Abstract
Towards a Framework for Addressing Immigrants’ Social Determinants of Health
Addressing Differential Impacts of COVID-19 in NYS

ABSTRACT

This study seeks to adapt and validate the National Institute of Minority Health Disparities Research Framework to immigrant communities who are culturally and linguistically diverse, defined in this study as foreign-born individuals who are Limited English Proficient. The Immigrant Social Determinants (ISD) Framework depicts the multidimensional, multilevel, intersectional, and complex factors that shape health outcomes across the lifespan. The framework for addressing health disparities posits that health outcomes are shaped by the interplay between determinants related to the (a) behavioral; (b) biological; (c) political and socio-cultural; (d) physical built environment, and (e) healthcare system forces. These determinants operate at four levels of influence: individual, interpersonal, community, and societal. Adaptation and validation of the Framework will deepen understanding of the interplay of these forces in the lives of members of immigrant communities, illuminate levers of change, inform the development and implementation of effective interventions, and track progress and success in alleviating disparities.

In this study, we adapt the framework based on a systematic review of literature, and then we validate the framework using the perspectives of health and social service providers who serve immigrant individuals and their communities. Data are gathered using (a) a survey of healthcare professionals; and (b) focus groups of healthcare, social service providers, and community leaders. Following the validation of the framework, we provide recommendations for policy and practice.

Validating the framework through the prism of healthcare professionals’ perspectives leverages a moment in time during a global pandemic that exposed vulnerabilities at all levels of influence and domains and that allows us to capture the determinants of health affecting culturally and linguistically diverse immigrant communities. Policy and practice recommendations will specify interventions at the moderators and mediators’ levels that can bring about positive health outcomes for immigrant individuals.


I. **INTRODUCTION**

Culturally and linguistically Diverse immigrant communities, defined as foreign-born individuals who speak diverse languages and hold diverse cultural belief systems and practices tend to experience negative health outcomes when compared with their native-born counterparts. Those negative health outcomes are largely socially produced and could have been avoided. Various vulnerabilities stem from a range of complex and intersecting variables, including structural stratifications, lower access to social and human capital, limited community resources, stigma, marginalization, and adverse public policies that restrict access to health insurance and publicly funded safety net programs. Vulnerabilities lead to a lower rate of healthcare utilization and poor physical, psychological, and social health outcomes.

Social determinants of health are socially produced, avoidable differences in health status. There is wide consensus that to address health inequities, one must tackle non-medical conditions in which people are born, grow and age. The National Institute of Minority Health Disparities (NIMHD) provides a framework that depicts the multidimensional, multilevel, intersectional, and complex factors that shape health outcomes across the lifespan. The framework for addressing minority health disparities posits that health outcomes are shaped by the interplay between determinants related to the (a) behavioral; (b) biological; (c) political and socio-cultural; (d) physical built environment, and (e) healthcare system forces. These determinants operate at four levels of influence: individual, interpersonal, community, and societal. The framework underscores the multi-level and intersecting factors that are determinants of health and wellbeing for minority populations and emphasizes the need for assessing these factors along the four domains and along with the micro, meso, and macro levels of influence to fully understand causes and symptoms that generate health disparities and that shape individual, family, organizational, community, and population health outcomes across the lifespan. Understanding the interplay of these factors in culturally and linguistically diverse immigrant populations’ lives illuminates the levers of change that can be used and inform the development and implementation of effective interventions at the policy, community, and practice levels.

II. **METHODS**

In this study, we adapt the ISD Framework based on a review of literature. Then we validate it using the perspectives of a group of health and social service providers who serve culturally and linguistically diverse immigrants. Data were gathered using (a) a survey of frontline healthcare and social service providers, and (b) focus groups of healthcare and social service providers and community leaders. We reviewed the literature regarding immigrant communities and the survey of frontline providers. The literature reviewed included research articles and practice publications produced from 2011 to the present. The survey was conducted electronically in October 2020 through Survey Monkey and yielded 202 responses from healthcare
professionals. We conducted three focus groups in May 2021 with healthcare professionals. We provide recommendations for policy and practice.

This study used deductive qualitative research proposed by Pearse (2019) which relied on theoretical frameworks derived from literature as a starting point. The National Institutes of Health framework served as our starting point. A review of literature revealed key variables and connected elements of the framework as they related to culturally and linguistically diverse immigrant individuals and communities. We identified interrelationship among variables and constructs and determined information that we needed to collect and analyse. We then identified assumptions and propositions based on the theoretical framework’s dimensions, delineated relationships between dependent and independent variables, created a code book for the variables and aligned survey and focus group questions against the variables we identified. After data was collected, we matched codes that appear in the data and connected codes to one another. We identified patterns within the data (Braun & Clarke, 2006), looked for evidence in the data of the patterns articulated in the propositions, compared the datasets with the framework and kept a record to confirm that the theory fits the data (Hyde, 2000). We moved back and forth between the data set and the literature. Our data analysis enhanced our theoretical framework, and our theoretical approach further informed our thematic analysis (Braun and Clark 2006) by illuminating subtle aspects of the data.

III. FINDINGS

Recruitment of focus group participants was conducted through the listserv of the Society of Refugee Providers. Participants represented 6 states: Virginia, Oregon, Illinois, Minnesota, Nevada, North Carolina. All participants were women. Participants provided direct services to refugee and immigrant families in a variety of capacities including co-director of a volunteer organization providing refugee services; postdoctoral fellow at School of Medicine; licensed clinician providing mental health and other behavioral health services; state refugee health coordinator; provider at an international family medicine clinic; assistant professor of nursing; medical social worker; coordinator of medical care at a refugee resettlement agency; medical case manager at a resettlement agency; refugee care coordinator for survivors of torture; AmeriCorps member serving with the International Rescue Committee; physician, professor and researcher at an international medicine clinic.

Our adaptation and validation of the model produced the following findings:

1. Biological
   • Genetical and Environmentally Determined Conditions

Biological determinants of health and wellbeing are conditions that individuals are genetically pre-disposed to, and although difficult to avoid, an individual’s response to them may be socially determined. The biological dimension encompasses two elements: genetic predisposition to certain diseases and environmentally induced diseases. Sickle cell anemia and
diseases seen more commonly with Ashkenazi Jews are examples of biological predisposition. Most biological ailments, however, are environmentally induced through exposure to mental and physical stress and violence in the pre- and post-migration periods. Often, immigrants arrive from countries with a prevalence of hepatitis B. According to a physician specialized in refugee and immigrant health who participated in the focus group “refugees and immigrants who are from countries with more than two percent prevalence rate have much higher rates of being hepatitis B carriers and dying of cirrhosis or liver cancer.”

Living in refugee camps for long periods of time is a risk factor for many conditions. A social worker and service provider in the focus groups summarized these conditions: “Some of them come here after 20 years in the refugee camp...the majority comes with high blood pressure and diabetes. Living in war and conflict torn countries and experiencing physical trauma and torture are biological determinants. Prevalent physical conditions may include epilepsy (a result of torture, “because there's a lot of beating on the head”), stress disorder, chronic pain from internalized trauma, psychosis, and obsessive-compulsive disorder (OCD).” She attributed early onset of stress-induced chronic disease such as diabetes to trauma and stress which alter the way the body processes glucose.

The mind-body connection is powerful, and distress on one front induces ailments on both fronts. Another focus group participant stated that “all of our clients cannot sleep... either because they have nightmares or because they are afraid of falling asleep which also affects them physically when they are sleep deprived.”

When providers are not aware of clinical issues connected to countries of origin, such lack of knowledge and lack of cultural humility to seek knowledge often led to devastating health outcomes. Parasites and malaria are examples of diseases that immigrants often carry. A Focus group participants explained: “If I was speaking to young resident physicians about being culturally humble with their patients around their kidney disease. You know, they probably roll their eyes and say, I'm a kind doctor. I'm a good listener. And that's not what I'm talking about. I'm talking about do you know that chronic kidney disease in Southeast Asia in part, is related to a very high prevalence of systemic lupus? I'm talking about a clinical knowledge.”

2. **Behavioral**

Health-seeking behaviors and attitudes are critical to health outcomes. These behaviors are influenced by a range of mediators:

- **Pre and Post Migration Characteristics**
  Human capital, pre-migration characteristics, age at arrival length of stay can serve as risk or protective factors. Existing research documents the association of productive assets such as English language proficiency and educational attainment with health literacy, access to health insurance, poverty, and access to resources whether legal or social. Similarly, pre-migration characteristics can shape post-migration outcomes. If an immigrant has arrived as a refugee from a war-torn country, psychological trauma may require more integration labor than
someone who has not endured the same experiences. Furthermore, age at arrival and length of stay are associated with acculturation, level of income, and educational level. Early arrival and longer stay may allow for a greater potential for acculturation, language acquisition and educational attainment. Late age migration has a wage penalty. It also matters which country one migrates from since it may influence educational preparation and language acquisition.

Behavioral determinants of health are influenced by socialization into positive healthcare norms. Socialization is also shaped by where one comes from and when. Arriving at a younger age helps with the acclimation process. “Younger people are generally able to do better, tend to learn English sooner, are able to acclimate a little faster and sooner. The middle aged and older tend to have more problems in acclimating, and more health concerns either when they arrive, or they develop (when they live for a period of time in the U.S).” Older women with lower education are more prone to health problems.

- Lack of Awareness of Preventive medicine and Systems of Care
A preventive system of care is often a foreign and misunderstood concept. Individuals may forgo preventive medicine, especially when notions of fatalism and destiny dominate one’s thinking. They may choose to seek medical interventions only when conditions worsen, increasing the cost of care. Focus group participants reflected on refugee and immigrant patients’ healthcare seeking behaviors. They attributed the tendency to be less active in seeking healthcare to lack of familiarity with the notion of a healthcare system and skepticism about the concept of preventive care. In some regions of the world, there is an absence of a healthcare infrastructure. “Some come with chronic disease or disease that were never diagnosed because of where they grew up. A lot of them have never seen an Ob Gyn.” Preventive medicine is not a concept generally widespread in a lot of the different places and certainly not in places where refugees were transiting. “They don’t come here with the mindset of seeking preventive health...They are being used to the fact that I can go to the doctor when I'm not feeling great, if it's not an emergency or if it hasn't escalated to something that I feel is critical. A lot of times adults and parents don't often go to the doctor until something is very, very wrong.” There is also the fear that preventive care would reveal a serious disease and would constitute “a death sentence” and a lack of awareness that preventive medicine is a tool to prevent serious disease.

Participants argued that outlook on preventive care is also influenced by the context of countries of origin where oftentimes, cancer is always a fatal illness because of the absence of proper care and high fatality rates. Participants contended that it is not fatalism per se that make immigrants shun healthcare, but it is pre-migration norms and contextual forces that shape outlooks on disease and healthcare. “A patient may absolutely not want to do routine screening for cancer because of the tremendous fear of finding a cancer. A participant referred to a survey her facility conducted where 19 out of 20 participants indicated that they would not want to find a cancer or seek treatment for it. They equated a cancer screening with a death
sentence. Once these same people knew that some cancers can be cured if detected early, 19 out of 20 welcomed the screening.”

- Mental Health stigma
Cultural and social stigma against seeking mental health may hinder wellbeing with potentially devastating impacts on the ability to pursue activities that would provide paths to self-sufficiency and access to opportunity structures and resources.\(^\text{41}\) Study participants alluded to experiences they had with patients who are only willing to discuss physical symptoms but are apprehensive about discussing mental health illnesses that may have caused physical illnesses: “A wall goes up when we suggest that unexplained physical symptoms may be caused by past trauma.”

Several focus group participants described the stigma of mental healthcare in many immigrant communities. There is significant resistance to accepting treatments for mental health problems that manifest themselves in physical form. The rejection of mental health treatment is seen as a challenge given the magnitude of mental distress and emotional disability that permeate into all aspects of their lives including the ability to hold a job. The problem is intensified because victims of trauma including kidnapping, torture and gang violence are not reporting these experiences for fear it will bring shame to their families. The lack of data complicates understanding of the magnitude of the problem.

According to a focus group participant, who serves as a provider at an international family medicine clinic, “We see a lot of young women, even as young as twenty coming in with multiple aches and pains, headaches, back pain everywhere... It’s a huge challenge for us to sort through the mind body connection and try to work up things from the biological side, but also move into the behavioral and work with folks about what their behavioral and mental health issues are doing to their bodies and coming up with ways to help them overcome their pain and their difficulties.” She also mentioned that “We never use words like depression or PTSD or any terminology that could be stigmatizing. We try to work within their framework so that they’re not feeling that it could lead to stigma and then they can tell their families whatever they want because they say, I’m going to family medicine. They don’t have to say I’m seeing the psychiatry department or whatever. It’s just a little bit easier overall.”

- Devaluing of Mental Health
Commitment to ongoing counseling is a challenge for many families because there is a lack of value placed on “talk therapy” and there are difficulties in balancing multiple demands on their time, taking time off and meeting basic survival needs of a family. “It’s really hard to talk to (them) about their depression and anxiety when they’re worried about putting food on the table and they’re worried about being evicted.”

- Prevalence of Harmful behaviors
Individuals may engage in risk behaviors such as drug abuse, drinking, and other unhealthy habits, or they may engage in protective and healthy behaviors including exercise and accessing
support systems that soften the blows of the experience of being uprooted, and enable the
development of coping skills. Cultural attitudes toward health and health seeking may chart
paths toward better or worse health outcomes.

Several harmful and risky behaviors are widespread in certain immigrant communities. For example, tobacco use is an overt behavioral issue that is more prevalent in some areas of the world and is one of the single biggest killers including smokeless tobacco in refugee and immigrant communities. High rates of alcohol use are also recorded in some immigrant communities. Behavioral issues around substance abuse vary by patient population.

According to a focus group participant “many members of immigrant communities shun exercise...The idea of going for a run to exercise would make everyone laugh at you because you're so busy working outside all day. So that dramatic change from being quite physically active to physically inactive in the US is a very significant behavioral driver.”

The devaluing of exercise becomes significant considering prevalence of obesity in some communities. There is also a tendency to overfeed children, including infants, resulting in more childhood obesity.

- Prevalence of Stereotypes about Healthcare Systems and Providers
  Trust in healthcare providers and the healthcare system is often dependent on securing a
  senior provider and accessing a private healthcare system. In countries of origin, seniority is
  associated with increased expertise and experience and public healthcare systems are
  associated with dysfunction, disarray and inferior care. These ideas adopted in countries of
  origin can create bias, low confidence, and lack of trust in some immigrant communities.

- Traditional Gender Norms, Roles and Relations
  Focus group participants argued that patriarchal gender norms serve as risk factors that hinder
  positive health seeking behaviors in several ways. The de-prioritizing of self-care, self-
  development, independent decision-making, and economic self-sufficiency by women is a
  hallmark of gendered social structures. Women’s identity in a traditional gender structure is
  intimately tied with the home and the care of children and family. Women’s role in the home
  traditionally limits them from accessing social and economic opportunities in the public sphere,
  such as benefiting from direct healthcare services, English language programs, workforce
  development and other social services. These services can help them more effectively navigate
  life in their new adopted country. A stark example provided by a participant is that of an
  immigrant woman who refused to acquire the COVID-19 vaccination for fear of subsequent
  symptoms and of being unable to care for her family as she recovers from the effects of the
  vaccine.

Participants also echoed the potential harmful impacts of women’s deference to men in their families. They expressed concerns that when men speak for women, answer questions, and make decisions, whether related to personal health or other factors with regards to how the
household is managed financially or otherwise, there is a lot of doubt as to whether these women are accessing quality healthcare that correspond to their personal needs and desires.

The prevalence of fear, anxiety and depression in many immigrant women’s communities is often a direct outcome of isolation imposed by traditional gender structures that may intersect with low language proficiency and cut women off from their adopted society. Employment opportunities in a traditional gendered family are not open for women. Even when women have higher educational attainment and language proficiency than the men in their families, they do not seek employment opportunities since those conflict with traditional gendered roles and relations. “Sometimes we’re really up against the partner who is insistent that she cannot learn English. She needs to be home. I'll work two shifts... Some of the strong traditions of their families and culture is very difficult to break through... The partner says sometimes that we interfere in the family’s way and putting ideas on the woman's head or things like that.”

Participants cautioned that it matters where immigrants lived in the pre-migration phase. Patriarchal norms are less pronounced in urban than rural areas. Women tend to be employed and healthcare systems are in better shape in the former.

3. Political and Socio-Cultural

Social stratification and hierarchical structures are dominant in our society, so is the construction of social ideologies that legitimates discrimination against different groups and limits access to opportunity structures. Social identities constructed along the lines of race and gender intersect in the lives of members of immigrant communities and serve as social determinants of health outcomes. For immigrant members, race, gender, and other social identifiers can destine them unfairly to a life of poverty and limit their access to resources and opportunities. Xenophobia and its intersections with racism and sexism can subject immigrants to discriminatory practices that affect their access to equitable health outcomes.

- Systematic Racism and Xenophobia

Racism is a public health crisis. It is a powerful social determinant of health. Having a darker skin color is associated with an earning penalty, lower earning, underemployment, increased poverty in many studies even when controlling for language and education. A wage gap between immigrant women and their male counterparts reveal that gender influences outcomes. Social identities instead of merit and qualifications determine wages, and the intersections of nativity status, race and gender can exacerbate wage disparities in the lives of many foreign-born.

Focus group participants argued that systemic racism is still is a huge issue in terms of caring for refugees and immigrants. The negative rhetoric in the US, particularly with the last administration, made people seek invisibility. “We saw people who not just with covid, but before covid just stopped coming into the clinic because they were fearful about how they
would experience the health care system. Patients feel they don't have a place they can go that is trustworthy and respectful of them ... that contributes to poor health outcomes.”

In the communities, there is often a negative reception of immigrants and refugees where “clients were physically assaulted in the street. Their veils were removed. They were spat on. They were emboldened during the last four years to do whatever they wanted. Our clients were very scared, especially women.” An unhealthy competition often arises among foreign and native born over services provided: “I've had African refugees in public housing who were feeling threatened by the Americans because they felt that they were getting better treatment, like they were getting services from the aid agencies.” Refugees and immigrants face discrimination in schools and while accessing basic services.

**• Deskilling of Refugees and Immigrants**
Deskilling is a common phenomenon experienced by refugees and immigrants. Skills gained in the home country may not be easily transferable to the host country. Lack of English proficiency may be a culprit in the inability to find comparable jobs. Additionally, refugees, are directed to areas where the economy cannot accommodate their skills. “We’re a smaller city, our employment options for families are pretty much service-related for working in hotels, working at the hospital.” Pressure to provide for their families forces refugees and immigrants to accept jobs that do not utilize their skills and talents and do not leave time for workforce development opportunities. The loss of social and economic status becomes a source of stress, dismay, and frustration for many. “They lose the respect within the family, especially the men. They feel ... emasculation...they feel that they lose the authority. And so, there's a lot of depression caused by that.” Furthermore, refugee resettlement focuses exclusively on self-sufficiency and employment of new arrivals at often fails to integrate health and wellness services.

**• Implications of “Dirty, Dangerous and Difficult” Occupations**
Furthermore, immigrants tend to be employed in “dirty, dangerous and difficult jobs” including construction work. They must work in “one hundred and sixteen degrees throughout all summer and (are) exposure to UV and potential for injury. These are populations that may not have health insurance and are not going to seek care.” For some immigrants, jobs that require physical effort can exacerbate physical and mental trauma experienced in pre migration.

**• Harmful Federal, State and Local Policies**
Policies that stigmatize, block access, and limit opportunities are extremely adverse determinants of health outcomes. Policies related to access to public benefits, labor, housing, and documentation have an enormous impact. Immigrants who do not have documentation have lower socio-economic status, wage penalties, higher poverty rates, and are reluctant to seek medical attention.xvi

There is no doubt that the lack of documentation impacts health and wellbeing for many immigrants. It hinders access to full employment and benefits: “during the previous administration, the fear public benefit was really great.” Participants witnessed declining
services and enrollment into state benefits because and reflected on the value of “sanctuary cities” and how it served as a “protective factor for health” where there was documented uptake of HIV screening rates and HIV prevention services.

4. Physical Built Environment

This dimension constitutes the community in which immigrants settle. There are three mediators of health outcomes in this dimension: neighborhood poverty, spatial segregation, and the context of community reception.

- The Concentrated Effects of Poverty

Poverty is strongly associated with several negative individual outcomes including infant mortality, low birth weight, child maltreatment, teenage pregnancy and parenthood, high school drop-out rates, suicide, and violence. Furthermore, it curtails the ability of communities to build sustainable social organizations to advance collective interest and community wellbeing. Poverty has a concentration effect. When one lives in a poorly resourced neighborhood, it affects educational quality, economic outcomes, and access to social services and other resources.

Living in ethnic enclaves can be a double-edged sword. It can reinforce separation from native-born communities, limiting language acquisition and acculturation as well as restricting access to bridging social capital (i.e., social capital that connects to the economy and open windows to employment). On the other hand, ethnic enclaves may provide immigrants with the needed support that immigrants require, and provide access to jobs. Spatial segregation often fuels fear of difference, prejudice, bias, and stereotyping. The lack of social cohesion among community members can create community fragmentation, community disengagement, and disorganization. Spatial integration tends to normalize difference and improve the context of reception. A supportive social reaction to immigrants and a welcoming community climate accelerates integration and positively influences health.

- Lack of Safe Affordable Housing and Accessible Transportation

Participants expressed profound frustration pertaining to the absence of affordable and safe housing for immigrants. Housing is a social determinant of health when residents fear leaving their homes and being exposed to violence and illegal activities: “our population always lives in the worst neighborhood (with) lot of a violence, which triggers other trauma that they suffered.” Inability to access social services and physical exercise affects health outcomes. Challenges with unsanitary housing were among the serious concerns raised by participants, including presence of bedbugs, rats, mold, food deserts and lack of green space. The implications include high levels of asthma and other diseases.

Lack of access to transportation often plagues those living in low-income housing which in turn hinders access to healthy food outlets and social services needed by immigrant and refugee
communities. Unsafe pedestrian crossings were responsible for traffic accidents and adults who must navigate streets by foot and public transportation.

5. **Healthcare System**

The healthcare system serves as a social determinant of health outcomes for immigrants.

- **A Legally Non-Compliant Healthcare System**

  Providing culturally and linguistically appropriate healthcare services takes more than just providing language assistance services. It takes changing every element of the system to become responsive to the needs of the immigrant patient, especially those who are culturally and linguistically diverse. The mediators and moderators are elements of the system where integration of needs must occur if a sustainable, consistent and solid system is sought. Federally mandated Culturally and Linguistically Appropriate Standards (CLAS) call for the provision of “effective, equitable, understandable, and respectful quality care and services that are responsive, to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs”.\textsuperscript{xii} CLAS mandates responsive governance, leadership and workforce, effective communication and language assistance mechanisms and continuous engagement improvement and accountability. Lack of cultural and linguistic concordance leads to many adverse health outcomes including restricted access to preventive care, denial of and delays in receiving care, lack of shared decision making and informed consent, compromised patient safety, medical misdiagnosis, legal liabilities, and adverse health outcomes.\textsuperscript{xii, xiii}

  Our survey findings revealed that during the pandemic, many healthcare facilities were not able to provide language assistance. Several survey participants painted a picture of a system that is fragile and that failed to fully integrate the priorities and needs of immigrant communities into their routine clinical operations. Under pressure, fragile systems disintegrate. Many also describe an alarming misunderstanding of the mandate that language assistance must be provided by trained medical interpreters and not by family and friends. Focus group participants listed the following forces as determinants of poor health outcomes for immigrants and refugees.

- **Lack of Linguistically and Culturally Responsive Healthcare System**

  Focus group participants spoke at length about the implications of the culturally and linguistically sensitive system of care: “This was already a wobbly, shaky system (before COVID-19)” They argued that a difficult situation was made even more difficult with the pandemic because of restrictions on being in the room with the patient, advocating for them remotely and navigating everyone’s elevated stress level of everyone. “It was less about a system not being resilient and more about we have less space in our lives for these barriers that already existed.” During COVID-19, language options are either English or Spanish and excluded all other language groups who sought vaccine information in their own language.

  While large healthcare facilities are mandated by law to provide language services at no cost, small practices are exempt from the law, and Medicaid does not cover language services in all
states. Even in large facilities, the CLAS are not well understood or applied. Participants reflected on cases where providers use family members to provide interpretation which is against CLAS. As a participant puts it, “we are far from realizing the CLAS standards,” which mandates using professionally trained interpreters. “About 99.9% of physicians don't know about the CLAS standards, and they do not know their legal requirements to provide adequate interpretation.”

Additionally, the lack of translations of prescription labels impacts people’s health in significant ways: “Not being able to understand your medications really affects your physical and mental health.” The concept of refills and the need for lifelong medications for chronic diseases may not be understood by many. When medication labels are not translated into language patents can understand, it can have dangerous implications for patients.

Translation of medical resources is a challenge when policies mandate translation of materials in languages where at least 10% of speakers of these languages reside in the community. Language communities that constitute less than 10% of the population do not have access to printed materials in their languages.

Medical interpretation is “not just about language” but about being a “cultural broker” and interpreting cultural nuances. The lack of qualified interpreters who can meet the need is considered a challenge of political will and funding. The failure to distinguish different cultures and the implication on care is critical. A participant recalled experiences where providers treated dark skinned patients similarly and based on the assumption that they all shared a common culture.

The immigrants encounter delay in treatments because of lack of interpreters at hospitals. Every time immigrants visit their physician; they have a new interpreter. And this at times leads to delayed communication as immigrants and interpreter face difficulty in understanding each other dialects.

A participant lamented the lack of validated instruments that are tailored to culturally and linguistically diverse patients: “A man needed Social Security disability benefits, but he had to get neuropsychic testing. And every psychologist we talked to said, well, the tests aren't validated in these languages, so we're not going to use an interpreter to do the neuropsychic testing. And this impacts this man's whole life and his livelihood and his family's livelihood.”

Awareness of pre-migration experiences also is integral to providing patient-centered care. Such awareness, for example, would include an understanding that community or family may not always be a source of comfort or care. Members of LGBTQ communities have had traumatic experiences in their communities and seek to cut off ties with sources of trauma and threats to their identities. “Transgender refugees are not going to get support in their own community. I've had folks who have just a horrible trauma history that they won't talk about within the community. Privacy is really important to them. And so, people keep saying, oh, you should go to this group, or you should go talk to people who speak your language over here. And we
realize that actually, that's not what they wanted. They really wanted somebody outside their community. They want to get away as far as possible.”

- A Complex and Cumbersome Healthcare System
  Streamlining, standardization, and simplifying access to healthcare services were cited by participants as solutions to a highly complex system, even for professionals: “It's hard for any of us to complete forms and navigate referrals and all of those different things. So, you know, the more that the health care system can streamline and simplify these things, I think the better. How many times have we filled out the exact same intake document for our clients?”

- Lack of Universal Health Insurance Coverage
  Employer-based health insurance is a challenge for many who may work with employers who are not required to provide health insurance and who may have to stay on Medicaid to retain coverage. Economic self-sufficiency is a goal that may not be attainable for many who cannot access except jobs that do not provide health insurance and must stay on public benefits.

- Lack of Culturally and Linguistically Appropriate Non-Health-Related Resources
  Community resources can effectively address social determinants of health related to food insecurity and the need for childcare, transportation, employment, which are inaccessible to those who do not speak English well. However, access to these resources can only be possible when resources are linguistically appropriate and when they take into consideration the cultural worldview and mindset of immigrants and refugees who may not be familiar with U.S. environments.

- Lack of Trust in the Healthcare System and in Institutions of Government
  A natural outcome of racism and discrimination is a lack of trust in the healthcare system. “A family told me they weren't going to get the vaccine because for four years we've been told that we're hated that we're not wanted. And now the government is saying, hey, by the way, get this shot. And there's no we're not going to. We don't we don't trust you because of your racist policies.”

- Lack of Providers' knowledge, Experience and Training
  Lack of Training in Communicating through an interpreter was cited by many participants in the focus groups. Additionally, there is also resistance to interpretation because it requires providers to spend longer time with patients and slows down the process. Patients are often “greeted by physicians and other providers who were impatient and unwelcoming... so people do not feel safe. They didn't understand the importance of showing respect and establishing trust as the fundamental basis for a successful relationship.”

Clinicians often lack cultural knowledge and humility to seek knowledge about different cultural groups. “They oftentimes would not know the difference between Laos and Cambodia and Vietnam. They wouldn't begin to know anything about the history or culture of that patient.”
Additionally, a lack of understanding of the pre-migration and migration context makes providers “view patients as a problem because they didn't speak English. (They are) sort of ignorant peasants who would not understand anything about health care.” Lack of knowledge is exacerbated by a lack of cultural humility, as mentioned earlier. “I always say to physicians, you have to ask everyone, where were you born and where have you traveled... And I think the reason most physicians don't ask that is they don't know what to do with the answer.”

- Providers’ Attitudes and Blaming the Patient
Participants rejected the notion of health literacy and perceived it as a framing that places the blame on the patient. “It's actually my responsibility as the healthcare provider. I have to do a better job of helping people understand the concepts of Western preventive medicine, such that fatalism would not be something that would keep you from accessing care...The onus is on me as the provider to spend enough time explaining pap smears, mammograms, colon cancer screening, in a culturally sensitive, culturally humble way.”

A participant also rejected the notion of fatalism as a barrier to seeking care that shapes patients’ attitudes. “We actually do not accept this idea that health disparities for immigrants exist because of fatalism. We believe it's because we are not competent or humble enough in a cross-cultural way to explain things adequately, because once people are basically imbued with modern health care knowledge, the vast majority of people agree to screening. We blame the patient (when) we say the reason the patient’s outcome was poor because of their cultural attitudes, their lack of English skills. And I actually don't believe that. I think that we have failed them.”

“You shouldn't practice refugee and immigrant health care if you aren't trained in the field that you need to know the history and culture of your patients. You need to know the social determinants of health for your patients. You need to know how to set up your care system and advocate for a care system that changes to be responsive to refugees. And then, you know, you shouldn't be taking care of people if you don't know about hepatitis B and Strongyloidiasis and schistosomiasis and tuberculosis and PTSD and major depression and anxiety, the things that are commonly seen in newly arriving refugee and immigrant communities...You wouldn’t practice cardiology if you're not a cardiologist and you shouldn't be practicing refugee and immigrant health care without specialized training.”

IV. POLICY & PRACTICE RECOMMENDATIONS

Participants in this study underscored the need for effective policies that move away from pathologizing immigrants to strengthening the capacity of the healthcare system to serve immigrant communities in a patient-centered manner. This requires (a) strengthening enforcement of the CLAS standards; (b) integrating healthcare with other systems of social services that can address non-health determinants; (c) creating a specialization in immigrant and refugee health for providers, and (d) evaluating health disparities through measuring key quality metrics at an aggregated granular demography, and (e) increasing transparency by
issuing regular disparities report card for each immigrant community. There is a need to recognize that immigrants and refugees’ needs are unique when compared to those of other minority groups. These communities were devastated by pandemic because of the lack of institutionalization of their needs in the strategic and operational infrastructure of healthcare facilities. These communities were devastated by the pandemic because of the lack of institutionalization of their needs in healthcare facilities' strategic and operational infrastructure.

V. CONCLUSIONS
Findings from the research and practice literature and from healthcare professionals who responded to the survey and participated in the focus group validate elements of the framework. We use a moment in time—in this case a pandemic—when fragile systems crumble under the weight of pressure and reveal vulnerability that may have been masked otherwise. Validating the framework through the prism of healthcare professionals’ perspectives leverages this moment in time, to validate the determinants of health affecting immigrant communities who are culturally and linguistically diverse. Policy and practice recommendations specify interventions that can bring about positive health outcomes.

Limitations of this study include the fact that focus groups relied on the perspectives of ten healthcare professionals who are purposively recruited from a community of practice that has high levels of commitment to serving this population. Their few numbers and their unique perspective are not representative of mainstream practitioners in the healthcare system. As professionals, they have reached a level of sophistication in serving immigrant populations that are not representative of other mainstream institutions or providers. While the fact that they are specialized in serving immigrant populations make them effective informants on social determinants of health which immigrants experience, they are the exception and not the norm. The question remains: Do other professionals in healthcare system have the political will to advance the ideal state of affairs that these dedicated professionals painted to address social determinants of health? This question is left to future research efforts.
Table A summarizes elements of the ISD Framework that emerged from this study.

**TABLE A: IMMIGRANTS’ SOCIAL DETERMINANTS FRAMEWORK**

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>DETERMINANTS OF HEALTH</th>
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<tbody>
<tr>
<td><strong>1. BIOLOGICAL</strong></td>
<td>• Genetically Determined Conditions</td>
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<td></td>
<td>• Environmentally Determined Conditions</td>
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<td><strong>2. BEHAVIORAL</strong></td>
<td>• Pre and Post Migration Characteristics</td>
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<tr>
<td></td>
<td>• Lack of Awareness of Preventive Medicine and Systems of Care</td>
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<td></td>
<td>• Mental Health Stigma</td>
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<td></td>
<td>• Devaluing of Mental Health</td>
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<td></td>
<td>• Prevalence of Stereotypes about the Healthcare Systems and Practices</td>
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<td></td>
<td>• Traditional Gender Norms, Roles, and Relations</td>
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<td><strong>3. SOCIO-POLITICAL</strong></td>
<td>• Systematic Racism and Xenophobia</td>
</tr>
<tr>
<td></td>
<td>• Deskilling if Refugees and Immigrants</td>
</tr>
<tr>
<td></td>
<td>• Implications of “Dirty, Dangerous and Difficult” Occupations</td>
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<td></td>
<td>• Harmful Federal, State, and Local Policies</td>
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<td><strong>4. PHYSICAL BUILT ENVIRONMENT</strong></td>
<td>• The Concentrated Effects of Poverty</td>
</tr>
<tr>
<td></td>
<td>• Lack of Safe Affordable Housing</td>
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<td></td>
<td>• Lack of Accessible Transportation</td>
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<tr>
<td><strong>5. HEALTHCARE SYSTEM</strong></td>
<td>• Legally Non-Compliant Healthcare System</td>
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<tr>
<td></td>
<td>• Lack of Culturally and Linguistically Responsive Healthcare System</td>
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<tr>
<td></td>
<td>• Complex and Cumbersome Healthcare System</td>
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<tr>
<td></td>
<td>• Lack of Universal Health Insurance Coverage</td>
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<td></td>
<td>• Lack of Trust in the Healthcare System and Institutions of Government</td>
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<tr>
<td></td>
<td>• Lack of Providers’ Knowledge, Experience, and Training</td>
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<tr>
<td></td>
<td>• Providers’ Attitudes and Blaming the Patient</td>
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</tbody>
</table>
ENDNOTES


