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Healing, trust, and care-seeking behavior: A comprehensive review of indigenous and diaspora knowledge in addressing health disparities

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Abstract

Healthcare disparities among immigrant and diaspora populations in the United States remain a persistent public health concern, which is shaped by structural inequities, cultural dynamics, and barriers to healthcare access. While existing research has examined these disparities, little is known about how indigenous knowledge systems, trust, and pluralistic healing practices intersect to influence care-seeking behaviors among diaspora populations. This review addresses this gap by synthesizing evidence on healing, trust, and healthcare engagement among diaspora populations in the United States through a comprehensive thematic review of empirical and review studies. The findings revealed four interconnected themes: (1) structural and systemic barriers as determinants of care-seeking, (2) language, communication, and relational trust, (3) pluralistic healing systems and the role of indigenous knowledge, and (4) sociocultural constructions of health and agency in care. The study concludes that advancing health equity in the United States requires an integrative, culturally responsive, and structurally informed approaches that recognize diverse healing systems, strengthen trust, and address systemic exclusion within the healthcare system.

Keywords: Health Disparities; Care-Seeking Behavior; Indigenous; Diaspora; Trust; Healing

1. Introduction

The United States is home to one of the world's most diverse populations, which is shaped by longstanding histories of migration, forced displacement, and transnational mobility (Duque et al., 2025): Notable immigrant and diaspora communities, including Latino, Asian, African, and other ethnically diverse populations, constitute a significant and growing proportion of the U.S. population, contributing to its social, cultural, and economic fabric (Lacey et al., 2025). However, persistent health disparities continue to disproportionately affect these groups, reflecting deep-rooted inequities in access to care, quality of services, and health outcomes (Lee et al., 2026). These disparities are embedded within broader structural, sociopolitical, and cultural contexts that shape how individuals experience health, illness, and healing.

The extant literature highlights that healthcare engagement among diverse populations is influenced by more than the availability of biomedical services. Certain factors such as immigration status, socioeconomic constraints, discrimination, and policy environments limit access and deter care-seeking (Yaru & Wau, 2025; Shin, 2024). Language barriers further complicate healthcare navigation, undermining patient-provider communication, reducing trust, and contributing to suboptimal care experiences (Joseph & Martinez, 2026; Ma et al., 2025). These structural and interpersonal challenges are often compounded by a lack of culturally responsive healthcare systems that fails to adequately recognize and integrate the diverse health beliefs held by immigrant and diaspora communities (Ugwu et al., 2025).

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Within this same context, indigenous knowledge systems, traditional healing practices, and complementary and alternative medicine (CAM) play a critical yet often under-recognized role in shaping care-seeking behaviors. Evidence suggests that many individuals from diaspora communities engage in pluralistic health practices, drawing on both biomedical and traditional systems of care based on accessibility, cultural alignment, and perceived efficacy (Cruz et al., 2022; Khosla et al., 2024). In some cases, traditional healers serve as primary points of contact, particularly when access to formal healthcare systems is limited by structural barriers (Cruz et al., 2022). Additionally, transnational ties and binational mobility enable individuals to navigate multiple healthcare systems, reinforcing cultural continuity in health beliefs and practices (Crocker et al., 2025).

The role of trust and information in shaping healthcare engagement is equally important (Nortey et al., 2025). The mistrust of healthcare institutions, which is often rooted in historical injustices, discrimination, and exclusion, can discourage individuals from seeking timely care. Simultaneously, disparities in health information access and preferences influence symptom recognition, decision-making, and healthcare system navigation (Hummel et al., 2025). Although culturally grounded, community-based approaches to health communication enhance engagement, such strategies remain insufficiently integrated into mainstream healthcare delivery.

Despite ongoing health reforms and increased attention to health equity, significant gaps persist in understanding how the intersection of indigenous knowledge systems and diaspora experiences within the U.S. healthcare landscape shape healing practices, trust, and care-seeking behaviors. Much of the existing literature has examined barriers to healthcare access in isolation, such as language, cost, or policy constraints, without integrating cultural, relational, and epistemological dimensions that influence how individuals perceive and engage with care. The role of traditional and complementary healing systems is often marginalized within biomedical discourse, limiting opportunities for integrative and culturally responsive care. Consequently, effective interventions to address health disparities among diverse populations in the United States are difficult to develop.

Given the above, this comprehensive review aims to synthesize existing evidence on healing practices, trust, and care-seeking behaviors among immigrant and diaspora populations in the United States to provide a holistic understanding of the drivers of health disparities and inform culturally responsive and equity-oriented approaches to healthcare policy and practice in the United States.

2. Methods

This study adopted a comprehensive narrative review approach to synthesize existing evidence on healing, trust, and care-seeking behaviors among immigrant and diaspora populations in the United States. Relevant studies were identified through a targeted and iterative search of peer-reviewed literature focusing on healthcare access, cultural health practices, and immigrant health in the United States. Although the review was not limited to a single database, studies included in the thematic synthesis were selected based on their relevance to the core constructs of healing practices, trust, and care-seeking behavior. Studies were included if they were: (1) conducted within the U.S. context or directly applicable to U.S. healthcare systems; (2) focused on immigrant or ethnically diverse populations; (3) examined healthcare access, utilization, health beliefs, or healing practices. Studies that did not address care-seeking behavior or lacked relevance to the conceptual focus of the review were excluded. After the suitable studies were identified, the analysis involved iterative comparison of findings across studies to identify convergent and divergent themes. Through this process, four overarching themes were developed: (1) structural and systemic barriers, (2) language and relational trust, (3) pluralistic healing systems, and (4) sociocultural constructions of health and agency.

3. Results

3.1. Thematic Discussion of the Findings

The review synthesized research across several immigrant and diaspora populations in the United States to show how the interplay of structural barriers, cultural knowledge systems, and sociopolitical contexts shape healing practices, trust, and care-seeking behaviors. The review identified four themes that are important to understanding and addressing health disparities among diaspora populations in the United States: (1) structural and systemic barriers as determinants of care-seeking, (2) language, communication, and relational trust, (3) pluralistic healing systems and the role of indigenous knowledge, and (4) sociocultural constructions of health and agency in care.

3.1.1. Structural and Systemic Barriers as Care-Seeking Determinants

The studies revealed that structural inequities are not merely contextual factors but constitute the foundation through which healthcare access and care-seeking behaviors are produced, constrained, and patterned. The evidence revealed that immigrant and diaspora populations in the United States face a set of interlocking barriers, such as financial uncertainty, lack of insurance, restrictive immigration policies, geographic discrimination of services, and institutional discrimination, which collectively function as a system of exclusion rather than isolated challenges (Yaru & Wau, 2025; Flynn et al., 2025; Shin, 2024). Notably, these barriers are structurally embedded within broader sociopolitical and economic arrangements that stratify access to healthcare along the lines of legal status, race, class, and language, consequently resulting in the reproduction of inequities in both access and outcomes.

For instance, evidence from the southeastern parts of the United States illustrates how these structural constraints materialize in everyday life. Flynn et al. (2025) argued that a substantial proportion of Hispanic immigrants lack primary care providers and health insurance, while facing transportation barriers and inflexible work schedules that limit their ability to seek care. The findings indicate that labor uncertainties, particularly among low-wage and undocumented workers, directly mediates healthcare access, effectively sabotaging health needs for economic survival. Beyond the economic barriers, the evidence also showed that the sociopolitical environment plays a decisive role in shaping healthcare engagement. For instance, Shin (2024) highlighted how fear, which is often associated with immigration status, coupled with discriminatory experiences in healthcare settings, discourages use of services and health seeking. This aligns with broader evidence that legal uncertainties and exclusionary policies create a chilling effect, in which immigrants avoid healthcare systems due to perceived risks of surveillance, deportation, or institutional mistreatment. Similarly, Joseph and Martinez (2026) argued that systemic barriers, particularly those linked to language and bureaucratic complexities, continue to undermine meaningful access to care even in the context of health reforms aimed at expanding coverage. This implies that policy reforms, when not accompanied by structural inclusivity, often fail to translate into equitable healthcare access.

Notably, these barriers are not isolated but intersectional and mutually reinforcing. Yaru and Wau (2025) noted that language barriers, financial limitations, and legal exclusions interact to produce compounded disadvantages, leading to delayed care, poorer health outcomes, and persistent disparities. For example, the inability to afford healthcare is intensified when individuals also lack culturally and linguistically appropriate services, resulting in both material exclusion and epistemic marginalization. This dual marginalization is further evidenced in the experiences of Chinese immigrants, where language discordance contributes to stress, isolation, and unmet healthcare expectations, ultimately undermining trust and engagement (Ma et al., 2025). Thus, structural inequities extend beyond access to the quality and relational dimensions of care.

Moreover, structural barriers actively reshape care-seeking behaviors by pushing individuals toward alternative care systems. Cruz et al. (2022) demonstrated this in their study with Latine populations, where it was revealed that traditional healers often served as primary points of contact due to their affordability, accessibility, and cultural congruence features that are frequently lacking in biomedical systems. Similarly, Crocker et al. (2025) revealed that Mexicans living along the U.S.-Mexico border leverage binational mobility to access healthcare in Mexico as a strategy to circumvent U.S.-based barriers. While these practices reflect resilience and agency, they also expose systemic failures within the U.S. healthcare system. Engagement with alternative care systems should be understood not only as a cultural preference but also as a structurally conditioned response to exclusion.

These findings imply that structural inequities do not simply limit access; rather, they actively shape perceptions of legitimacy, trust, and belonging within healthcare systems. Healthcare institutions may be perceived as inaccessible or untrustworthy when individuals encounter repeated barriers, discrimination, or exclusion, further reinforcing disengagement. This dynamic is compounded by limited access to health information and resources, which constrains individuals' ability to effectively navigate complex healthcare systems (Hummel et al., 2025).

Therefore, addressing these disparities requires a shift from individual-level interventions to upstream structural transformations. While expanding insurance coverage is necessary, it is insufficient to isolate. Comprehensive strategies must also address immigration-related exclusions, labor market inequities, and geographic disparities in healthcare provision. This calls for the need to dismantle institutional discrimination and invest in culturally and linguistically responsive care infrastructures in the United States. As the evidence suggests, efforts to improve healthcare access will remain partial and inequitable without confronting these structural determinants, ultimately perpetuating the very disparities they seek to resolve.

3.1.2. Language, Communication, and Relational Trust

Language barriers emerged across the literature not only as technical barriers to information exchange but also as structural and relational determinants of healthcare access, quality, and trust. The findings revealed that limited English proficiency (LEP) shaped how individuals encounter, interpret, and engage with the U.S. healthcare system, affecting everything from insurance enrollment to clinical decision-making and continuity of care (Joseph & Martinez, 2026; Ma et al., 2025). Conversely, communication gaps produced by language discordance often translate into misdiagnoses, misunderstandings of treatment plans, reduced patient satisfaction, and diminished trust in biomedical institutions.

Joseph and Martinez (2026) further argued that language barriers persist even in the wake of health reforms designed to expand access, revealing the limitations of policy interventions that fail to account for linguistic diversity. Their findings show that individuals with limited English proficiency faced compounded challenges at multiple points of care: which includes difficulties completing enrollment processes, navigating complex healthcare systems, and communicating effectively during clinical encounters. These barriers are embedded within bureaucratic and institutional structures that require English proficiency as a prerequisite for access. Language operates as a gatekeeping mechanism that stratifies healthcare access along linguistic lines.

Similarly, Ma et al. (2025) highlighted how language discordance among Chinese immigrants extends beyond miscommunication to producing psychosocial consequences, such as stress, isolation, and unmet care expectations. Dialect mismatch, which is often overlooked in mainstream discussions of language access, further complicates communication, even when interpretation services are available. This underscores a critical gap in healthcare delivery, where linguistic accommodation is frequently treated as a standardized intervention rather than a nuanced and culturally embedded practice. Patients may feel unseen or misunderstood, reinforcing perceptions of marginalization within healthcare settings.

The evidence suggests that language is not merely a conduit for information but a central medium through which relational trust is built or destroyed. Trust in healthcare is co-produced through interactions that signal respect, recognition, and cultural attunement. When patients are unable to communicate in their preferred languages or when their linguistic needs are inadequately met, the clinical encounter becomes a site of exclusion rather than care. This dynamic is further reinforced by broader structural inequities. For example, Yaru and Wau (2025) identified language barriers as key contributors to miscommunication and suboptimal care, particularly when coupled with limited cultural competence among providers. Linguistic marginalization intersects with systemic inequities to produce both practical and relational deficits in care.

Moreover, language barriers have downstream effects on health literacy and information access, shaping individuals' ability to recognize symptoms, understand risk, and navigate healthcare systems. For instance, Hummel et al. (2025) noted that ethnically diverse populations often exhibit limited health information-seeking behaviors, partly due to gaps in accessible, culturally appropriate communication channels. This suggests that language barriers extend beyond the clinical setting into broader health information ecosystems, further constraining the need for informed care-seeking and early intervention.

At the same time, the literature highlights the critical role of community-based actors and culturally competent providers in mediating these challenges. Joseph and Martinez (2026) documented how immigrant advocates and healthcare workers actively bridge linguistic gaps, improve patient experiences, and foster trust. Similarly, Flynn et al. (2025) emphasized the importance of culturally and linguistically competent staff in enhancing healthcare engagement among immigrant populations. These efforts demonstrate that when communication is grounded in cultural humility and responsiveness, trust can be rebuilt.

However, relying on ad hoc or community-driven solutions risks shifting responsibility away from healthcare institutions and onto marginalized communities. A more critical reading of the evidence suggests that language access must be institutionalized as a core component of health equity rather than treated as an ancillary service. This requires sustained investment in professional interpretation services, recruitment and retention of multilingual healthcare providers, and culturally aligned communication strategies that go beyond literal translations to encompass cultural meaning-making.

3.1.3. Pluralistic Healing Systems and Indigenous Knowledge's Role

A major revelation across the reviewed studies is that care-seeking among immigrant and diaspora populations in the United States is primarily pluralistic, reflecting the coexistence and often strategic integration of biomedical, complementary, alternative, and traditional healing systems. This pluralism is not an indication of indecision or the lack

of knowledge; rather, it represents a rational, culturally grounded, and structurally conditioned response to both the opportunities and limitations embedded within the U.S. healthcare system (Khosla et al., 2024; Cruz et al., 2022; Crocker et al., 2025). Pluralistic care-seeking challenges the dominance of biomedical paradigms by emphasizing alternative health and healing knowledge systems that are deeply rooted in indigenous and diaspora belief systems.

For instance, complementary and alternative medicine (CAM) is widely utilized among South Asian youth in the United States due to its affordability, accessibility, and alignment with familial and cultural traditions (Khosla et al., 2024). Importantly, participants did not reject biomedicine outright but instead adopted a hierarchical and situational approach, which involved reserving biomedical care for acute or severe conditions while relying on CAM for preventive, chronic, or less urgent concerns. The findings reflect a form of pragmatic medical pluralism, where decisions are informed by cost, perceived efficacy, cultural familiarity, and prior experiences with the healthcare system.

Similarly, Cruz et al. (2022) demonstrated that traditional healers, such as curanderos, often served as the first point of contact for care within Latine communities. Their prominence was not attributed solely to cultural preference but was closely tied to structural realities, including affordability, accessibility, and linguistic and cultural compatibility. In many cases, traditional healers filled critical gaps left by the biomedical system, offering forms of care that are relationally grounded, culturally meaningful, and responsive to patients lived experiences. Thus, their use reflects both cultural continuity and systemic exclusion, complicating narratives that position traditional practices as peripheral or supplementary.

Transnationalism's role further deepened this pluralistic landscape. Crocker et al. (2025) highlighted how Mexicans living along the U.S.-Mexico border leveraged binational mobility to access healthcare services across national boundaries. This mobility enabled individuals to circumvent barriers such as cost, discrimination, or limited access within the U.S. system while maintaining connections to culturally familiar healing practices in Mexico. This underscores that healthcare-seeking behaviors cannot be fully understood within a bounded national framework; rather, they are shaped by transnational flows of knowledge, resources, and practices that extend beyond U.S. institutional structures.

While pluralistic healing systems offer adaptive strategies for navigating inequities, they also expose tensions within the broader healthcare landscape. The coexistence of multiple systems raises important concerns regarding care coordination, potential interactions between treatments, and the risk of delayed biomedical interventions for serious conditions (Khosla et al., 2024; Cruz et al., 2022). However, framing traditional and alternative practices primarily as risks or barriers reflects a biomedical bias that fails to adequately recognize their legitimacy and value within patients' health worlds.

The marginalization of indigenous and traditional healing within formal healthcare structures constitutes a form of epistemic inequity, where certain ways of knowing and healing are devalued or excluded. This not only limits opportunities for integrative care but also undermines trust and engagement among populations whose health beliefs are not reflected in biomedical practice. Yaru and Wau (2025) noted that cultural incongruence between providers and patients contributes to miscommunication and suboptimal care, further reinforcing the appeal of alternative systems that are perceived as more culturally attuned.

Therefore, advancing health equity requires moving away from assimilationist models that expect patients to conform to biomedical norms and toward integrative frameworks that recognize and incorporate indigenous and diaspora knowledge systems. Such models would facilitate safer care coordination, reduce the risk of harmful interactions, and enhance patient trust and adherence.

3.1.4. Sociocultural Constructions of Health and Agency in Care

Health beliefs and care-seeking behaviors among immigrant and diaspora populations are deeply embedded within sociocultural frameworks that extend beyond and often challenge the assumptions of dominant biomedical models. The reviewed literature consistently demonstrated that many communities conceptualize health holistically, integrating physical, emotional, spiritual, and social dimensions into a unified understanding of well-being (Crocker et al., 2025). These multidimensional frameworks shape how individuals interpret illness, assign causality, prioritize interventions, and ultimately engage with healthcare systems.

In their study, Crocker et al. (2025) provided a particularly nuanced account of these dynamics among Mexicans living along the U.S.-Mexico border, where health is understood through an integrated mind-body-soul paradigm that is closely tied to social relationships, environmental contexts, and cultural identity. Within this framework, healing is not viewed as a passive process delegated solely to medical professionals but an active, self-directed endeavor in which

individuals assume primary responsibility for their own well-being. This contrasts sharply with the biomedical model, which often positions patients as passive recipients of expert knowledge and intervention. Thus, the divergence between these paradigms can create frictions in clinical encounters, particularly when healthcare providers fail to recognize or validate the holistic health beliefs of patients.

Similarly, Khosla et al. (2024) highlighted how South Asian youth navigated healthcare through culturally informed logics that prioritize balance, prevention, and familial knowledge systems. Their strategic use of biomedical and alternative therapies not only reflects pluralism but also a culturally grounded sense of agency in decision-making. These choices are not arbitrary, as they are shaped by intergenerational knowledge, perceptions of safety and efficacy, and prior experiences with healthcare institutions. This underscores that care-seeking behaviors are shaped by deeply embedded cultural values and belief systems and not merely reactive responses to illness.

Simultaneously, these sociocultural constructions of health are dynamically negotiated within the context of migration, acculturation, and structural constraints. For example, while individuals may hold holistic beliefs about health, their ability to act on these beliefs is often mediated by access to resources, healthcare availability, and systemic barriers (Yaru & Wau, 2025). Thus, agency care-seeking must be understood as both enabled and constrained, shaped by the interplay between cultural frameworks and structural conditions.

A critical implication of these findings is that biomedical systems often fail to adequately engage with or accommodate diverse health worldviews, leading to misalignment between patient expectations and provider practices. This misalignment can result in dissatisfaction, reduced adherence to treatment plans, and disengagement from care. As noted by Ma et al. (2025), unmet expectations in healthcare encounters, which are intensified by cultural and linguistic gaps, can undermine trust and contribute to feelings of marginalization. Thus, the failure to recognize sociocultural constructions of health is not merely a cultural oversight but a driver of inequitable care.

Furthermore, dominant healthcare frameworks often pathologize or dismiss alternative health beliefs as irrational or non-compliant, thereby reinforcing epistemic hierarchies that privilege biomedical knowledge over other forms of knowing. This not only marginalizes the lived experiences of patients but also limits the potential for more holistic and patient-centered approaches to care. As Cruz et al. (2022) noted, culturally grounded care, such as the ones provided by traditional healers, can precisely enhance engagement because it aligns with patients' sociocultural understandings of health and healing.

Fundamental reorientation of healthcare delivery toward culturally responsive and patient-centered models that recognize the legitimacy of diverse health worldviews is required to address these gaps. This includes training providers in cultural humility, fostering shared decision-making, and creating dialogue spaces that allow patients to articulate their beliefs and preferences. Moving beyond standardized, one-size-fits-all approaches to more flexible and context-sensitive practices is also required.

4. Implications for Health Equity in the United States

The themes discussed in this review make a clear case that health disparities among diverse U.S. populations cannot be adequately understood or addressed through individualistic or behaviorist frameworks alone. Disparities are systematically produced through the dynamic interaction of structural inequities, cultural knowledge systems, and relational processes within healthcare encounters. Evidence across the reviewed studies consistently demonstrated that access constraints such as cost, insurance, and legal status shape care-seeking behaviors and the extent to which healthcare systems recognize, respect, and engage with the linguistic, cultural, and epistemological realities of immigrant and diaspora communities. In this sense, healing, trust, and care-seeking must be understood as deeply interconnected and co-constructed processes embedded within broader systems of power and inclusion.

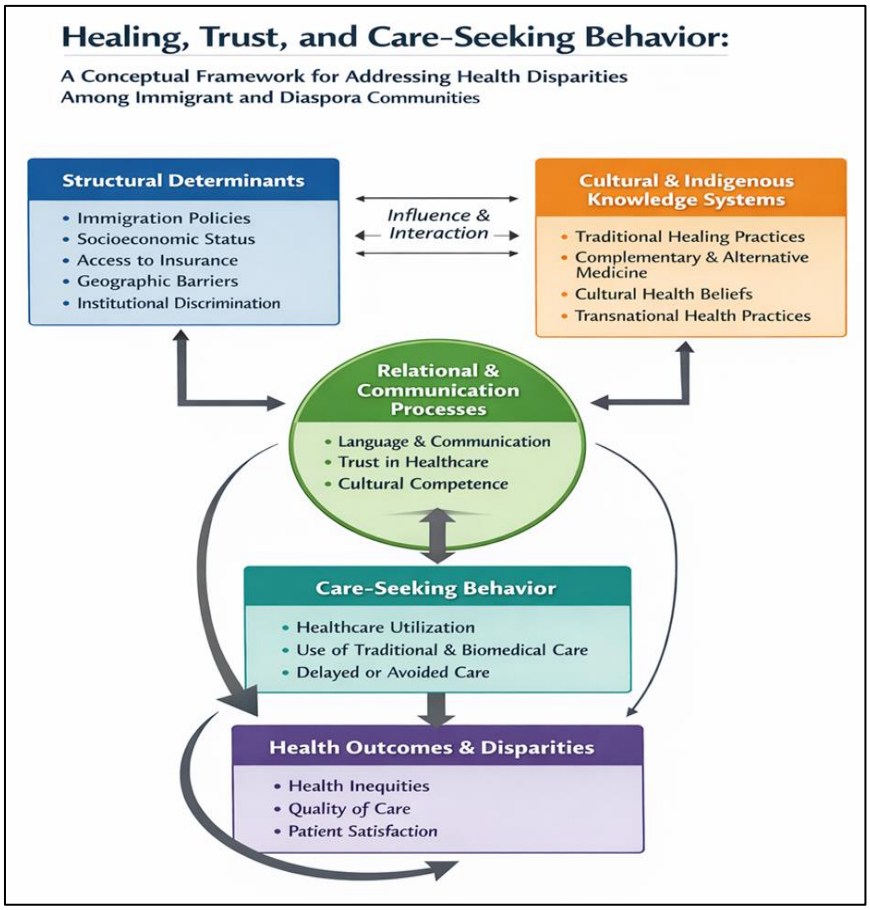
A critical implication is that current health equity efforts in the United States remain insufficiently transformative because they often focus on downstream interventions, such as expanding coverage or promoting health education, without adequately addressing the structural conditions that produce exclusion (Ajayi & Thompson, 2025). While expanding insurance is necessary, the evidence shows that coverage alone does not guarantee access or utilization, particularly in contexts where fear of immigration enforcement, labor uncertainties, and discrimination persist. Moreover, even policy reforms designed to increase access can fall short when linguistic and bureaucratic barriers remain unaddressed. Thus, health equity requires a structural reorientation that situates healthcare within broader social justice frameworks, including immigration reform, labor protections, and anti-discrimination policies.

The need to redefine language access as a fundamental dimension of equitable care rather than a supplementary service is equally important. Persistent communication barriers limit navigation and understanding, erode trust, and reinforce exclusion (Joseph & Martinez, 2026; Ma et al., 2025). Therefore, investments in interpretation services, multilingual workforce development, and culturally attuned communication strategies are essential. However, these efforts must move beyond procedural compliance toward relational competence to ensure that communication fosters dignity, recognition, and trust within clinical encounters.

The findings also call for a critical rethinking of the epistemological foundations of U.S. healthcare. The widespread reliance of diaspora populations on complementary, alternative, and traditional healing systems highlights the limitations of a biomedical model that marginalizes non-Western knowledge systems (Yaru & Wau, 2025; Shin, 2024). Pluralistic care-seeking should not be viewed as a deviation from normative practice but as an adaptive response to both cultural values and structural constraints. Integrating indigenous and traditional knowledge into healthcare delivery through respectful collaboration, coordinated care models, and culturally grounded interventions can enhance trust, improve adherence, and reduce disparities.

Finally, the evidence underscores the importance of recognizing sociocultural health constructions as central to patient engagement (Crocker et al. 2025; Khosla et al. 2024). Holistic understandings of health, which incorporate physical, emotional, spiritual, and social dimensions, shape how individuals interpret illness and make care decisions. When healthcare systems fail to engage with these perspectives, they risk creating misalignment between providers and patients, leading to dissatisfaction and disengagement. Therefore, advancing equity requires embedding cultural humility and patient-centered care in clinical practice, enabling providers to engage with patients as active agents rather than passive recipients of care.

5. Conceptual Framework



This conceptual framework positions health disparities among immigrant and diaspora populations as the outcome of dynamic interactions between structural determinants, cultural knowledge systems, and relational processes within healthcare encounters. Structural inequities shape access and institutional trust, while indigenous and diaspora knowledge systems inform health beliefs and healing practices. These forces converge within relational spaces,

particularly communication and trust, which mediate care-seeking behaviors. Ultimately, health outcomes emerge from this interplay, reinforcing, or mitigating disparities through recursive feedback mechanisms.

6. Conclusion

The review has demonstrated that healing, trust, and care-seeking behaviors among immigrant and diaspora populations in the United States are shaped by the intersection of structural inequities, cultural knowledge systems, and relational dynamics within the United States healthcare system. The evidence underscores that health disparities are not merely the results of individual choices but are systematically produced through exclusionary policies, socioeconomic constraints, linguistic barriers, and culturally incongruent healthcare systems that limits access to care and also shape perceptions of trust, legitimacy, and belonging within healthcare institutions. The review argues that advancing health equity in the United States would require a paradigm shift that moves away from biomedical-centric models towards holistic, structurally informed, and culturally grounded frameworks of care. This would entail addressing upstream determinants such as immigration policies and labor inequities, institutionalizing language access, and integrating indigenous and traditional healing systems that emphasize the lived experiences of immigrant and diaspora communities. Future research and healthcare policy initiatives in the United States must focus on intersectionality and community-informed approaches that leverage structural reforms with culturally responsive care to achieve meaningful and sustained health equity.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

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