values, sharing within the cultural unit, and resiliency have been shown to contribute towards coping and problem-solving during very difficult circumstances (O'Mahony, & Donnelly, 2010). –pg. 8 Moreover, sustainable interdisciplinary models of care are necessary which support an integrated approach that incorporates not only multi-disciplinary health care providers, but intensive care coordination and case management, trusted, gender-matched, patient health navigators and interpreters, as well as community capacity-building and empowerment(pg. 8)
2	Healthcare Access for Iraqi Refugee Children in Texas: Persistent Barriers, Potential Solutions, and Policy Implications.	https://www.ncbi.nlm.nih.gov/pubmed/25236769 Vermette, D., Shetgiri, R., Al Zuheiri, H., & Flores, G. (2015). Healthcare Access for Iraqi Refugee Children in Texas: Persistent Barriers, Potential Solutions, and Policy Implications. *Journal of Immigrant and Minority Health.*, *17*(5), 1526-1536.	Potential interventions to improve access include community-oriented efforts to educate parents on Medicaid renewal, obtaining services, and accessing specialists. Given the enduring nature of language and Medicaid renewal barriers, policies addressing eligibility alone are insufficient (pg. 1526)
3	"We find a way": challenges and facilitators for health care access among immigrants and refugees with intellectual and developmental disabilities.	https://www.ncbi.nlm.nih.gov/pubmed/25215921 Bogenschutz, M. (2014). "We find a way": Challenges and facilitators for health care access among immigrants and refugees with intellectual and developmental disabilities. *Medical Care.*, *52*(10 Suppl 3), S64-S70.	Factors challenging access included difficulty finding accurate information on insurance and service providers, troubles with coordinating multiple specialist services, and a lack of cultural competence in all levels of health service provision (s64).
#	**ARTICLE**	**SOURCE**	**FINDINGS**
4	We left one war and came to another: resource loss, acculturative stress, and caregiver-child relationships in Somali refugee families.	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4315611/ Betancourt, T. S., Abdi, S., Ito, B., Lilienthal, G. M., Agalab, N., & Ellis, H. (2015). We Left One War and Came to Another: Resource Loss, Acculturative Stress, and Caregiver-Child Relationships in Somali Refugee Families. *Cultural Diversity & Ethnic Minority Psychology*, *21*(1), 114–125. http://doi.org/10.1037/a0037538	Many of these locally occurring protective resources have the potential to be leveraged by family and community-based interventions. These findings are being used to design preventative interventions that build on local strengths among Somali refugees in the Boston area (pg 1).

5	Chronic Disease Burden Among Bhutanese Refugee Women Aged 18-65 Years Resettled in Northeast Ohio, United States, 2008-2011.	http://search.proquest.com.proxy.library.emory.edu/docview/1695351744?accountid=10747 Bhatta, M.P., Shakya, S., Assad, L. et al. J Immigrant Minority Health (2015) 17: 1169. doi:10.1007/s10903-014-0040-9	As the Bhutanese refugees acculturate to the US life-style, chronic diseases are likely to have increasing impact on their health. We have the opportunity to intervene early in the resettlement and acculturation process using clinical and public health interventions to prevent and mitigate the impact of chronic disease in this new South Asian immigrant group to the US
6	Respiratory Health in Migrant Populations: A Crisis Overlooked	http://www.atsjournals.org/doi/full/10.1513/AnnalsATS.201608-592PS Holguin, F., Moughrabieh, M., Ojeda, V., Patel, S., Peyrani, P., Pinedo, M., . . . Roman, J. (n.d.). Respiratory Health in Migrant Populations: A Crisis Overlooked. *Annals of the American Thoracic Society., 14*(2), 153-159.	The need for adequate investment of resources to better define these challenges through research and for the development of efficient strategies for intervention.
7	Rapid Weight Gain in Pediatric Refugees after US Immigration.	https://www.ncbi.nlm.nih.gov/pubmed/27393334 Olson, B.G., Kurland, Y., Rosenbaum, P.F. et al. J Immigrant Minority Health (2017) 19: 263. doi:10.1007/s10903-016-0461-8	Pediatric refugees are at increased risk of rapid weight gain after US immigration.
8	Creating a Bridge of Understanding between Two Worlds: Community-Based Collaborative-Action Research with Sudanese Refugee Women.	https://www.ncbi.nlm.nih.gov/pubmed/25572485 Baird, M., Domian, E., Mulcahy, E., Mabior, R., Jemutai-Tanui, G., & Filippi, M. (n.d.). Creating a Bridge of Understanding between Two Worlds: Community-Based Collaborative-Action Research with Sudanese Refugee Women. *Public Health Nursing., 32*(5), 388-396	CBCAR is a distinct type of community participatory research that engages communities as collaborators to address community concerns. Community-based research has been shown to be a relevant approach to address health disparities associated with marginalized and hard-to-reach populations such as resettled African refugee women. The challenges refugee women face in resettlement are related to a complex web of social determinants that require full engagement of the community. Interventions based in the community, that engage members as collaborators in development and implementation, have been found to be particularly effective with immigrant and refugee populations (Balcazar, Garcia-Iriarte, & Suarez-Balcazar, **2009**; Choudhry et al., **2002**).
#	**ARTICLE**	**SOURCE**	**FINDINGS**
9	Congolese and Somali beliefs about mental health services.	https://www.ncbi.nlm.nih.gov/pubmed/24566506 Piwowarczyk, L., Bishop, H., Yusuf, A., Mudymba, F., & Raj, A. (n.d.). Congolese and Somali beliefs about mental health services. *The Journal of Nervous and Mental Disease., 202*(3), 209-216.	The findings of this study speak to the importance of community-based programming in an effort to reach refugee populations that are reluctant to use mainstream mental health services. Varying definitions of mental illness as well as cultural and logistical barriers to care seeking are potential factors that may influence treatment utilization. Further education must take place within communities regarding concepts of trauma and depression because individuals may not articulate their feelings or draw the connection between past traumatic events and current symptom presentation. Local communities of faith may be important gateways to access individuals who are suffering but have not sought western medical treatment. Providers should be educated on the prevailing health beliefs within African refugee populations and the primacy that these populations place on faith and prayer (pg. 215).

10	Well-being in refugee women experiencing cultural transition.	https://www.ncbi.nlm.nih.gov/pubmed/22869211 Baird, M. (n.d.). Well-being in refugee women experiencing cultural transition. *Advances in Nursing Science., 35*(3), 249-263.	Social support has been found to play an important role in the health and well-being of refugees from a variety of cultures, age groups, and across different host countries (pg. 251).
11	Infectious Disease Screening for Refugees Resettled in the United States.	https://academic.oup.com/cid/article/39/6/833/358587/Infectious-Disease-Screening-for-Refugees Barnett, E. (n.d.). Infectious disease screening for refugees resettled in the United States. *Clinical Infectious Diseases., 39*(6), 833-841.	Refugees bear a disproportionate burden of infectious diseases because of the circumstances under which they immigrate to the United States (pg. 840).
12	PTSD in Refugees	http://www.ptsd.va.gov/professional/trauma/other/ptsd-refugees.asp PTSD in Refugees, Elisa E. Bolton, PhD, 2016	Taken together, these results suggest that in addition to an emphasis on treating the most severely affected individuals, communities hosting refugees can enhance refugees' well-being by addressing psychosocial variables.

ANALYSIS

The above themes reveal that in order to be successful in serving refugees, there is a need for a multi-layered and multi-faceted approach. Refugees are a unique population with unique health challenges that require a unique approach to address them. Language and culture are the most obvious barriers and cannot be ignored. It is imperative that there is clear understanding between providers of services and those that are receiving the services. Communication is key to facilitate language lines, interpreters, culturally sensitive questionnaires, and culturally sensitive screening are necessary to better respond to the needs of this community. Furthermore, contextually tailored programs that are specific to the unique needs of this population are important. Different cultures have different belief systems pertaining to health. Myths and taboos are rampant in some of these cultures and therefore need to be understood and addressed to provide much needed health care. Background information is also key in serving this population. Refugees coming from different countries of origin have different medical issues. Some refugees are coming from countries where intestinal parasites

are endemic, others are coming from countries where malnutrition is prevalent. Medical providers need to be aware of these contextual needs when serving these unique communities.

Lastly, a community approach is most effective in serving refugee populations. Refugees come from communities where informal leadership exists. Identifying key community leaders including religious leaders, elders, and parents is beneficial in mobilizing and organizing communities to provide them with healthcare or health education. A community health worker model with workers that are representative of the communities is highly recommended for outreach programs. CHW's that are bicultural, and bilingual provide culturally sensitive navigation tools to their communities and are more openly received. Service providers working in refugee communities must also work in consortium with other providers like clinics, institutions of learning, health departments, refugee community based organizations, and state officials. This is imperative to best respond to the needs of the refugee population as well as to inform policy on unmet needs that exist in serving the health needs in the refugee community and the most effective and efficient way to address them.

Chapter 5 – Discussion

Introduction

The purpose of this study was to gather key findings from various researchers on how to effectively and efficiently meet health care needs in the refugee community. Increasing evidence-based research suggests that public health interventions based on social and behavioral science theories are more effective than those without a theoretical framework (Institute of Medicine, 2000; Institute of Medicine, 2001; Glanz et al, 2010). Refugees represent a distinct subgroup of the larger population and research has concluded that multi-faceted interventions are necessary in addressing refugee health issues effectively and efficiently. The social ecologic model (SEM) presents a systematic approach in understanding what works in providing much needed healthcare in the refugee community. Numerous studies have confirmed that behavior is influenced by an individual's social and physical environment (Davison and Lawson, 2006; Franzini, et al., 2009).

Table 3. Below is a breakdown of the 5 levels of the SEM and what each level represents.

LEVEL	DESCRIPTION
INDIVIDUAL	Knowledge about health issue or risk.
INTERPERSONAL (family, friends, peers)	Knowledge about health issue or risk by family, friends and peers.
ORGANIZATIONAL (Churches, stores, community orgs.,)	Churches, community organizations, leaders knowledge and involvement in addressing health issue or risk in refugee community.
COMMUNITY	Community norms regarding health issue.
PUBLIC POLICY (Local, state, federal)	Regulations and polices surrounding health issue or risk.

Key Study Findings

The key themes that emerged from the literature review are best presented through the various layers of the social ecological theoretical framework. The five levels of the social ecological framework provide a unique lens to understand the interplay between individuals, their community, organizations, and policy makers in providing healthcare to the refugee community.

Individual level

The first level of analysis in the socio-ecological model is the individual level, which constitutes the characteristics of the individual, namely: knowledge, skills, life experience, attitudes, and behaviors and how they interplay with the environment and society. This means that individual perceptions of health and health risks must be taken into consideration when providing healthcare to refugees. Most refugees face numerous personal barriers in trying to gain access to healthcare, most notably linguistic, cultural and perceptions towards health. It has been identified that language and communication influence access to healthcare from scheduling doctors' appointments all the way to prescription pick up. These barriers must be addressed when serving this population. Health workshops that address these problems can be very effective in dispelling and addressing myths and taboos around certain health issues or concerns. Special note should be taken to ensure that translators or interpreters must be provided as per title VI of the Civil Rights Acts so that service providers can better meet the needs of this unique population.

Marie Chantal resettled in Clarkston, Georgia from Tanzania. She has mastered enough English to get by. However, two years post resettlement she still struggles with navigating the medical system. She stopped by Amani Women Center to see if she could get help with

scheduling an appointment with her doctor. She expressed frustration with the automated system that provides no option for language. When she finally got to speak to someone at the clinic she could not communicate her reason for wanting to see the doctor in her broken English. The clinic does not provide interpreters over the phone.

Interpersonal level

The interpersonal level constitutes the second level of the socio-ecological model and it encompasses the immediate physical environment and social networks in which individual lives, including family, friends, peers, and coworkers. At this level, perceptions of the health risk or disease by family, friends and peers may influence the way the individual responds to receiving healthcare. In some refugee communities certain myths and taboos exist around some health issues and can prove to be a barrier when trying to provide healthcare. For example, there are several cultural perceptions associated with the continuation of the practice of female genital mutation. FGM is perceived as a rite of passage, preserving chastity, ensuring marriageability, religion, hygiene, improving fertility, and enhancing sexual pleasure for men (Nour, 2015). It is important to recognize, and respect that cultural and family beliefs play an integral role in delivering health care. This requires spending more time with patients and their families to get a better understanding of their perceptions of the health issue of concern.

Fatima is a refugee from Somalia who resettled in Clarkston, Georgia in the early 1990s. She recalls her first encounter with an obstetrician. She arrived at her appointment and much to her dismay it was a male doctor. She had never been to a male doctor in her whole life while seeking female healthcare. She recounts her horrifying and embarrassing experience when the doctor queried her on her "deformed" private parts. Something that was so normal

to her was clearly of grave concern to her doctor. This initial experience has made her shy away from visiting any kind of doctor ever since.

Refugees will shy away from tapping into services that disregard their cultural needs and increasingly many wait till they are very sick to seek medical care.

Community Level

The community level seeks to understand the intersection of culture, context, and community. An example of addressing health concerns at a community level would be a collaborative approach. A study on HIV prevention among Somali immigrant/refugee young adults in the US recommends a collaborative approach involving community leaders (parents, elders, religious leaders) and educational (schools), media, and healthcare settings (*Kingori et al*., 2010). It is imperative that we recognize the very important role community and cultural beliefs play in influencing an individual's effort to seek healthcare. Decisions to seek treatment are typically driven by ethnically based health belief systems that are deeply engrained. Identifying intra-ethnic social networks and ethnic leaders can be very beneficial in not only gaining a better understanding of the target community but also in gaining influence in the community. Most refugees come from communities where community leaders make decisions for the entire community. Therefore, support from these leaders goes a long way in mobilizing and educating a community on health issues of concern. Leadership in most of these communities does not present itself in what may be the equivalent of leadership in Western cultures. In some communities the leader could be the eldest woman in the community, who is trusted and respected due to her age and therefore considered to be the wisest person. She most likely has never had any formal education but a wellspring of experience in different matters.

Mama Amina resides in Clarkston, Georgia and has played a huge role in advocating for her community. She's usually called upon to facilitate health education workshops because of her knowledge of the cultural nuances that exist in her community. Mama Amina speaks 4 languages: Arabic, Swahili, Somali, and English. She came to the United States when she was 70 and at 89 is still unstoppable in her role as a community leader.

Organizational Level

This level provides an understanding and appreciation of how organizational systems and organizational policies affect delivery of effective and efficient healthcare to refugee communities. Included in this level are health care systems, schools, employers or worksites, city government, local health departments, VOLAGS, and ethnically based community organizations (EBCO's). A collaborative approach with the afore mentioned entities is advisable when addressing health issues in refugee communities. Communities where refugees have resettled can play a proactive role in ensuring the health and safety of this population. For example, many refugees come from a background of a walking-culture. Clarkston, Georgia a city where thousands of refugees have resettled has invested in providing safe walk-ways aptly named the *Clarkston Streetscape Project and Pedestrian Enhancement Project* (City of Clarkston Connection, 2016).

Schools can also play and important role in addressing health needs in refugee communities because they are a trusted institution that has access to children and parents. School clinics can partner with local health departments to engage these families on health issues that concern them and to provide tailored health programs for the priority community. Local health department and VOLAGS can be instrumental in identifying priority health issues that are unique to this population and engage communities and organizations in problem

solving. Georgia Team Empowerment (GATE) coalition is one example of a concerted effort that is currently addressing a very unique substance abuse health concern affecting the Bhutanese and Burmese communities in Clarkston, Georgia. Betel quid is a combination of betel leaf, areca nut, and slaked lime. In many countries, tobacco is also added, and the product is known as *gutka*, *ghutka*, or *gutkha*. This is a good example of different organizations, health departments and community leaders coming together to resolve a pressing issue in a culturally sensitive manner.

Little research exists regarding the significant role that ethnically-based community organizations (EBCOs) play in refugee communities post-resettlement. Most refugee communities form ethnically-based community organizations after resettlement. Though many of these organizations are grassroots organizations, they play a very important role in that they are the resource for refugees way after they lose their connections with the larger resettlement agencies. The role of these groups has not been appreciated when trying to reach the communities. These organizations, if provided with the technical and financial support and working in tandem with larger agencies, can be an important vehicle in not only reaching the communities, but ensuring sustainability of health programs and health care efforts in these communities. A PSA translated in the language that the communities speak can be found on YouTube. [1]

[1] https://www.youtube.com/watch?v=i0N3u941yQ0.

Policy Level

At this level we look at how policy makers can influence the delivery of effective and efficient healthcare by implementing policies that target population subgroups. Policies and the political climate of the country of resettlement play an integral role in the refugee resettlement process. One example of a policy that has far reaching repercussions in the refugee resettlement process is the executive order protecting the nation from foreign terrorist entry into the United States. Due to the uncertainty around the travel ban and what the final ruling of the Supreme Court will be, refugee families have found themselves confused and fearful. Families that have resettled in the United States are anxiously waiting for family members who were supposed to join them. Resettlement agencies can provide no information regarding when or if these families/loved ones will be reunited.

Hamisa is a lady who resettled in Clarkston, Georgia from a refugee camp in Uganda. She was a frequent attendee of the Amani women's sewing group and suddenly stopped showing up. Upon inquiring from some of her friends on her absence, it was revealed that she was suffering from depression and anxiety of not knowing when her husband would be joining her from Uganda. Her anxiety compounded with the challenges of resettlement as well as finding herself to be the sole bread winner of her family that includes her elderly mother-in-law is overwhelming. She has expressed a lack of motivation to work and feeling suicidal.

Policies, on the other hand, can play a very positive role in shaping the refugee resettlement experience. An example of this would be to address policies that target health coverage to ensure that refugee communities receive much needed healthcare. Collaborations provide opportunities for communities and community leaders to gain access to policy makers and public health experts that typically would not cross paths. Engaging communities to ensure

endorsement from leaders and community members as well as gathering from the community the perceived needs that are unique to the community is imperative. Lastly, mobilizing and organizing key stakeholders in engaging policy makers to effect change in the community is critical. For example, stakeholders in the community in Clarkston, Georgia recognized the need to engage the city government to implement laws that would aid in curbing tobacco usage that was rampant in the community. Recognizing cultural perceptions around this health issue and addressing the issues through education, advocacy, and awareness was pivotal in achieving this objective. Hookah culture which transcends many of the ethnicities represented in Clarkston was an issue in passing a tobacco ordinance. Hookah is a water pipe with a smoke chamber, a bowl, a pipe and a hose. Specially made tobacco is heated, and the smoke passes through water and is then drawn through a rubber hose to a mouthpiece (Mayo Clinic, 2015). There was a lot of resistance regarding this issue from some of the community members who expressed that smoking Hookah is a cultural past-time and moreover a source of livelihood for those that sell it. A series of town halls meetings were conducted to come to a resolution.

"The City of Clarkston recently adopted a comprehensive smoke-free ordinance, effective Sept. 4, 2016, to reduce second hand smoke exposure, improve health outcomes and promote a healthier DeKalb County. The smoke-free ordinance prohibits the use of smoking, hookahs and e-cigarettes in all public places and all public and private workplaces, (DPH, 2016)."

A resolution was reached whereby the city did not implement an immediate ban but was willing to cooperate with the community and give them time to remodel their businesses as smoke-free establishments.

Limitations

Very few studies have been done on this unique population from a socio-cultural perspective therefore the research involved several articles before finally narrowing down to the selected articles. Moreover, few experts exist in this field of study to provide the much-needed insight and guidance on this subject matter. Though the limitations do not impact the outcome and findings of this research, they bring attention to the fact that there is a gap in research studies that provide a socio-cultural angle.

Implications

Research broadly documents the serious health and financial ramifications of poor health care. There are over 3 million refugees resettled in the United States who need health care but are not necessarily receiving the much-needed health care for various reasons as stipulated in this study. There is very little study that has been done on the long-term effects of poor health care delivery in this unique population. However, like in any other population this translates into the larger society bearing the costs through lower productivity, increased rates of communicable disease, and a huge burden on the national budget.

Conclusion

In conclusion, the data reveals the importance of research studies from a socio-cultural perspective to gain an understanding of how behaviors, cultural nuances, religion and environment to name a few, shape health promotion and provision in the refuge community. This is reflected in the emerging themes from the systematic literature review revealing the need for culturally and linguistically appropriate services, contextually tailored programs, and collaborations to facilitate reaching this unique population successfully.

Recommendations

The results suggest that the public health community should re-evaluate the current methods of providing health care to the refugee community and implement evidence-based interventions from a socio-cultural perspective. There is a need for group-specific research addressing the socio-cultural nuances pertaining to each ethnic group. This type of formative research will be helpful in informing funders and other stakeholders on development of health programs that are unique to this population. Finally, there is a need for designing policies that ensure access to healthcare for refugees.

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