2023

The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice

Dominique Menard

The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice

By Dominique Menard, OTDS

Advisor: Breann Lamborn, EdD, M.P.A

A Scholarly Project

Submitted to the Occupational Therapy Department

of the

University of North Dakota

In partial fulfillment of the requirements

For the degree of

Doctor of Occupational Therapy

Grand Forks, North Dakota

May 2023

This scholarly project, submitted by Dominique Menard, OTDS in partial fulfillment of the requirement for the Degree of Occupational Therapy Doctorate from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

DocuSigned by:
Breann Lamborn
A241B9634D534A7...

Faculty Advisor

4/12/2023

Date

PERMISSION

Title: The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice

Department: Occupational Therapy

Degree: Occupational Therapy Doctorate

In presenting this scholarly project in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my project or, in their absence, by the Chairperson of the department or the Dean of the School of Graduate Studies. It is understood that any copying or publication or other use of this scholarly project or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and the University of North Dakota in any scholarly use which may be made of any material in my scholarly project.

DocuSigned by:
2C28B1E4579446C...

Dominique Menard

4/12/2023

Date

TABLE OF CONTENTS

Acknowledgments

The author wishes to express her utmost appreciation for her advisor, Dr. Breann Lamborn, EdD, M.P.A. She provided continued support, compassion, invaluable expertise, and scholarly advice throughout the development of this project. The author of this scholarly project also wants to thank the individuals who sacrificed their time and energy to help the author better understand the unique needs, challenges, and experiences of this population, specifically their doctoral experiential site mentor, Theresa Paulsen, MA, OTR/L. Finally, the author would like to express countless thanks to her family and friends who have provided endless support and encouragement throughout the entirety of this journey.

Abstract

Title: The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice

Purpose: At the end of 2021, there were 836,300 Somali refugees and asylum seekers worldwide; in Minnesota alone, there are more than 70,000 Somali refugees, which is the largest concentration in the United States (Culture Care Connection, 2022; The UN Refugee Agency, n.d.). As with many refugee populations, Somali refugees experience many healthcare inequities including limited understanding of the resettled nation's healthcare system, poor functional health literacy, provider and/or interpreter gender preferences, discrimination, and limited cultural competence of providers (Eklöf et al., 2019; Fang et al., 2015; Gele et al., 2016; Houston et al., 2021; Njenga, 2022; Wångdahl et al., 2018). This negatively affects Somali refugees during healthcare encounters and has detrimental impacts on their health and well-being during and following discharge from a healthcare setting.

Methods: A literature review needs assessment was conducted on topics related to the issues faced by the Somali refugee population when seeking services and their experiences within the healthcare system in their country of resettlement. The literature supported the need and provided a foundation, for the development of a comprehensive reflective resource guide for occupational therapy personnel working with Somali refugees in a U.S. healthcare setting.

Results: The reflective resource guide was created to promote occupational therapy practitioners' knowledge of Somali refugees' history, culture, and occupational preferences and how that may alter the occupational therapy process. The reflective resource guide also includes tools for special consideration in healthcare settings and opportunities for users to reflect on their own culture and biases to determine how that may impact interactions with the Somali refugee population.

Conclusions: This reflective guide is intended to increase occupational justice for Somali refugees by expanding the knowledge and culturally specific tools used by occupational therapy personnel with the population. It is recommended that the reflective guide be used when working with Somali refugees across all healthcare settings, but it is more specifically related to healthcare encounters related to physical impairments.

Chapter I: Introduction

Introduction

In 2019, there were 79.5 million people internationally displaced (26 million under the age of 18) and 45.7 million people internally displaced within their country of origin (United Nations, n.d.)

Many refugees transition to host countries with limited financial resources, and possess language barriers, and physical/psychosocial impairments (Huot et al., 2016). With the plethora of barriers that refugees experience, susceptibility to inequities experienced through the healthcare system is also a concern. Refugees experience substantial inequities in healthcare services during and after the transition into a host country (Black, 2019; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022; Robertshaw et al., 2017; Tengilimoglu et al., 2021; Tomkow et al., 2019; World Health Organization, 2022). These inequities are due to barriers like language proficiency, comprehensive health literacy, limited knowledge of the healthcare system, and intentional and unintentional discrimination (Alwan et al., 2020; Centers for Disease Control and Prevention, 2022; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022; Robershaw et al., 2017; Wangdahl et al., 2018). These barriers impact an individual's quality of life, health, and well-being.

Somali Refugees

The refugee population of choice for this particular scholarly work is the Somali population. Somalia is located in Eastern Africa and is a part of the Horn of Africa, which is along the coast of the Arabian Sea and the Indian Ocean (Centers for Disease Control and Prevention, 2021). The climate in Somalia is largely arid/desert-like, but some areas within the country experience intense rainy seasons and monsoons (Centers for Disease Control and Prevention, 2021). Extreme climate leads to recurring droughts, frequent dust storms in the

eastern plains, and flooding during the rainy season (Centers for Disease Control and Prevention, 2021).

At the end of 2021, there were 836,300 Somali refugees and asylum seekers worldwide, with most of them living in neighboring countries with 279,200 in Kenya, 250,719 in Ethiopia, 69,940 in Yemen, and 61,853 in Uganda (The UN Refugee Agency, n.d.). Between the years 2010 and 2016, the United States welcomed 47,000 Somali refugees; since 2014, there has been a consistent increase of about 9,000 Somali refugees a year transitioning to the United States(Centers for Disease Control and Prevention, 2021). Alone in the state of Minnesota, there are estimated to be more than 70,000 Somali refugees, which is the largest population in the United States (Culture Care Connection, 2022).

The number of Somali refugees in the United States has only continued to grow within the last several decades. This crisis is largely due to the ongoing civil war, which began in 1991, and continued political instability within Somalia. (Centers for Disease Control and Prevention, 2021). Since colonization by Italy, France, and Great Britain, there have been deep divides between clans, insurgent groups, and rival militias due to clashing clans being grouped into the same colonized area (Ingiriis, 2016). Ongoing conflicts have been about brutality, suppression of opposition groups, nationalistic and Islamic claims, and exacerbation of inter-clan rivalries (The Organization for World Peace, 2022). Further, there has been a catastrophic drought that has been plaguing 90% of Somalia, which has water sources drying up and prices of food rising; the drought has also impacted existing refugee camps within the country. This has resulted in millions of Somalis displaced, with many fleeing the East African region altogether (The UN Refugee Agency, n.d.). This is made worse by an already dramatic reduction in food assistance due to funding shortfalls and the global economic crisis that has caused all foods and

commodities to increase in price (The UN Refugee Agency, n.d.). This is largely contributing to famine throughout Somalia.

Health Inequity Experienced by Somali People

The Somali refugee population experiences many of the same inequities that other refugees experience, including limited understanding of the host nation's healthcare system, poor comprehensive and functional health literacy, gender taboos resulting in a mismatch of provider and/or interpreter preferences, discrimination, and limited cultural competence of providers (Eklöf et al., 2019; Fang et al., 2015; Gele et al., 2016; Houston et al., 2021; Njenga, 2022; Wångdahl et al., 2018). This negatively affects Somali refugees during healthcare encounters and consequently has detrimental impacts on their health and well-being post-discharge from a healthcare setting (Eklöf et al., 2019; Fang et al., 2015; Gele et al., 2016; Houston et al., 2021; Njenga, 2022; Wångdahl et al., 2018). Many studies had reports from Somali clients on the need for healthcare providers to understand the Somali culture and the religion they practice (Eklöf et al., 2019; Im et al., 2017; Njenga, 2022).

Hennepin Healthcare

The agency in question, Hennepin Healthcare, completed a community needs assessment in 2019 to learn more about how the organization can best meet the unique needs and serve the community. One of the subgroups within this needs assessment was individuals who identify as being part of the Somali community. The three areas that they reported as a need to improve were improved access to care, culturally responsive care, and building trust with clients (Hennepin Healthcare, 2019).

Access to care has been limited for Somali clients because of the rising costs of care and medication (even with the use of insurance), the complexity of obtaining medical assistance, and

the lack of knowledge of the Western healthcare system (Hennepin Healthcare, 2019). Culturally responsive care is also lacking in Somali clients' medical experiences. There is a high potential for re-traumatizing or misdiagnosing a Somail client if there is limited knowledge of the communities cultural and historical context (Hennepin Healthcare, 2019). Hennepin Healthcare (2019) also identified that having trusting relationships, especially with the Somali population, is low/fragile and that it should be a priority for providers to repair relationships with the community.

Purpose Statement

The purpose of this scholarly project, *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice*, is to increase occupational justice for Somali refugees by providing culturally responsive clinical approaches to occupational therapy personnel. The creation of the product was directed by the theory of the Person, Environment, Occupation (PEO) model (Law et al., 1996). Its emphasis on the "fit" of its constructs (person, environment, occupation), client-centeredness, client autonomy/choice, empowerment of clients, and respect for clients' diversity makes it an appropriate model to direct occupational therapists in providing care for the Somali refugee population (Baptiste, 2017; Cole & Tufano, 2020).

Theoretical Framework

The PEO model considers the transactive nature of it its main domains, the person (physical, cognitive, sensory, affective, and spiritual), environment (physical, social, cultural, institutional, and virtual), and occupation (self-care, productivity, and leisure) (Law et al, 1996). These domains are dependent on and affected by one another (Law et al., 1996). The overlapping area of person, environment, and occupation shapes occupational performance and represents the

"fit" between the domains (Law et al., 1996). The greater the overlap, the better their occupational performance, and the more satisfied a person is with their functioning in society (Law et al., 1996)

This model was chosen because of the interconnectedness of the three major domains (person, environment, occupation) and how the model views change (Law et al., 1996). Change occurs through client motivation toward personal growth and self-actualization (Cole & Tufano, 2020). This is related to the purpose of the product as it hopes to enable occupational therapy staff to change/grow as individuals and healthcare providers to provide more adequate and equitable services to Somali refugees. Although inequities are being experienced by the Somali refugee population, many healthcare providers do want to be more competent when providing services to this population but lack the resources and time to complete the undertaking(Cole & Tufano, 2020). By increasing the occupational therapy staff's occupational performance through the product (a reflective resource guide), the Somali refugee population will be afforded more appropriate and equitable care during their healthcare experiences, thereby increasing their occupational performance.

Significance of Project to Occupational Therapy

A tenant of the occupational therapy profession is providing client-centered care to all individuals that are served (AOTA, 2020). Occupational therapists must listen to understand a client's cultural values and beliefs about health and well-being to provide effective, culturally sensitive, and client-centered care (Black, 2019). Culture naturally impacts the occupations that an individual chooses and participates in. Occupational choice is determined by one's values, interests, beliefs, social situation, gender, age, sexual identity, and physical/cognitive/emotional abilities (Black, 2019). Due to various factors, like high patient numbers, setting of practice, or

lack of time, practitioners do not have enough time to get to know their clients; this leads to assumptions about the occupations that an individual participates in, how they participate, and what the outcome is (Black, 2019). In the healthcare system, it is the role of the occupational therapist to utilize a client's occupational choices during the occupational therapy process so that skills are developed in the areas in which an individual participates and engages in (Black, 2019).

Conclusion

The author of this scholarly project used a needs assessment literature review, a theoretical model, and a learning theory to create the product. The remainder of the scholarly product is as follows. Chapter II presents a needs assessment literature review. Chapter III presents the methodological process used in developing the manual. Chapter IV includes the entire product *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice*. Chapter V is the final chapter and includes the summary of the scholarly project, limitations of the product, and recommendations for the product's use and further research.

Key Terminology

- **Asylum Seeker:** An asylum-seeker is someone whose request for sanctuary has yet to be processed. Every year, around one million people seek asylum (UNHCR, n.d.).
- **Cultural cruise control**: Acting as though our values, beliefs, and experiences are universal; when you find yourself in this mode of thinking and acting, you are oblivious to different cultural cues or experiences (Bucher, 2015)
- **Health literacy:** Links to literacy and entails people's knowledge, motivation and competencies to access, understand, appraise, and apply health information to make

judgments and decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve the quality of life during the life course (Wångdahl et al., 2018)

- **Implicit bias:** Actions based on prejudice and stereotypes *without intending* to do so. This is an unconscious act or thought. Implicit bias can be more dangerous because individuals cannot refrain from acting on them. After all, the individual is unaware that they exist (Hennepin Healthcare, 2023).
- **Interpreter:** Members of the healthcare team that provide translations for clients that speak a language other than English. They are the bridge for medical providers (including OTs!) to be able to effectively communicate with a population that would otherwise be unreachable.
- **Occupational Justice:** A justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences (AOTA, 2020)
- **Occupational preferences:** The occupational choices of individuals. Preferences are influenced by age, gender, ethnicity, location, socioeconomic status, and other factors related to diversity.
- **Refugee:** People who have fled war, violence, conflict, or persecution and have crossed an international border to find safety in another country and are unable or unwilling to return to their country of origin (UNHCR, n.d.)
- **Somalia:** Officially the Federal Republic of Somalia, is a country in the Horn of Africa. The country is bordered by Ethiopia to the west, Djibouti to the northwest, the Gulf of

Aden to the north, the Indian Ocean to the east, and Kenya to the southwest. Somalia has the longest coastline on Africa's mainland.

- **Somali:** Relating to Somalia, the people, or their language.
- **Trauma-informed care:** An approach that recognizes the pervasive impact of trauma on health, applies this knowledge of trauma and its consequences into practice, and actively seeks to prevent re-traumatization (Miller et al., 2019)

Chapter II: Literature Review

In 2019, there were 79.5 million people internationally displaced (United Nations, n.d.). The United States sees a large influx of refugees every year from all over the world. Although refugees transition to new countries like the United States in hopes of a better life, many refugees experience struggles upon transition, especially within their healthcare experiences.

Refugees and Transition

According to the United Nations, the definition of a refugee is

> …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, is unable or, owing to such fear, is unwilling to return to it (n.d., para. 2).

Many refugees transition to host countries with limited financial resources, language barriers, and physical/psychosocial impairments (Huot et al., 2016). Due to these limitations, a vast number of refugees experience occupational injustices like occupational deprivation (Darawsheh, 2019; Huot et al., 2016; Khan et al., 2021; Trimboli & Taylor, 2016*)*. With the plethora of barriers that refugees experience, susceptibility to inequities within their healthcare experiences is also a concern. Refugees experience substantial inequities in healthcare services during and after the transition into a host country (Alwan et al., 2020; Black, 2019; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022; Robertshaw et al., 2017; Tengilimoglu et al., 2021; Tomkow et al., 2019; World Health Organization, 2022). Overall, these barriers impact an individual's quality of life, health, and well-being.

Occupational Therapy and The Refugee Population

According to the American Occupational Therapy Association (AOTA, 2020, p. 1), occupational therapy is the "therapeutic use of everyday life occupations with persons, groups, or populations (i.e., the client) to enhance or enable participation". Occupational therapy practitioners approach each client holistically to evaluate their roles, habits, and routines while considering contextual, environmental, and personal factors (AOTA, 2020). Through an occupational therapist's knowledge, evidence-based practice, and therapeutic rapport-building skills, they collaborate with the individual, group, or population to design interventions that focus on the individual, group, or population's success in occupational participation and engagement (AOTA, 2020).

With the increasing number of refugees within the United States, and a growing number requiring healthcare services, occupational therapy staff must meet the unique needs of the population. A tenant of the occupational therapy profession is providing client-centered care to all individuals that are served (AOTA, 2020). Occupational therapists must listen carefully to understand a client's cultural values and beliefs about health and well-being to provide effective, culturally sensitive, and client-centered care (Black, 2019).

Refugee Person Factors and Transition

Refugees experience increased trauma, poverty, and stress due to the nature of forced migration. These experiences cause distress to their overall quality of life (QoL) and well-being which impacts engagement in occupations (Cummings, 2021; Schick et al., 2016; United Nations, n.d.). Trauma is defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that

has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being" (Miller et al., 2019, pp. 1-2). Persecution based on race (physical), religion (spiritual), nationality (physical), membership of a certain organization; and experiencing forced migration, civil unrest, or abuse, are traumatic and impact a refugee's life post-migration (Miller et al., 2019; United Nations, n.d.). Because refugees so often experience trauma, it is imperative to employ trauma-informed care principles when interacting with the refugee population. Cummings (2021) reported that refugees' cognitive skills/factors are affected by the persecution and challenging living conditions they have endured. Refugees also stated the importance of using coping strategies that rooted them in their collective identity (Frounfelker et al., 2020). An example would be reframing a traumatic "individual" experience into the frame of the "collective" experience; this is a frame of mind that many refugees see themselves in the world and can potentially impact engagement, adherence, and outcomes of therapeutic services (Cummings, 2021).

Emotion and mood are extremely variable for refugees during and after the transition. Their affective state is run by negative emotions like fear; having a surplus of negative emotions (with very few instances of positive) leads to conditions that can affect a person's life within a new country (Schick et al., 2016). Developing mental illnesses, like depression and PTSD, repetitive traumatic experiences, and stress can have a significant impact on a refugee's ability to integrate into society and can cause future complications (Schick et al., 2016). These conditions can manifest in any one of the personal factors like limited sleep, fatigue, depressive mood, or sensory stimuli triggers (Schick et al., 2016). Over time, these stressors can cause physical limitations that may cause negative interactions with the medical system.

Spirituality is something that many refugees identify as being important in themselves

and their lives. Participants found that having a strong religion/spirituality, no matter what religion it may be, gave them better QoL and a sense of well-being (Abraham et al., 2021). This means that spirituality can be grounding for individuals within life in their host country; however, individuals who were unable to practice their religion regularly, for various factors, can feel more stress. Overall, healthcare providers must understand the person factors of refugees as it will impact the services that are provided to them.

General Environmental Factors

Barriers

There are parts of the social environment that also make the transition and living within the United States challenging. Many refugees stated that they felt like outcasts within their host countries, that they were looked down upon, and that others were unfriendly, ignorant, discriminatory, and thought to be uneducated (Ballentyne et al., 2021). Not only do refugees have difficulties with language/communicating with individuals of their host country, but also have difficulty relating to them (Brickhill-Atkinson & Hauck, 2021). Refugees report that there are limited opportunities to talk with those who understand what they are currently enduring (Ballentyne et al., 2021).

The cultural environment is often very different in a refugee's host country compared to that of their home country; this brings many obstacles for refugees to endure. Religion and spirituality are aspects that many refugees find meaningful (Ballentyne et al., 2021). Due to typically having dissimilar religious practices than the native population of the host country, there is a lack of physical spaces for differing religious worship (ex. mosques, synagogues, temples) as well as limited societal acceptance of different religions in the United States (Ballentyne et al., 2021).

Benefits

Institutionally, there are many more freedoms that refugees experience following the transition to a new society. Women have more opportunities to work, there are more opportunities to join social groups, and policy-level mitigation can occur (Ballentyne et al., 2021; Brickhill-Atkinson & Hauck, 2021). Although there were many negative outcomes of the COVID-19 pandemic, the Society of Refugee Healthcare Providers created techniques and preventative measures for healthcare providers to better avoid complications and harm to the refugee community (Brickhill-Atkinson & Hauck, 2021). These include providing weekly email updates, watching for PTSD reemerging, remaining mindful of patient tolerance and attention span for telehealth, maintaining flexibility for in-person visits, and knowing about local resources (food bank, unemployment, shelter resources, etc.). Psychological first aid is recommended including information dissemination, active outreach, extensive case management, and telemedicine services (Brickhill-Atkinson & Hauck, 2021).

Barriers for Refugees in the Healthcare System

With the plethora of barriers that refugees experience, susceptibility to inequities within their healthcare experiences is also a concern. Overall, these barriers impact an individual's quality of life, health, and well-being. Refugees experience substantial inequities in healthcare services during and after the transition into a host country (Black, 2019; World Health Organization, 2022). There are several common obstacles that refugees experience when interacting within the healthcare system. Some of these obstacles include language proficiency, comprehensive health literacy, limited knowledge of the healthcare system, and intentional and unintentional discrimination (Alwan et al., 2020; Centers for Disease Control and Prevention,

2022; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022; Robertshaw et al., 2017; Wangdahl et al., 2018).

Communication and language barriers pose one of the most limiting barriers to healthcare access for refugees (Joseph et al., 2020; Lebano et al., 2020; Rashoka et al., 2022). Although there are an increasing number of interpreters and ways to access them (phone, video calls, or in-person), many refugees dislike technological ways of accessing interpreters and feel uncomfortable sharing private medical information in front of interpreters (Mangrio & Forss, 2017; Rashoka et al., 2022). Although interpreter services are provided in many languages, it may not be the precise language or dialect of the refugee client, so language and cultural barriers are conveyed in the interpretation of medical information (Rashoka et al., 2022). This leads refugees to utilize family and/or friends to translate, which leads to even more substantial gaps in the medical information shared (Robertshaw et al., 2017). Healthcare staff frequently do not implement best practice skills with interpreters, and this causes a disconnect between clients and their providers. Because of language barriers, refugees only utilize healthcare services when they are profoundly sick and/or injured and require emergency medical services (Rashoka et al., 2022).

Health literacy is defined as the degree to which an individual can find, understand, and use information and services to inform health-related decisions and actions for themselves and others (Centers for Disease Control and Prevention, 2022). In addition to limited language proficiency, many refugees struggle with health literacy (Alwan et al., 2020; Lebano et al., 2020; Robertshaw et al., 2017; Wangdahl et al., 2018). In one study, 67% of refugees reported that they had inadequate or problematic health literacy (Wangdahl et al., 2018). Healthcare systems fail to provide written information within native languages; further, due to disruptions in learning

during resettlement, many refugees do not know how to read their native language, which furthers the gap in health literacy (Robertshaw et al., 2017). Refugees perceived having poorer health and psychosocial well-being when having inadequate health literacy; when perceived health literacy levels were lower, refugees were also more likely to avoid seeking healthcare services until extreme instances, often requiring emergency services (Wangdahl et al., 2018).

Many refugees report extreme difficulties when navigating a foreign healthcare system (Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2020; Robertshaw et al., 2017). Healthcare in the host country likely looks different than in a refugee's native country. Many refugees assume that the healthcare in their host county is better than that of their native country; when they find out it has flaws that significantly impact their care, they cease seeking services, despite how much they may need it (Joseph et al., 2020; Robertshaw et al., 2017). However, the most common reasons why refugees cannot access healthcare are due to cost, inability to participate in national programming (Medicaid, private health insurance, or Medicare), and knowledge of how to access primary and preventative care services (Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022). Without knowledge of how to access primary/preventative services, most refugees only utilize emergency services when they are extremely sick or experience traumatic accidents (Lebano et al., 2020; Rashoka et al., 2022). Due to the inequities that refugees experience, they experience a higher incidence of critical care incidences like accidental injuries, hypothermia, trauma injuries, burns, and mental health conditions following the transition to the United States which requires emergency services (World Health Organization, 2022).

Discriminatory practice is frequently experienced by refugees. Traditions and customs are widely marginalized by healthcare workers; providers have been known to change their

demeanors while working with refugees due to race, health status, and country of origin (Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017). Refugees have refused to be seen and go home without treatment due to a lack of accommodation for gender preferences in healthcare encounters (Rashoka et al., 2022). Further, consistent exposure to other social determinant stressors precludes health-seeking behavior (Alwan et al., 2020). Factors like poor housing and neighborhoods, reliving traumatic events, limited opportunities for paid job opportunities, depression and anxiety, and social isolation impact a refugee's health significantly (Alwan et al., 2020; Lebano et al., 2020)

Occupational Performance Factors

Occupational Justice

Occupational justice is defined as "a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (AOTA, 2020, p. 11). Refugees have many unique needs that healthcare personnel are not equipped to deal with; this leads to many instances of injustices and inequities within their care (Black, 2019; World Health Organization, 2022).

When healthcare providers are not providing services that meet the unique needs of the refugee population, it will inhibit access to resources that the average client has access to; participation in meaningful occupations, educational materials that the client understands, and being able to participate in conversations about their health are all things that refugees consistently do not have access to. This is a systemic injustice that refugees experience, and it causes them to be occupationally deprived during their hospital stay as well as post-discharge. Occupational deprivation is described as being deprived of engagement in meaningful activities, which ultimately leads to negative effects on health, well-being, and sense of humanity

(Darawsheh, 2019; Huot et al., 2016; Khan et al., 2021; Siddiqui et al., 2019; Trimboli & Taylor, 2016). It continues to be an issue due to reasons like the availability of resources (physical, social, and institutional) to participate in occupations, time, social injustices, and context (Darawsheh, 2019; Huot et al., 2016; Khan et al., 2021; Trimboli & Taylor, 2016).

Occupational Performance in the Healthcare System

Acute care or emergency medicine is the first-place refugees turn to; it is when there is a need for medical/surgical diagnosis or intervention (Roberts & Evenson, 2019). Inpatient rehabilitation differs as it is used to provide intensive therapy from multiple disciplines to make progress toward rehabilitation goals, problems, or barriers to safely discharging to home/next setting (Roberts & Evenson, 2019). Occupational therapy plays a substantial role in each of these settings. Within acute care, the focus is on positioning, range of motion, splinting/casting, early mobilization, and ADLs (Roberts & Evenson, 2019). Although there is some overlap (self-care tasks), inpatient rehabilitation focuses further on functional cognition, social cognition, IADLs, and community reintegration (Roberts & Evenson, 2019).

Refugees who are admitted into the hospital endure substantial impacts on occupational performance in most (if not all) occupational areas and make insufficient progress in the areas during their stay. Limited occupational progress during hospitalization is due to inequities like language proficiency, comprehensive health literacy, limited knowledge of the healthcare system, and intentional and unintentional discrimination (Alwan et al., 2020; Centers for Disease Control and Prevention, 2022; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Rashoka et al., 2022; Robertshaw et al., 2017; Wangdahl et al., 2018).

Best Practices for Refugee Care

Within healthcare, there have been several techniques that have been used that have benefited refugees and the outcomes of their care. Incorporating trauma-informed care, implementing more culturally appropriate care, creating better interpersonal relationships with refugees, and including them in the coordination of their care have been found to positively impact health outcomes for refugees (Centers for Disease Control and Prevention, 2020; Mangrio & Forss, 2017; Miller et al., 2019; Randl-Karimi et al., 2022; Robertshaw et al., 2017; Substance Abuse and Mental Health Services, 2014).

Trauma-Informed Care

Although there are many barriers that refugees experience, healthcare systems have started implementing changes to make care more appropriate for the refugee population. Some of these changes include trauma-informed care, implementing more culturally appropriate care, creating better interpersonal relationships with refugees, and including them in the coordination of their care.

Trauma-informed care is an approach that recognizes the pervasive impact of trauma on health, applies this knowledge of trauma and its consequences into practice, and actively seeks to prevent re-traumatization (Miller et al., 2019). It is imperative that all members of an organization or system have a basic realization of trauma and how it can affect individuals, groups, and populations; they also need to recognize the signs of trauma (Substance Abuse and Mental Health Services, 2014). From there, organizations and systems need to respond to trauma by applying the principles of a trauma-informed approach to all areas of functioning and resisting re-traumatization (Miller, 2019; Substance Abuse and Mental Health Services, 2014).

There are six guiding principles to a trauma-informed approach; these include safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment voice

and choice, and cultural, historical, and gender issues (Substance Abuse and Mental Health Services, 2014, p. 11). Overall, trauma-informed care emphasizes a strength-based approach, a friendly/trustworthy climate for refugee clients, and the promotion of trusting relationships with refugee clients and families (Miller, 2019; Substance Abuse and Mental Health Services, 2014).

Implementing trauma-informed approaches requires systemic change on multiple levels of an organization within alignment with the six guiding principles. There are ten domains to consider when implementing trauma-informed care including governance and leadership, policy, physical environment, engagement and involvement, cross-sector collaboration, screening, assessment, treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation (Substance Abuse and Mental Health Services, 2014, pp. 13-14).

Language and Literacy

Access to interpreters has been increasing over the years due to having many different ways to access them, whether via phone, video calls, or in person (Mangrio & Forss, 2017; Rashoka et al., 2022). However, many factors can influence what medium works best for a client; due to this, it is best practice to consider all those factors and ask the client when making that decision. It is also best practice for healthcare staff to implement best practices principles when working with an interpreter. Some best practice principles include looking at the client when speaking to them, avoiding using language like “tell them xyz…”, slowing down, using shorter sentences, understanding the context of situations, and positioning within the room (Harrison & Mirza, 2019). Incorporating best practices with interpreters aids in building better relationships with clients and ensures that they understand what is happening in their medical care (Harrison & Mirza, 2019).

There are multiple best practices ways to educate clients who have limited health literacy skills. This includes improving patient-provider communication, simplifying health information in educational materials, eHealth interventions (i.e., PCs and tablets with videos & interactive self-help tools), and efforts to improve underlying health literacy skills, such as the ability to read (County Health Rankings & Roadmaps, n.d.; Jacobs et al., 2016). There is a lot of promise with the utilization of multi-modal approaches, such as eHealth or different technologies, the use of visuals, and the teach-back method, in improving aspects of health literacy in populations (County Health Rankings & Roadmaps, n.d.; Jacobs et al., 2016).

Culturally Sensitive/Appropriate Care

Culturally appropriate care has been found to benefit refugees within the healthcare system (Mangrio & Forss, 2017; Robertshaw et al., 2017). Cultural sensitivity training was found to be beneficial for healthcare staff specifically for culturally appropriate health promotion interventions to make lifestyle changes (Mangrio & Forss, 2017). Clients appreciate healthcare providers who are ready to learn and gain knowledge and understanding about culture as it facilitates cross-cultural care (Mangrio & Forss, 2017; Robertshaw et al., 2017). Care and intervention must be reflective of refugees' cultures; this means understanding differences in values, body language, health and life practices, and health presentations (Mangrio & Forss, 2017; Robertshaw et al., 2017). Overall, healthcare providers found that specific training and guidance (ex. orientation to services and resources available for refugees, culture-specific information, and trauma-sensitive care) facilitated their clinical practice, improving their competence and confidence when working with the refugee population (Robertshaw et al., 2017).

Creating intentional and interpersonal relationships with refugees was found to increase

health outcomes for the refugee population (Mangrio & Forss, 2017; Randl-Karimi et al., 2022; Robertshaw et al., 2017). Refugees want to play a collaborative role with healthcare providers, however, often feel restricted due to feeling like healthcare providers don't care, or have limited time or tolerance for their needs (Randl-Karimi et al., 2022). It is important to create trusting relationships with refugees; doing this will increase refugee engagement in their healthcare services and will increase the levels of disclosure about their health and social needs/concerns (Robertshaw et al., 2017).

A way that a deeper relationship can be built, and that was found to be important to refugees, is having continuity in healthcare providers (Mangrio & Forss, 2017; Randl-Karimi et al., 2022; Robertshaw et al., 2017). Furthermore, ways to be more intentional in the relationship with the refugee population are demonstrating patience and tolerance, creating a safe place for refugees to share health needs, and explaining health information in a way that the refugee can understand (Radl-Karimi et al., 2022).

Conclusion

In conclusion, the need for this product was established through an extensive literature review. As refugees try to navigate the healthcare system, they experience a minimal overlap of the PEO domains due to person factor barriers (increased trauma, poverty, stress, impaired cognition, and reduced emotional regulation skills), environmental limitations (language proficiency, comprehensive health literacy, limited knowledge of the healthcare system, and intentional and unintentional discrimination), and occupational exclusions (inability to participate in variants of occupations in the healthcare setting that are more culturally important to the population) that limit performance/participation within the healthcare setting (Law et al., 1996). Therefore, this project will explore how to increase the overlap of these domains to create

better occupational participation, engagement, and performance for the refugee population during hospital stays and post-discharge.

There are several evidence-based themes for occupational therapy personnel to implement to provide better healthcare experiences, and therefore better health outcomes, for the refugee population. These themes include increasing culturally competent/appropriate care, utilizing trauma-informed care principles, appropriately using interpreter services, and implementing best practice health literacy strategies. Implementation of these themes will be completed by occupational therapy providers through a six-part reflective resource guide on the history, culture, occupational differences, and additional resources to use with the Somali refugee population to overall improve their healthcare experiences during their hospital stay and post-discharge.

Chapter III: Methodology

The goal of this scholarly project was to aid occupational therapy staff in decreasing the occupational injustices that Somali refugees experience within healthcare. The author identified a consistent need for a reflective resource guide for occupational therapy personnel for the Somali refugee population to increase outcomes and occupational justice during healthcare experiences and post-discharge. The needs included:

- Limited occupational progress during hospitalization due to inequities like language proficiency, comprehensive health literacy, limited knowledge of the healthcare system, and intentional and unintentional discrimination (Alwan et al., 2020; Centers for Disease Control and Prevention, 2022; Eklöf et al., 2019; Fang et al., 2015; Gele et al., 2016; Houston et al., 2021; Joseph et al., 2020; Lebano et al., 2020; Mangrio & Forss, 2017; Njenga, 2022; Rashoka et al., 2022; Robershaw et al., 2017; Wångdahl et al., 2018)
- Client-perceived inadequacies in the implementation of culturally-sensitive care in healthcare settings for the Somali refugee population (Eklöf et al., 2019; Fang et al., 2015; Im et al., 2017; Njenga, 2022; Odunukan et al., 2914)

The process of creating *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice* took several steps. To begin the process, keywords pertaining to the research topic were identified. Keywords utilized included “refugee”, “displaced person”, “asylum seeker”, “migrant”, “occupational therapy”, “occupational deprivation”, and “occupational changes”. The author inserted the keywords and search threads into several search platforms, databases, professional websites, and journals including CINAHL, PUBMED, American Occupational Therapy Association (AOTA), and the American Journal of Occupational Therapy (AJOT).

Additionally, the University of North Dakota's School of Medicine and Health Sciences Library, and government websites were used. Articles were included in the literature review if they were in the English language, published in 2012 or later, and were from textbooks, professional journals, and governmental guidelines/databases. Conference presentations were excluded. Articles were included within a ten-year span due to the nature of the topic; occupational therapy practice with refugees is an emerging area, so the literature was limited.

The process of the literature review required several sub-steps. The literature collected was evaluated based on a perceived level of evidence. From there, detailed summaries of the most informative articles pertaining to person variables of refugees, the environment that they live in (before and after transition), the occupations that they participate in, and occupational therapy's role were created. Further review of the literature occurred in 2 major areas. The first area was on healthcare-specific person variables, environmental challenges, and occupational limitations that the common refugee experienced; I then narrowed the research field to better understand these challenges and limitations through the lens of a Somali refugee. The second area was a deeper delve into Somali culture before, during, and after the migration/transition.

The resources utilized to guide the development of *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice* included content from the literature review, Mezirow's Transformational Learning Theory (Mezirow, 1991), and Bucher's (2013) Diversity Consciousness framework. Considering the target population for the product content, occupational therapy personnel, the author incorporated the existing literature, theory, and framework into the design of the resource guide.

Various theories and models were reviewed to see which one could best meet the needs of the population for whom this reflective resource guide was designed. The environment was a crucial factor in determining an occupational therapy-based model. The person-environment-occupation (PEO) model was chosen because it looks at the "fit" of an individual through the three domains of person, environment, and occupation; minimal overlap of the domains negatively affects a person's occupational performance (Law et al., 1996).

Beyond occupation-based models, an adult learning theory was considered. Mezirow's Transformational Learning Theory was chosen based on the idea that learners can adjust their thinking and previous knowledge based on new information (Mezirow, 1991). It has been shown to be an effective model for educational materials for healthcare workers (Briese et al., 2020; Rojo et al., 2023). It is imperative for occupational therapy personnel can adjust their practice based on the new information regarding Somali refugees. With the target population for this resource guide being occupational therapy personnel in healthcare, Mezirow's Transformational Learning Theory is appropriate (Mezirow, 1991).

The reflective resource guide was organized according to Richard Bucher's (2015) *Diversity Consciousness* framework as it recognizes that the process of being "diversity conscious" is dynamic, requiring a person to commit to constant learning and practice for change to occur. The process of organizing this reflective resource guide is based on the 6 areas of development for becoming "diversity conscious": (1) examining ourselves and our worlds, (2) expanding our knowledge of others and their world, (3) stepping outside of ourselves, (4) gauging the level of the playing field, (5) checking on ourselves, and (6) following through. (Bucher, 2013, p. 100).

Chapter IV: Product

The goal of *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice* is to aid occupational therapy personnel in learning about Somali refugees' history, culture, potential occupational preferences, and hospital-based resources. Congruently, by increasing the knowledge and skills of occupational therapy personnel, the Somali refugee population will increase their occupational performance within the healthcare setting.

The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice is broken down into six sections. The sections are based on Bucher's (2015, p.100) diversity consciousness framework, "examining ourselves and our world, expanding our knowledge of others and their world, stepping outside of ourselves, gauging the level of the playing field, checking up on ourselves, and following through". The product is designed as a reflective resource guide that includes reflection questions throughout the content, activities, and stand-alone resources for occupational therapy personnel to utilize in day-to-day practice. There are embedded links and resources throughout the reflective guide, so users can learn more about topics and how to complete the occupational preferences of the population. These links were included as a significant component of being "diversity conscious" is taking on an active role in the learning process.

Implementation of *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice* can occur in multiple ways. The partnering facility was urged to provide the resource guide to all current occupational therapy personnel and all new hires within the department. Occupational therapy personnel can work through the resource guide at their own pace and refer back to

information when needed. Resources within the guide are recommended to be utilized at different frequencies (ex. The interpreter checklist was encouraged to be used following every interaction with an interpreter). It is at the discretion of occupational therapy personnel, as well as the continual changing of needs at the partnering facility, to revisit the guide as much or as little as needed following completion.

As mentioned previously, the development of the product was guided by PEO, Mezirow's transformational learning theory, and the diversity consciousness framework (Bucher, 2015; Law et al., 1996; Mezirow, 1991). PEO was used to expand the goodness of fit between the person (occupational therapist), occupation, and environment to better serve the Somali refugee population. Further, PEO was chosen because of how the model views change; change occurs through client motivation toward personal growth and self-actualization (Cole & Tufano, 2020). This is related to the purpose of the product; to enable occupational therapy staff to change/grow as individuals and healthcare providers to provide more adequate and equitable services to Somali refugees. Mezirow's transformational learning theory and Bucher's diversity consciousness framework were utilized throughout as a way to format the reflective resource guide and scaffold the participants' learning.

The Somali refugee reflective resource guide for occupational therapy personnel is supported by an extensive literature review, methodology, the PEO model, and informal needs assessment. The reflective resource guide was set up to allow occupational therapy personnel to learn more about the history and culture of the Somali refugee population, potential occupational preferences, and hospital-based resources to use with appropriate clients. In conclusion, the main purpose of this scholarly project was to create a product that would be an educational resource for occupational therapy personnel about the unique needs of Somali refugees.

To gain access to the entirety of the product, *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice*, contact the author:

Dominique Menard

dominiquemenard7@gmail.com

Chapter V: Summary

Chapter V Summary consists of an overview of the entirety of the project and subsequent sections. The strengths and limitations of the completed product are described as well as suggestions for continued development and research. Included are recommendations for use and implementation of the product in physical disabilities healthcare settings.

Overview

The purpose of this scholarly project is to increase occupational justice for Somali refugees by providing culturally responsive clinical approaches for use by occupational therapy personnel. This scholarly project explored the history and culture of the Somali refugee population, potential occupational preferences, and hospital-based resources to use with the population. A needs-based literature review, as well as consultation with clinicians who work with the population, was conducted to gather information about best practices with the Somali refugee population in a healthcare setting. The majority of the current literature found that the Somali refugee population experiences many of the same inequities that other refugees experience, including limited understanding of the host nation's healthcare system, poor comprehensive and functional health literacy, gender taboos resulting in a mismatch of providers and/or interpreter preferences, discrimination, and limited cultural competence of providers (Eklöf et al., 2019; Fang et al., 2015; Gele et al., 2016; Houston et al., 2021; Njenga, 2022; Wångdahl et al., 2018).

Strengths and Limitations

Strengths

One of the greatest strengths of this guide is that it is the first Somali refugee-specific resource of its kind. There are currently no other guides that are occupational therapy specific

that are about the Somali refugee population. Further, many of the resources that informed the development of the product were from Somali authors or Somali resource bases. Lastly, the resource guide contains reflective aspects that aid clinicians in examining their cultural biases and challenges them to progress their cultural competency with the Somali population. These reflective aspects are not static but rather depend on the user of the guide to be an active learner in the process. Being an active learner is best practice when considering diversity-based topics, so this is also a strength for this product.

Limitations

Although this is a fairly comprehensive guide, the history and cultural sections are only a brief glimpse into the history and culture of the population. There are more aspects of the history and culture that make up the population; however, for reasons of length and usability, only the most important aspects were included in the guide. Additional resources were included throughout for independent exploration of the history and culture of the population. Another limitation was that the author found a limited amount of current evidence on refugees relating to the occupational therapist's role with the Somali refugee population, especially in hospital-based settings. Lastly, author biases, like not identifying as Somali, could act as a barrier.

Recommendations for Use

The implementation of this reflective resource guide can occur in several different ways. It was designed to facilitate understanding of the Somali refugee population who receive occupational therapy services in a hospital setting. The author made the resource guide in a way that allows participants to utilize it as thoroughly as desired. The guide is sequential, however, if a participant needs specific information, they can easily jump to that part of the guide quickly. The manual is beneficial to occupational therapists, certified occupational therapy assistants, and

occupational therapy students. It provides a background of the Somali refugee population and provides information on occupational preferences, and resources to use in a hospital-based setting. Lastly, it is important to note that no one strategy will work with all clients.

Recommendations for Future Research

This section consists of recommendations for further research or action that occupational therapy personnel can implement to help improve the quality of care that Somali refugees receive. These are a few recommendations, of many, that can be acted upon.

- Further quantitative and/or qualitative research on the unique needs of Somali refugees in the U.S. healthcare setting is indicated. This could include occupational therapy-specific interventions with Somali refugees, the effectiveness of healthcare services within the United States for Somali refugees, and resettlement experiences in the United States (including overall experiences with the healthcare system).
- Advocating for the unique needs of the Somali refugee population is recommended in healthcare and community settings. This could lead to additional and/or more specific program development, emerging areas of occupational therapy, and an increased level of culturally appropriate care.
- It is recommended that *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice* be tested in practices other than that of the original partnering facility.

Conclusion

Even though limitations of this scholarly project exist, the importance of the project was clear through the lack of an existing comprehensive reflective resource guide on Somali refugees for guiding occupational therapy practice. The increasing number of Somali refugees in the

United States, and therefore the increased need for healthcare services, is an indicator of the need for action to support this population. Occupational therapy personnel have the responsibility to provide culturally responsive approaches in all encounters with the Somali refugee population.

In summary, this scholarly project presents *The Newly Arrived Client: Applying Culturally Responsive Occupational Therapy Approaches to the Refugee Population to Promote Occupational Justice;* the product is a reflective resource guide for occupational therapy personnel. This gives occupational therapy personnel more context to past situations that Somali refugees experience, understand how occupations may differ from the traditional "westernized" occupations typically seen in practice, and provide additional resources to support the population during hospitalizations. Overall, this resource will not only help Somali refugees have more successful interactions with occupational therapy personnel in hospital settings but will also increase independence in their daily occupations upon discharge.

References

Alwan, R. M., Schumacher, D. J., Cicek-Okay, S., Jernigan, S., Beydoun, A., Salem, T., & Vaughn, L.M. (2020). Beliefs, perceptions, and behaviors impacting healthcare utilization of Syrian refugee children. *PLOS One.* https://doi.org/10.1371/journal.pone.0237081

American Occupational Therapy Association [AOTA]. (2020). Occupational therapy practice framework: Domain and process (4th ed.). *American Journal of Occupational Therapy*, *74*(Suppl. 2), Article 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

Abraham, R., Leonhardt, M., Lien, L., Hanssen, I., Hauff, E., & Thapa, S. B. (2021). The relationship between religiosity/spirituality and quality of life among female Eritrean refugees living in Norwegian Asylum Centres. *International Journal of Social Psychiatry*, *68*(4), 881–890. https://doi.org/10.1177/00207640211010207

Ballentyne, S., Drury, J., Barrett, E., & Marsden, S. (2021). Lost in transition: What refugee post-migration experiences tell us about processes of social identity change. *Journal of Community & Applied Social Psychology*, *31*(5), 501–514. https://doi.org/10.1002/casp.2532

Briese, P., Evanson, T., & Hanson, D. (2020). Application of Mezirow's Transformative Learning Theory to simulation in healthcare education. *Clinical Simulation in Nursing*. https://doi.org/10.1016/j.ecns.2020.08.006

Black, R. M. (2019). Culture, diversity, and culturally effective care. In B. A. Boyt Schell & G. Gillen (Eds.), *Willard and Spackman's occupational therapy* (13th ed., pp. 223-239). Wolters Kluwer.

Brickhill-Atkinson, M., & Hauck, F. R. (2021). Impact of covid-19 on resettled refugees. *Primary Care: Clinics in Office Practice*, *48*(1), 57–66. https://doi.org/10.1016/j.pop.2020.10.001

Bucher, R. (2015). *Diversity consciousness: opening our minds to people, cultures, and opportunities* (4th ed.). Pearson.

Centers for Disease Control and Prevention. (2020). *Infographic: 6 guiding principles to a trauma-informed approach*. https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

Centers for Disease Control and Prevention. (2021). *Somali Refugee Health Profile*. Centers for Disease Control and Prevention. https://www.cdc.gov/immigrantrefugeehealth/profiles/somali/index.html

Centers for Disease Control and Prevention. (2022). *What is health literacy?* https://www.cdc.gov/healthliteracy/learn/index.html

Cole, M. B., & Tufano, R. (2020). *Applied theories in occupational therapy: A practical approach*. Slack Incorporated.

County Health Rankings & Roadmaps. (n.d.) *Health Literacy Interventions*. https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/health-literacy-interventions

Cummings, M. (2021, November 18). *Study: Poverty, not trauma, affects cognitive function in refugee youth*. YaleNews. https://news.yale.edu/2019/10/24/study-poverty-not-trauma-affects-cognitive-function-refugee-youth

Culture Care Connection. (2022). *Somali*. https://culturecareconnection.org/cultural-responsiveness/somali/

Darawsheh, W. B. (2019). Exploration of occupational deprivation among Syrian refugees displaced in Jordan. *The American Journal of Occupational Therapy*, *73*(4). https://doi.org/10.5014/ajot.2019.030460

Eklöf, N., Hupli, M., & Leino-Kilpi, H. (2019). Factors related to privacy of Somali refugees in Health Care. *Nursing Ethics*, *27*(2), 514–526. https://doi.org/10.1177/0969733019855748

Fang, M. L., Sixsmith, J., Lawthom, R., Mountian, I., & Shahrin, A. (2015). Experiencing 'pathologized presence and normalized absence'; understanding health related experiences and access to health

care among Iraqi and Somali asylum seekers, refugees and persons without legal status. *BMC Public Health, 15*(1). https://doi.org/10.1186/s12889-015-2279-z

Frounfelker, R. L., Mishra, T., Dhesi, S., Gautam, B., Adhikari, N., & Betancourt, T. S. (2020). "We are all under the same roof": Coping and meaning-making among older Bhutanese with a refugee life experience. *Social Science & Medicine, 264*, 113311. https://doi.org/10.1016/j.socscimed.2020.113311

Gele, A. A., Pettersen, K. S., Torheim, L. E., & Kumar, B. (2016). Health literacy: The missing link in improving the health of Somali immigrant women in Oslo. *BMC Public Health, 16*(1). https://doi.org/10.1186/s12889-016-3790-6

Harrison, E. A., & Mirza, M. (2019). *Occupational therapy across languages: Working with interpreters to ensure effective and ethical practice*. American Occupational Therapy Association. https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CE_article_July_2019.pdf

Hennepin Healthcare. (2019). *Hennepin Healthcare community health needs assessment 2019*. https://www.hennepinhealthcare.org/wp-content/uploads/2020/01/2019-Community-Health-Needs-Assessment-2020-2022-Community-Health-Needs-Assessment-Implementation-Plan-Health-Services-Plan.pdf

Houston, A. R., Lincoln, A., Gillespie, S., Da Fonseca, T., Issa, O., Ellis, H., & Salhi, C. (2021). You have to pay to live: Somali young adult experiences with the U.S. health care system. *Qualitative Health Research*, *31*(10), 1875–1889. https://doi.org/10.1177/10497323211010159

Huot, S., Kelly, E., & Park, S. J. (2016). Occupational experiences of forced migrants: A scoping review. *Australian Occupational Therapy Journal*, *63*(3), 186–205. https://doi.org/10.1111/1440-1630.12261

Im, H., Ferguson, A., & Hunter, M. (2017). Cultural translation of refugee trauma: cultural idioms of distress among Somali refugees in displacement. *Transcultural Psychiatry*. https://doi-org.ezproxylr.med.und.edu/10.1177/1363461517744989

Ingiriis, M. H. (2016). *The suicidal state in Somalia: The rise and fall of the Siad Barre regime, 1969-1991*. University Press of America.

Jacobs, R. J., Lou, J. Q., Ownby, R. L., & Caballero, J. (2016). A systematic review of eHealth interventions to improve health literacy. *Health Informatics Journal.* https://doi.org/10.1177/1460458214534092

Joseph, L., Ismail, S. A., Gunst, M., Jarman, K., Prior, D., Harris, M., & Abbara, A. (2020). A qualitative research study which explores humanitarian stakeholders' views on healthcare access for refugees in Greece. *International Journal of Environmental Research and Public Health*. https://doi.org/10.3390/ijerph17196972

Khan, S. A., Kanji, Z., Davis, J. A., & Stewart, K. E. (2021). Exploring occupational transitions of Syrian refugee youth to Canada. *Journal of Occupational Science*, 1–18. https://doi.org/10.1080/14427591.2021.1975557

Law, M., Cooper, B. A., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The person-environment-occupation model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9-23.

Lebano, A., Hamed, S., Bradby, H., Gil-Salmeron, A., Dura-Ferrandis, E., Garces-Ferrer, J., Azzedine, F., Riza, E., Karnaki, P., Zota, D., & Linos, A. (2020). Migrants' and refugees' health status and healthcare in Europe: A scoping literature review. *BMC Public Health*. https://doi.org/10.1186/s12889-020-08749-8

Mangrio, E., & Forss, K. S. (2017). Refugees' experiences of healthcare in the host country: A scoping review. *BMC Health Services Research.* https://doi.org/10.1186/s12913-017-2731-0

Mezirow, J. (1991). *Transformative dimensions of adult learning*. Jossey-Bass Higher and Adult Education Series.

Miller, K. K., Brown, C.R., Shramko, M., & Svetaz. M.V. (2019). Applying trauma-informed practices to the care of refugee and immigrant youth: 10 clinical pearls. *Children on the Move: The Health of Refugee, Immigrant, and Displaced Children*. https://doi.org/10.3390/children6080094

Njenga, A. (2022). Somali refugee women's experiences and perceptions of western health care. *Journal of Transcultural Nursing*, *34*(1), 8–13. https://doi.org/10.1177/10436596221125893

Radl-Karimi, C., Nielsen, D. S., Sodemann, M., Batalden, P., & von Piessen, C. (2022). "When I feel safe, I dare to open up": Immigrant and refugee patients' experiences with coproducing healthcare. *Patient Education and Counseling*. https://www-clinicalkey-com.ezproxylr.med.und.edu/#!/content/playContent/1-s2.0-S0738399121007291?scrollTo=%23top

Rashoka, F. N, Kelley, M. S., Choi, J., Garcia, M. A., Chai, W., & Rashawka, H. N. (2022). "Many people have no idea": A qualitative analysis of healthcare barriers among Yazidi refugees in the midwestern United States. *International Journal of Equity in Health*. https://doi.org/10.1186/s12939-022-01654-z

Robertshaw, L., Dhesi, S., & Jones, L. L.(2017). Challenges and facilitators for health professionals providing primary healthcare for refugees and asylum seekers in high-income countries: A systematic review and thematic synthesis of qualitative research. *BMJ Open.* https://doi.org/10.1136/bmjopen-2017-015981

Rojo, J., Ramjan, L., George, A., Hunt, L., Heaton, L., Kaur, A, & Salamonson, Y. (2023). Applying Mezirow's Transformative Learning Theory into nursing and health professional education programs: A scoping review. *Teaching and Learning in Nursing*. https://doi.org/10.1016/j.teln.2022.09.013

Schick, M., Zumwald, A., Knöpfli, B., Nickerson, A., Bryant, R. A., Schnyder, U., Müller, J., & Morina, N. (2016). Challenging future, challenging past: The relationship of social integration and psychological impairment in traumatized refugees. *European Journal of Psychotraumatology*, *7*(1), 28057. https://doi.org/10.3402/ejpt.v7.28057

Siddiqui, S. M., Said, E., Hanna, B., Patel, N. H., Gonzalez, E. L., Garrett, S. L., Hilton, C. L., & Aranha, K. (2019). Addressing occupational deprivation in refugees: A scoping review. *Journal of Refugee & Global Health*, *2*(1), 1–5. https://doi.org/10.18297/rgh/vol2/iss1/3

Substance Abuse and Mental Health Services. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Tengilimoglu, D., Zekioglu, A., Budak, F., Eris, H., & Younis, M.(2021). Refugees' opinions about healthcare services: A case of Turkey. *Healthcare (Basel, Switzerland)*. https://doi.org/10.3390/healthcare9050490.

The Organization for World Peace. (2022). *Somali Civil War*. The Organization for World Peace. https://theowp.org/crisis_index/somali-civil-war/

The UN Refugee Agency. (n.d.). *Somalia refugee crisis explained*. https://www.unrefugees.org/news/somalia-refugee-crisis-explained/

Tomkow, L., Kang, C. P., Farrington, R. L., Wiggans, R. E., Wilson, R. J., Pushkar, P., Tickell-Painter, M. C., Lee, A. R., Whitehouse, E. R., Mahomood, N. G., Lawton, K. M., & Lee, E.C. (2019). Healthcare access for asylum seekers and refugees in England: A mixed methods study exploring

service users' and health care professionals' awareness. *European Journal of Public Health.* https://doi.org/10.1093/eurpub/ckz193

Trimboli, C., & Taylor, J. (2016). Addressing the occupational needs of refugees and asylum seekers. *Australian Occupational Therapy Journal*, *63*(6), 434–437. https://doi.org/10.1111/1440-1630.12349

United Nations. (n.d.). *Refugees*. United Nations. https://www.un.org/en/global-issues/refugees

United Nations High Commissioner for Refugees [UNHCR]. (n.d.). *What is a refugee?* UNHCR. https://www.unhcr.org/en-us/what-is-a-refugee.html

Wangdahl, J., Lytsy, P., Martensson, L., & Wersterling, R. (2018). Poor health and refraining from seeking healthcare are associated with comprehensive health literacy among refugees: A Swedish cross-sectional study. *International Journal of Public Health.* https://doi.org/10.1007/s00038-017-1074-2

World Health Organization. (2022). *Refugee and migrant health*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/refugee-and-migrant-health