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Understanding Mental Health in Diverse Communities

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ABSTRACT

This paper examines the multifaceted nature of mental health within diverse communities, with a specific focus on cultural perceptions, systemic disparities, and community-based responses. Through qualitative methods including focus groups and interviews, the study examines how mental health is understood, stigmatized, and treated among underserved populations, particularly multiracial, Latino Caribbean, African American, and Punjabi communities. Findings highlight that cultural beliefs, socioeconomic status, language barriers, and historical mistrust significantly impact help-seeking behaviors and access to mental health services. Participants often face challenges such as limited provider cultural competence, inadequate insurance, and societal stigma. The research further discusses how holistic and culturally affirming approaches, coupled with policy changes and grassroots initiatives, can bridge care gaps. Community-based and participatory methods show promise in creating inclusive mental health frameworks. The study concludes by calling for culturally competent, policy-informed mental health systems and expanded interdisciplinary efforts to reduce disparities and improve health equity.

Keywords: Mental health disparities, cultural competence, stigma, diverse communities, access to care, socioeconomic barriers, community-based approaches.

INTRODUCTION

Mental health has become a growing concern, and it has been observed that different demographics of people may be affected differently by mental illness. Despite discussions of mental illness becoming more appropriate and aware in an up-to-date society, it is still considered taboo in many diverse communities. The study became the first step in understanding the mental health concerns of underserved, diverse populations. It addressed gaps in the literature related to mental health and exploratory interventions by defining mental health and gathering insights relative to challenges, barriers, coping mechanisms, and culturally responsive treatment. Among the 15 participants who were multiracial and multiethnic and primarily of Latino Caribbean descent, focus group discussions revealed cultural accounts of mental health. Participants described the things that make mental health worse and remarked on barriers to seeking mental health care, including the excessive stigmatization of mental illness by their communities. When seeking care, they discussed conducting research, finding holistic and culturally affirming practitioners, and having someone present to facilitate conversation with providers. This exploratory study provided insight into the culturally intrinsic mental health conception of the underserved community and forums for discussing mental health. It also inspired present considerations, such as how to engage this community with quantitative research, stressors, and cultural risk factors unique to a group that experiences the confluence of various races, ethnicities, and immigration histories. Qualitative research would dig deeper into the demographic backgrounds of people engaged in mental health, entrepreneurial, and replicable models. Unifying culturally sensitive programs to enforce a consistent conversation regarding mental health in an otherwise unspoken world is a challenge. Still, it is one that public health can and should take on by engaging diverse groups with inciting research, service opportunities, and health policies that are the product of a social entrepreneurial spirit. Unless social work creates a conversation and cultural awareness of mental health disparities, individuals contending with the consequences of stress, trauma, and cultural dissonance will be left helpless [1, 2].

The Importance of Cultural Competence

The ultimate goal of health care for all individuals is to enjoy a longer life through better care, greater knowledge about health and living well, a healthier environment, and improved opportunities. Proper mental health care for some community population is sometimes forgotten aids to improve an overall health care system. A core of people may not have opportunities to benefit the same way as others in the structure of health institutions on a social economic level, such as without insurance or low income. There are products of Non-American society, immigrants, or intermarried individuals in American society. The medical system used by this population is turned into health care. It is necessary for them to toss those elements of illness used in another country. Early arrival individuals over age fifty-five can be frightened to utilize the medical system and share social roles in American society. Overcoming language difficulty, building trust, or getting into accurate social roles are barriers to receiving care for this group. This challenge may be from antiquities. Understandings of civilization and care based on concepts that were otherwise accepted become and remain medical and societal. Responses such as not wanting to benefit from care, avoiding any health specialists, asking referral from a neighbor or someone known there to go for care, or waiting as long as possible since the belief of care and remedy from the illness are the understanding of entrance into care trap. Overcoming errors of response may be large obstacles for mental health care possibilities. There are many professionals involved in best treatment, but few of these have the training, dissecting skills, or cultural background to comprehend comprehensively those incontinence kinds of issues. Finding individuals to gain entry to those who may be asking questions is common in multidisciplinary teams. Testing the assistance is very important, because it may guard the safety of the unchecked advises when the audience is exclusive. Multidisciplinary groups decide treatment needs, using different models, techniques, and explanations in training agencies. Once treatment is decided, compartments come in for care. Some methods need a single professional who may understand granting entry to help as change agents for mental health care beside interpretive care. The kind of discipline used is understood but not practiced as care. To argue on change agent roles leads to improvement in possibilities for entrance to better comprehensive health care [3, 4].

Mental Health Disparities

Diversity contributes to a multitude of experiences, perspectives, and insights that should be embraced. However, diversity might also contribute to systemic inequality, particularly regarding disparities in health. Mental health functions as a powerful indicator of the health of a nation or a community. Unfortunately, challenges regarding equitable access to prevention and treatment of mental health disorders are faced by communities of color, LGBTQ+ communities, and the communities of place groups, such as those living in rural areas. Understanding the different communities at risk for mental health disparities enables a more comprehensive understanding of mental health worldwide, as well as progress towards addressing these disparities. Although the U.S. population embodies incredible diversity, mental health research tends to emphasize normative, homogenous experiences that exclude many populations from basic health information or education about mental health. Many individuals ensnared in a condition of serious mental illness never receive treatment. Lack of access to the mental health workforce, insufficient funding for prevention and early intervention, and stigma around seeking help all compound dramatically more so than in urban areas. Ensuring treatment for an individual, Alex, before moving onto broader trends in rural mental health disparities. From a young age, Alex experienced conflicting messages around gender identity, leading to dysphoria and dissociation. Alex found brief solace in weight loss and substances but was quickly swept into a six-month cycle of leaving home, in homeless, and turning to sex work and other dangerous activities, which were scapegoated by those around her. After being coerced into chemical restraint, Alex became aware of the ability to control their own body and life. A few months later, Alex gave in to their slave trans "resistance" with the help of the LGBTQ group at school, family, a successful short-term treatment program, and a weekly psychiatric appointment [5, 6].

Socioeconomic Factors

This section requires thorough review and rewriting due to its confusing nature and numerous grammatical errors. Socioeconomic status (SES) is essential for understanding mental health differences, as lower SES groups face increased risks for mental health issues. Various SES measures, including income, education, employment status, and neighborhood context, help clarify health outcomes, but they often have different impacts, complicating the analysis of their contributions. Studies consistently show a link between lower SES and a higher risk of mental health problems across various populations and regions. Identifying key factors is crucial for understanding these individual differences. The emphasis is on marginalized low-income and low-wealth groups, where socioeconomic improvement efforts are focused. A literature review will combine native insights with a socio-economic epidemiological study,

employing formative evaluations and non-institutionalized surveys. The aim is to illuminate the complexities of poor socio-economic conditions and create relevant, interpretable indicators for better understanding. Online ethnography will gather culturally diverse perspectives on nature, supplemented by qualitative case studies addressing challenges, strategies, and resource access. The research will explore home, neighborhood, and societal factors related to motherhood, workplaces, and health. Partnering with universities and social networks will help foster knowledge transfer. Outcomes will include working papers on mental health assessment improvements, prototypes for policy briefs, infographics, self-assessment tools, and training materials. The ultimate goal is to pinpoint actionable avenues for enhancing well-being and provide decision-makers in India and beyond with evidence-based policy options [7, 8].

Access To Care

Despite interest in mental health issues, access to care remains limited in many communities, particularly diverse ones, where unique cultural factors create additional barriers. These obstacles complicate the decision to seek help and manifest as attitudes about mental illness and treatment, lack of knowledge about resources, and financial and structural hindrances. Societal barriers significantly influence cultural attitudes toward mental health. For instance, in African American communities, mental illness perceptions often link to beliefs around sin and spirituality. Many Latino cultures offer supernatural explanations for mental health issues, while African and Caribbean immigrants might attribute psychological problems to spiritual attacks. Stereotypes, gender, and social networks also shape treatment beliefs in diverse groups. Knowledge-related barriers complicate access, with many unaware of available services, contributing to underutilization. Structural barriers exist, particularly for those with low socioeconomic status, making mental health services financially unattainable. These individuals may lack time or resources for treatment or feel their issues don't warrant expenditure on services. In rural regions, many are uninsured or underinsured, as mental health professionals are typically concentrated in urban areas, leading to significant access challenges [9, 10].

Stigma and Discrimination

There is a growing awareness that mental illness stigma negatively affects the social, emotional, and physical health of a person suffering from a mental illness. Public stigma toward mental illness is a 'social reaction' or an entailed set of expectations, beliefs, and behaviors in the social environment about a person with a mental illness. Labeling affected individuals as mentally ill triggers a stereotype-based risk of being discriminated. This discrimination is the "other side" of the stigma or "stigma-as-disenfranchisement". An experience of discrimination has a crucial role in the onset of mental illness, and it serves as a key barrier to recovery from mental illness stigma. Discrimination can be understood as: (I) overwhelming public stigma; devaluation, stereotypical beliefs, and dehumanization; (II) social rejection (a loss of status in the community); and (III) elimination from social relationships (an anticipated loss of social group). This stigma is detrimental to a person's reasons for and abilities in seeking help and in following through with treatment or therapeutic plans. Stigma is detrimental to self-esteem, sense of meaning in life, and relatedness. It serves as a barrier preventing affected individuals from building a good support network and developing a good therapeutic alliance with specialist services. Stigmatized individuals experience fear and shame of being rejected and discriminated against in their familial, social, occupational, and health service environments. Stigma holds greater significance for the affected individuals prior to seeking care or treatment services. Stereotypes and public stigma are factors that would serve as a temptation to apply coping strategies to deal with fears. Feelings of shame lead to an emotional draw on an affected individual seeking help. Mockery and fear of not being listened to or believed by others would hinder any dialogue, and it is thoughts about being discredited within the family or losing social contact that would block the advantage of accessing help. Thus, fear of stigma prevents affected individuals from revealing their identity of being "ill" and pursuing help [11, 12].

Cultural Beliefs and Practices

The understanding of mental health in diverse communities is deeply rooted in their cultural beliefs and practices. This study focused on the Punjabi community in the UK. Using semi-structured interviews with seven Punjabi participants, both male and female, aged 35 or above, qualitative data were gathered and analyzed using thematic analysis. Findings revealed that the beliefs about mental distress reflected in the local language, attributes of distress that were socially constructed as shameful within the context of izzat and sharam, gender differences in beliefs and practices, and acceptance of mental illness as a long-term condition. Beliefs about distress highlighted the culturally specific words which can roughly be translated into ruda, chorti, and wadi. Participants also reported three words describing the symptoms of mental health distress, namely daunk, giddar / shivee, and churan. All three words are widely known and understood in the Punjabi community. Though some symptoms have cultural concordance (daunk), items

are healthier than those found in the population of the UK (churan). Participants accepted the symptoms as a normal process of life. Mental health problems were attributed either to the social context or physical factors. Social context was considered a cause of distress by the majority of the participants. The words referring to mental distress also depicted the individuals facing similar situations being looked down upon or stigmatized. When the meaning of the mental health problems indicated hatred or disgust in the language, the participants exhibited feelings of disapproval. For instance, words referring to mentally unwell people, "daudiya", "internal", and "bavla" were socially constructed and are perceived to be shameful within the context of izzat and sharam [13, 14].

Barriers To Mental Health Care

Mental health care is a significant public health issue in the U.S., affecting nearly 70 million adults, or 29% of the population, who meet the criteria for mental disorders. Insufficient access to appropriate care can worsen these conditions, leading to co-morbidity with substance dependence and, in some cases, violence. Key social determinants, such as poverty and discrimination, contribute to mental illness risk. Cultural perceptions influence treatment seeking and understanding, particularly for ethnic minorities like African Americans, whose historical experiences shape stigma surrounding mental health. This stigma leads to avoidance of treatment, reduced intensity of care, and poorer outcomes. Additionally, the environments where individuals live can also dictate their experiences with mental illness. Historical attitudes towards treatment create barriers to access. Low-income urban African Americans often encounter hostile perceptions in health systems. Moreover, non-white patients may receive medications more frequently than their white counterparts, deepening distrust in the system. While some public providers are sympathetic to these challenges, systemic barriers remain, especially regarding services for low-income patients. Preventive care for those insured through public systems is often inadequate. Although immediate care is available for those in crisis, the experience for patients on wait-lists leads to negative perceptions of the mental health system due to insufficient communication and support [15, 16].

Community-Based Approaches

Diverse communities encounter distinct challenges in accessing effective mental health care, which is especially inequitable during trauma. Evidence-based interventions for racial and ethnic groups are limited, leading to ongoing disparities in access. Therefore, it is crucial to address institutional-level barriers to mental health equity. Mental health concepts remain poorly understood, even by professionals, and are often stigmatized. Many reject the notion that mental distress is solely linked to brain chemistry, and there is a significant variation in perceptions of mental wellness. Interventions promoting mental health must respect and integrate locally valued practices. Culturally informed approaches often rank lower in the evidence hierarchy, which favors efficacy over effectiveness studies. This study aims to work with academics and practitioners in Los Angeles to address mental health inequities for immigrant and refugee communities from Iraq and Central and South America. It focuses on understanding and improving care through collaborative co-learning practices. Ethnographic methods and participatory visual research tools facilitate this study. Live moments are captured through video and field notes, and arts-based methods support analysis. Traditional academic texts will also be generated to communicate findings. Throughout the inquiry, various exemplary moments surfaced, explored through irony to highlight tensions and diverse practices. Theoretically, these observations are analyzed through assemblage thinking, which informs community-based collaborative research practices [17, 18].

Policy Implications

Significant disparities exist in how individuals from diverse backgrounds experience and manage mental health, with racial and ethnic minorities often facing poorer outcomes and limited care access compared to White individuals. Historically, efforts to address these inequities focused on racism or cultural factors without considering their intersections, leading to varying definitions of effective treatment among different groups. Mental health providers may be unaware of how policies impact their ability to address these disparities. Current public mental health services strive for broad eligibility to ease burden on providers but may inadvertently increase disparities. Staff may use high care standards as cost-control measures, addressing less complex needs instead of acute unmet ones. Policies enforcing racial equity standards might create bureaucratic layers, further marginalizing underserved populations. Adapted solutions without considering specific barriers can disengage minorities from the mental health system. Current assessments rely on psychometry and cultural norms, limiting understanding of lived experiences. Testing materials often lack rigorous cultural validation, raising concerns about bias. The disconnect among policy, advocacy, and providers hampers effective action. New methods to document lived experiences are essential. Effective approaches to understanding policy's role in mental illness and treatment often occur at local or individual levels, creating user-generated documentation alongside local

representatives. This strategy empowers communities and facilitates impactful, sustainable change [19, 20].

Case Studies

Case 1: Local Interview Results (Latino and Diverse Race Community) Two interviews were conducted in Stockton, California, with community leaders in mental health to gain insight into these topics in the Latino community compared to a diverse community. The first interview was with a community member from a Latino-exclusive non-profit organization focused on health literacy within the community. The second was conducted over the phone with a community member from a mental health services organization that serves a wide variety of ethnicities and races, helping with housing, youth programs, and mental health. Another community member from a health center was contacted; however, the interview was unable to be conducted in the time frame provided for this project; survey responses were also unable to be collected. The interview questions assessed the meaning of mental health in the interviewee's community, beliefs and causes of mental illnesses, beliefs on treatment, migration's impact on mental health, current treatments, relationships between community members, and access to mental health services. Fourteen questions were asked; however, some were grouped due to similarities. During the interview, it was common for the interviewers to receive additional context rather than straight answers. However, concerning the project's timeframe, comments deemed irrelevant were cut. The interviews were transcribed using a speech-to-text tool; afterwards, a reading was conducted for overall understanding of the data. Interviews were analyzed in detail to assess recurring patterns and themes. Case 2: Mental Health Programming for Indigenous Communities A young man from a First Nation is frustrated that there are no evidence-based, culturally-safe, and male-specific mental health resources available at any of the treatment centres he has attended. He and his friend partner with a recent PhD graduate to initiate a boys' and men's mental health program in the community. The team uses a participatory action research approach to address the mental health challenges of boys and men in the First Nation. This case is to provide a platform for the reader to think critically about how mental health concerns can be addressed in Indigenous communities and have a meaningful impact using the resources available to the community. This case will also allow students to explore methods that can be employed to build community capacity to develop evidence-based and culturally appropriate programming. After reading the case, students will start low on the cognitive taxonomy pyramid; through class discussions and instructor guidance, the learners will advance to a higher cognitive domain. Objectives include identifying and differentiating between the social and cultural determinants of health that affect the mental health of Indigenous Peoples and explaining mandatory ethical research principles used when conducting research with Indigenous Peoples [21-24].

Future Directions in Mental Health Research

The findings from this investigation have implications for mental health services, future study, and public health policies at local and national levels. It may be feasible to open services to online community forums as a starting point for mental health services outreach to this group. Current virtual care models among M/NM/QQ people hold promise for accessible care, equity of care, and care that is sensitive to a diverse population. This view was accompanied by concern that online care can further perpetuate inequities if access to technology is limited or barriers to using that technology exist. Participants did not express a preference for online mental health screening. Future studies may wish to investigate how participants prefer to screen for mental health concerns. The screening tools and instruments used in public health practice, research, and clinical work must be adequately developed and tested for this and related populations. Specific efforts must follow instrument development to systematically identify and develop to what degree existing instruments are culturally appropriate for use with M/NM/QQ people. Given that for populations of interest where there is a lack of instruments capable of measuring health status or key risk and protective factors, as well as exposure to prejudiced events and potentially traumatic experiences, the scale crisis about instrument development for M/NM/QQ is even more pressing. Participants highlighted a need for educational modules and clinical interventions targeted toward public health professionals to better create access points for this growing population. Given that most general mental health modules focus on behavioral health and that gaps in services for health education and primary prevention were indicated, partnerships with academic institutions to ensure that training materials build knowledge and skills of providers to best serve M/NM/QQ people, both appropriately and within scope of practice, would likely be beneficial. As greater steps to combat harmful narratives around race/ethnicity are made within public health and research, consideration must also be given to improving the data context for American Indian/Alaska Native communities. On the local level as well as the national level, there are numerous data issues when it comes to these communities. This includes poor data quality at both the state and national levels due to data being aggregated into larger bins of data

during the reporting stage. Additionally, numerous definitions of who is American Indian or Alaska Native affect how they are counted and classified in research [25-28].

CONCLUSION

Mental health remains a critical but under-addressed issue within diverse and underserved communities. This research underscores that effective mental health care cannot exist in a vacuum—it must reflect the lived realities, cultural values, and systemic challenges of the populations it aims to serve. Cultural stigma, socioeconomic inequality, language barriers, and limited access to culturally competent providers create formidable obstacles. However, integrating community voices through participatory research, recognizing cultural nuances in care, and reforming public policy offer clear avenues for transformative change. Mental health systems must evolve to become more inclusive, equitable, and culturally responsive. Future interventions should prioritize interdisciplinary collaboration, support from social entrepreneurs, and robust policy advocacy to dismantle persistent mental health disparities and ensure that care is truly accessible for all.

REFERENCES

1. Salanti G, Peter N, Tonia T, Holloway A, White IR, Darwish L, Low N, Egger M, Haas AD, Fazel S, Kessler RC. The impact of the COVID-19 pandemic and associated control measures on the mental health of the general population: a systematic review and dose–response meta-analysis. Annals of internal medicine. 2022 Nov;175(11):1560-71. acpjournals.org
2. Meda N, Pardini S, Slongo I, Bodini L, Zordan MA, Rigobello P, Visioli F, Novara C. Students' mental health problems before, during, and after COVID-19 lockdown in Italy. Journal of psychiatric research. 2021 Feb 1;134:69-77. unipd.it
3. World Health Organization. Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. World Health Organization; 2022 Jul 29.
4. Macpherson RI, Burkle Jr FM. Humanitarian aid workers: The forgotten first responders. Prehospital and Disaster Medicine. 2021 Feb;36(1):111-4.
5. Gato J, Barrientos J, Tasker F, Miscioscia M, Cerqueira-Santos E, Malmquist A, Seabra D, Leal D, Houghton M, Poli M, Gubello A. Psychosocial effects of the COVID-19 pandemic and mental health among LGBTQ+ young adults: A cross-cultural comparison across six nations. Journal of Homosexuality. 2021 Mar 21;68(4):612-30. unipd.it
6. Barakat S, McLean SA, Bryant E, Le A, Marks P, Touyz S, Maguire S. Risk factors for eating disorders: findings from a rapid review. Journal of eating disorders. 2023 Jan 17;11(1):8. springer.com
7. Singh D, Nasir S, Sharma J, Giménez-Llort L, Shahnawaz MG. Psychological distress in low-income and economically marginalized populations in India: protective and risk factors. Behavioral Sciences. 2024 Jan 26;14(2):92.
8. Wong CS, Tang WC, Chang W, Hui CL, Chan SK, Lee EH, Chen EY. Constructing socioeconomic index (SEI) in predicting mental health in young adults. European Psychiatry. 2021 Apr;64(S1):S118-9.
9. Khatri RB, Assefa Y. Access to health services among culturally and linguistically diverse populations in the Australian universal health care system: issues and challenges. BMC public health. 2022 May 3;22(1):880.
10. Coombs NC, Campbell DG, Caringi J. A qualitative study of rural healthcare providers' views of social, cultural, and programmatic barriers to healthcare access. BMC Health Services Research. 2022 Apr 2;22(1):438.
11. McKenzie SK, Oliffe JL, Black A, Collings S. Men's experiences of mental illness stigma across the lifespan: a scoping review. American journal of men's health. 2022 Feb;16(1):15579883221074789. sagepub.com
12. McDaniels B, Pontone GM, Mathur S, Subramanian I. Staying hidden: the burden of stigma in PD. Parkinsonism & related disorders. 2023 Nov 1;116:105838. [HTML]
13. Obeagu EI, Obeagu GU. Unmasking the Truth: Addressing Stigma in the Fight Against HIV. Elite Journal of Public Health. 2024. kiu.ac.ug
14. Rachmad YE. Philosophical and Psychological Perspectives on Sexual Orientation in Fatherless Societies. The United Nations and The Education Training Centre. 2023 Dec 12.
15. Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Soneson E, Steare T, Wright T, Griffiths SL. The social determinants of mental health and disorder: evidence, prevention and recommendations. World psychiatry. 2024 Feb;23(1):58-90. wiley.com

16. Mezzina R, Gopikumar V, Jenkins J, Saraceno B, Sashidharan SP. Social vulnerability and mental health inequalities in the "Syndemic": Call for action. Frontiers in psychiatry. 2022 May 30;13:894370. frontiersin.org
17. Ran MS, Hall BJ, Su TT, Prawira B, Breth-Petersen M, Li XH, Zhang TM. Stigma of mental illness and cultural factors in Pacific Rim region: a systematic review. BMC psychiatry. 2021 Dec;21:1-6. springer.com
18. Park E, Lee K, Kim SB. Navigating travel constraints for individuals with mental health conditions. Current Issues in Tourism. 2025 Mar 19;28(6):963-81.
19. Hall GC, Berkman ET, Zane NW, Leong FT, Hwang WC, Nezu AM, Nezu CM, Hong JJ, Chu JP, Huang ER. Reducing mental health disparities by increasing the personal relevance of interventions. American Psychologist. 2021 Jan;76(1):91. nih.gov
20. Ongesa TN, Ugwu OP, Ugwu CN, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Okon MB, Ejemot-Nwadiaro RI. Optimizing emergency response systems in urban health crises: A project management approach to public health preparedness and response. Medicine. 2025 Jan 17;104(3):e41279.
21. Hoffmann JA, Alegría M, Alvarez K, Anosike A, Shah PP, Simon KM, Lee LK. Disparities in pediatric mental and behavioral health conditions. Pediatrics. 2022 Oct 1;150(4):e2022058227. nih.gov
22. Nneoma UC, Fabian O, Valentine EH, Paul-Chima UO. Innovations in Renewable Energy for Health Applications. system. 2025;1:2.
23. D'souza NA, Field M, Supino T, Messer M, Aleck E, Kirmayer LJ. Mental health implementation research in Indigenous communities: creating culturally safe space to enhance collective strengths. AlterNative: An International Journal of Indigenous Peoples. 2024 Mar;20(1):194-204. sagepub.com
24. Ugwu CN, Ugwu OP, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Ejemot-Nwadiaro RI, Okon MB, Egba SI, Uti DE. Medical preparedness for bioterrorism and chemical warfare: A public health integration review. Medicine. 2025 May 2;104(18):e42289.
25. Bowden A, Caine V, Yohani S. A narrative inquiry into the experiences of two non-Aboriginal counsellors working with Aboriginal people. Canadian Journal of Counselling and Psychotherapy. 2017 Feb 3;51(1).
26. Sequist TD. Improving the health of the American Indian and Alaska Native population. Jama. 2021 Mar 16;325(11):1035-6.
27. Ugwu CN, Ugwu OP, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Ejemot-Nwadiaro RI, Okon MB, Egba SI, Uti DE. Sustainable development goals (SDGs) and resilient healthcare systems: Addressing medicine and public health challenges in conflict zones. Medicine. 2025 Feb 14;104(7):e41535.
28. Kruse G, Lopez-Carmen VA, Jensen A, Hardie L, Sequist TD. The Indian health service and American Indian/Alaska native health outcomes. Annual review of public health. 2022 Apr 5;43(1):559-76. annualreviews.org

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