

Barriers and facilitators to improving access to healthcare for recently resettled Afghan refugees: A transformative qualitative study

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Abstract

Introduction: Refugee communities in the United States require increased attention to reduce barriers to public health. The current dearth of research on Afghan refugees in the U.S. does not move beyond the binary identification system of 'sick-immigrant' versus 'healthy immigrant', fails to provide a platform for Afghan refugees to provide critical insight into systematic issues, and to articulate a path towards actionable change.

Methods: Researchers utilized a transformative qualitative approach to explore the health-related issues by identifying barriers and facilitators to accessing healthcare for Afghan refugees resettling in a county near the US capital. Twenty participants were recruited using purposive sampling. Data were collected using in-depth semi-structured interviews and were analyzed thematically.

Results: A range of barriers and facilitators were identified. Barriers included: trust, communication, mental health, and navigation. Facilitators included: Practical support (public assistance with finances and medical insurance, orientation class, and interpreting), provider rapport, and continuity of care. Qualitative research demonstrates the complex overlap between different issues that should be understood contextually. Implications from this study are discussed in a socio-ecological perspective (individual, relationships, organizations, community, and policy/systems).

Conclusion: A nuanced understanding of stakeholders' experiences in healthcare is necessary to shape policy and improve the quality of services for this vulnerable community. To promote a more equitable health care system, more research must be done to understand refugee health conditions in post-resettled populations from a culturally responsive approach.

KEY WORDS: Afghan; health equity; qualitative; refugees; resettlement; socio-ecological framework.

INTRODUCTION

Globally there are 2.5 million registered Afghan refugees, and they represent the second largest refugee population in the world [1, 2]. More than three million refugees have been resettled in the United States since the Refugee Health Act of 1980 [3]. A total of 90,000 Afghan refugees reside in the United States [4]. The growing community of Afghan immigrants in the U.S. faces numerous challenges when engaging with the U.S. public health system, but the community also has unique strengths that enable their health. Achieving health equity among refugees and asylum seekers navigating health care and negotiating wellbeing during resettlement in a new country is a persistent challenge. Recently resettled Afghan refugees, like migrants before them, arrive with a broad range of issues, including securing employment, transportation, and housing [5]. Upon arrival in the host community, some might endure other challenges like deferred preventive care; pre-existing medical conditions, particularly untreated diabetes and hypertension; and severe mental distress arising

from prior exposure to chronic stress in their home countries [6]. All of these challenges are layered within the complexities of being immersed within a new culture sometimes with limited English language skills. For example, Afghan refugees, like other resettled migrants in the U.S., have 8 months to become economically independent. After that, their cash assistance from the U.S. government will be terminated and they then become subject to standard eligibility requirements of Medicaid.

Challenges accessing health-enabling resources can become difficult during the resettlement process despite the economic opportunities and robust health systems in the United States. The barriers to access can negatively affect migrants' health and overall quality of life [7, 8]. Arabs in America are more likely to have adverse health outcomes than the general population [9]. Refugee populations have complex and unique needs, thus it is important to address issues in healthcare using a socio-ecological approach [10, 11]. This transformative qualitative study [1] utilized a culturally responsive and socio-ecological lens

TAKE-HOME MESSAGE

The majority of the participants asserted that the current political circumstances in the US precluded refugees from reaching an adequate level of trust with health care providers, further preventing them from sharing medical information for fear of stigma and adverse consequences.

Competing interests - none declared.

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to identify recently resettled Afghan refugees' barriers and facilitators to accessing health care. The study's findings were used to develop strategies that will help increase access to public health services in clinical settings.

METHODS

Study design and procedure

The researchers employed a transformative framework [1], a research paradigm that guides investigators in culturally responsive methods and critically examines the phenomenon from various aspects (i.e. individual, social, political, and historical contexts). Data were collected and analyzed over the course of six months from May to November in 2018. Researchers partnered with a public health department (DOH) that provided screenings to refugees. Local medical centers routinely provide health screening for refugees who have recently arrived in the U.S. and continue to offer refugees primary care. The site was chosen due to the proximity of the university the primary researcher was affiliated with and that it had a significant Afghan refugee population [12].

Study participants and sampling

To represent a variety of viewpoints from refugees and health care workers, all participants were recruited through purposive sampling. A total of 20 adults (ten refugees and ten key informants) participated in the interviews (Table 1). All of the participants were at least 18 years of age, had knowledge of or first-hand experience with refugees in the area who were seeking primary health care, and were willing and able to provide voluntary informed consent.

Refugee was defined as any individual who self-identified as a refugee, asylee, or special immigrant visa holder from Afghanistan; and who was resettling in the county and utilized the DOH refugee clinic. Refugees received flyers written in Dari-Farsi and English from staff working in the DOH; and contacted the research team if interested in the study. Afghanistan is a multilingual country in which

Dari-Farsi is one of the most common spoken languages; Dari-Farsi refers to all varieties of the Persian language [12]. Key informants were defined as individuals who were directly or indirectly involved with providing services to Afghan refugees. Key informants were recruited via an email to the county's DOH, organizations serving refugees, and professional contacts.

Study instruments and measures

Twenty in-depth semi-structured interviews were conducted (10 - Afghani refugees; 10 - key informants). Interviews allowed us to understand the barriers and facilitators to accessing health care related to Afghan refugees. Interviews were conducted at a time and place convenient to the participant, performed in the least restrictive language, lasted on average one hour, and were audio-recorded, translated (if applicable) and transcribed verbatim into English for data analysis. The primary researcher is bilingual in Farsi/English and conducted the Dari-Farsi interviews.

Ethical aspects

The George Washington University's Institutional Review Board (IRB) approved this study. During recruitment, each participant received a copy of the informed consent form that was read and explained to the participant in the language they found most accessible (English or Dari-Farsi). Given concerns about confidentiality, the researchers took extra care to ensure that participants understood their involvement was voluntary, anonymous, and without reprimand, if they declined involvement. We created culturally relevant pseudonyms for participants to allay any concerns with sharing sensitive information. Researchers built rapport by communicating in the preferred language and ensuring that the interviewers were gender-appropriate. In accordance with the transformative beliefs, the refugees were offered light refreshments (tea and snacks) during their interview and a \$15 grocery gift card in appreciation for their involvement.

Data analysis

Data were analyzed thematically within the transformative framework [1] to critically examine issues of social justice, human rights, and health equity. Thematic analysis has been largely used in other formative qualitative studies in the fields of psychology and public health [13]. Data were coded into two main categories – barriers and facilitators. Next, recommendations, which are grounded in the data, were confirmed by participants and are articulated within the socio-ecological model.

RESULTS

Results are organized in two main categories: barriers and facilitators. Four main themes emerged regarding barriers (communication, mental health, navigation, and trust); and three main facilitators emerged (practical support, provider rapport, and continuity of care (Table 2). Later, we will discuss how these findings inform the implications for practice.

Barriers

Four main barriers emerged from the interviews with participants: trust, communication, mental health, and navigation. All participants (refugees and key informants) discussed the difficulties caused by communication barriers typically manifested by the lack of understanding of the common language (English) or lack of competence in the refugee's first language (Dari-Farsi or Pashto). Mental health, which was another common theme, was split into two subcategories: services and stigma. Trust was also an important issue for participants due the uncertainties within the US political climate. Lastly, navigation was a major issue cited; which revealed either navigation of the US healthcare system or navigation to and from healthcare facilities.

Barriers of trust

Refugees and SIV-Holders were suspicious about discussing personal information and did not trust the health care system. Almost all SIV holders expressed concerns about sha-

ring their mental health concerns with their providers due to fear of consequences. All participants asserted that the current political environment precludes them or Afghan refugees they work with from reaching a certain trust level with health care providers and sharing medical information that may cause *further stigma and bias*.

"... Most of the people don't want to share their mental problems. They don't want to accept they have a mental problem. And even they don't want to share with each other because it's like taboo... and they don't want to share with the providers for that purpose that they think they might lose the job or they don't find a job you might close out social security benefits... they don't share even if it's Post Traumatic Stress Disorder. They think the information that they give to the doctor will go to their job place or their workplace so it affects them"

(Farzaneh - Medical interpreter from Afghanistan)

Barriers of communication

A common issue with communication is the lack of access to qualified medical interpreters who are skilled in Dari or other common languages spoken by Afghans such as Pashto. Though medical offices receiving U.S. government funding are required by Title VI of the Civil Rights Act of 1964 to provide language interpretation services, refugee/SIV holders frequently described their frustration with the interpreters' lack of linguistic competence, knowledge of medical terminology, and cultural responsiveness, as well as providers' lack of understanding how to use the language accommodation service effectively. One key informant captures the issue of communication access here:

"Although people know that most Northern Afghan people speak Farsi, their Dari dialect is very much different from the dialect that Iranian Farsi. So, for example [Fisbar ballah] is like "high blood pressure" when translated word by word in Iranian Farsi. In contrast, in Afghanistan dialect [it] is slang for high stress or tension. This may become an issue when they hire interpreters that are Iranian Farsi-speakers, instead of Afghan

Table 1. Participant characteristics.

Characteristic	Participants Total (N=20)
Afghan Refugee Participants	N=10
Gender	
Men	5
Women	5
Ages	18-55 years
Refugee Status	
SIVH	7 (4 male; 3 female)
Refugee/asylee	3 (2 male; 1 female)
Key Informants	N=10
Key Informant Roles	
Resettlement Coordinator/Refugee Case Worker	3
Clinical Medical Provider	3
Medical Interpreter	2
Mental Health Provider	1
Journalist	1

Table 2. Key themes, main findings and example quotes.

Key Themes for Barriers	Main Findings as Reported by Participants	Quotes
Trust	Uncertain political climate due to anti-immigrant rhetoric Feeling suspicious about disclosing personal information that will be placed in a medical record	“... Most of the people don't want to share their mental problems...and they don't want to share with the providers for that purpose that they think they might lose the job or they don't find a job you might close out social security benefits... They think the information that they give to the doctor will go to their job place or their workplace so it affects them.” (Farzaneh)
Communication	Lack of Language Access Lack of in-person interpreters Lack of Interpreter Competency Feeling helpless/frustrated	“...their Dari dialect is very much different from the dialect that Iranian Farsi. So, for example <i>الاب راشف</i> [Fisnar ballah] is like “high blood pressure” when translated word by word in Iranian Farsi. In contrast, in Afghani dialect [it] is slang for high stress or tension...[the] Iranian translator conveyed to the physician [that the] Afghan patient has a history of high blood pressure when in reality it is not, it is just “high-stress.” Sometimes it makes them feel helpless, and just give up elaborating their medical conditions.” (Farzaneh)
Mental Health	Mental health issues are compounded by years of trauma and cultural stigma Overlooked Burden of Trauma Cultural stigma	“Many of us have been dealing with years of war and instability in Afghanistan. For that reason, per se, the level of anxiety is very high. For example, I used to live in a war zone and [hear] ambulance sirens...Still to this day when I hear a siren from [an] ambulance I feel [a] shake in my body.” (Kabul)
Navigation	Health care systems Tensions between benefits and ability to support family	“... it's still not enough to be able to purchase health insurance and make ends meet... I am always afraid that we may lose Medicaid and they may cut our benefits...” (Farjaad)
	Transportation logistics Large families Public transit Language barriers	“Transportation is a big issue for them [Afghan refugees] too. A lot of time they don't have cars and they have very large families... [public transit] is not very straightforward if you've never done it before in the US, especially when one is struggling with language at the same time...” (Mary)

Key Themes for Barriers	Main Findings as Reported by Participants	Quotes
Practical Support	Public assistance programs Cash Assistance Supplemental Nutrition Assistance Program Medicaid, Refugee Medical Assistance	"There are different programs that assist refugees financially. One of them is the Refugee Cash Assistance (RCA) program which helps recently resettled refugees by providing cash assistance for up to eight months from their arrival date in the United States." (Jacob)
	Education Resettlement orientation classes Housing, employment, travel and transportation, education, health, money management, rights and responsibilities, and cultural adjustment	"I had a three day class in the resettlement agency... during which they taught us different things like how to write a check [and] some cultural issues. [they told us] when you get sick, where should we go... Overall, that was good." (Hashem)
	Language access Culturally competent interpreters can support increased access Remote interpreters	"Every time we go to the clinic, Physician asks us if we require interpreters. If we ask for it, they will easily call an interpreting agency, choose the language and in less than five minutes, they will provide a Farsi interpreter. However, not all Farsi interpreters speak our Afghan dialect, so it is not ideal, but it is certainly helpful." (Akbar)
Provider Rapport	Positive provider rapport	"We really like the staff and doctors and nurses in the clinic. They all smiled at us, very kind, very polite. They took time to explain everything to us..." (Asmah)
Continuity of Care	Continuity of care ideally includes a Universal electronic record system for Health and social work services, Coordinating for a case workers to accompanying refugees and asylum seekers Communication/coordination /collaboration with other services	Back in Afghanistan, we still do not have Electronic Health Records in most places... It is very good that in America the referral system is very good and they have access to our records and this facilitates the continuity of care and makes everyone on the same page." (Hussam)

interpreters. In this case, [the] Iranian translator conveyed to the physician [that the] Afghan patient has a history of high blood pressure when in reality it is not, it is just "high-stress." Sometimes it makes them feel helpless, and just give up elaborating their medical conditions".
 (Farzaneh - Medical interpreter from Afghanistan)

Barriers of mental health

All of the key informants and a majority of the refugees/SIV holders noted mental health issues. The two main mental health-related barriers were accessing services and overcoming stigma. Stigma prevented refugees from seeking services, disclosing information to service providers, and readily trusting professionals. Afghan refugees and SIV holders are not an exception when it comes to inadequate mental health services (other issues include: lack of cultural responsiveness of service providers, therapy costs, insurance coverage, stigma, etc.). However, because of the trauma refugees have experienced in their home country and the challenges related to the re-

settlement process, they are more predisposed to mental health problems [14]. One refugee/SIV holder captured this complex issue of mental health services in the quote below. "Many of us have been dealing with years of war and instability in Afghanistan. For that reason, per se, the level of anxiety is very high. For example, I used to live in a war zone and [hear] ambulance sirens. Once there was a siren in the neighborhood after a bombing where 50 Afghan people died. Still to this day when I hear a siren from [an] ambulance I feel [a] shake in my body".
 (Kabul, a SIV Holder)

Barriers of navigation

The refugees perceived two major barriers related to navigation: challenges navigating the healthcare system and navigating transport between locations. Key informants only discussed transportation as a barrier, not healthcare system navigation. During the first eight months in the U.S., refugees qualify for Medicaid and state based health insurance; however, restrictions apply to this subsidized government insurance based on employment

status, household, and monthly income [15]. For many refugees, there is a tension between the thought of losing benefits from government social support programs and the need to find gainful employment rapidly. All of the refugee participants asserted that access to employment both directly and indirectly affected their health and healthcare coverage. The issue of navigating the healthcare system is well-captured by a refugee who was a physician in Afghanistan:

“... They offered me to work in a food packaging company for \$9 an hour and got a “survival job”... one should understand this is a major stressor for me and my family... it’s still not enough to be able to purchase health insurance and make ends meet... I am always afraid that we may lose Medicaid and they may cut our benefits...”

(Farjaad, Afghan SIV, former medical doctor)

Similar to the issue of navigating the healthcare system was the issue of transportation. Although case workers provide transportation for the first visit to the pre-screening clinic, still most of the participants mentioned that follow up appointments and primary care visits required much more logistical assistance that was not provided:

“Transportation is a big issue for them [Afghan refugees] too. A lot of time they don’t have cars and they have very large families so they’re relying on individuals in the community or learning how to take up the public transportation system which is not very straightforward if you’ve never done it before in the US, especially when one is struggling with language at the same time...”

(Mary, Physician serving Afghan refugees)

Facilitators

There were a total of four facilitators identified through the interviews with participants (key informants and refugees). These facilitators include: Practical Support (public assistance, education, and interpreting); Provider Rapport; and, Continuity of Care. Barriers and facilitators are not mutually exclusive. For instance, though all participants acknowledged that the federal and state public health

assistance programs were major facilitators that enabled refugees to access much needed support; public assistance could also be a barrier if participants feared losing benefits for various reasons. This complexity is important to note as we chose to present the data in a bifurcated format.

Practical support

Practical support was such a strong facilitator that participants emphasized, these include public assistance, an orientation class, and interpreting. Public assistance includes financial programs (e.g., Cash Assistance), food assistance (e.g., Supplemental Nutrition Assistance Program), and government health insurance (e.g., Medicaid, Refugee Medical Assistance). Although such supports can be a facilitator to access healthcare resources, factors like household size, transportation constraints, and cost of living may complicate a refugees’ ability to access these benefits.

“There are different programs that assist refugees financially. One of them is the Refugee Cash Assistance (RCA) program that helps recently resettled refugees by providing cash assistance for up to eight months from their arrival date in the United States. For example, a married couple of two would get \$459 if they have no income. Of course, that has its own limits and conditions. For instance, if one or both are working, count half of the earnings against the household’s grant. Or if that couple earns over \$839 per month, they would no longer receive RCA”.

(Jacob, Refugee health coordinator)

Regardless of the limitations, practical support in the form of public assistance was a major facilitator for refugees and their families. In addition to public assistance, refugees were enrolled in an orientation class that increased their self-efficacy. The class covered several topics including housing, employment, travel and transportation, education, health, money management, rights and responsibilities, and cultural adjustment in the U.S. These classes were great facilitators in helping refugee participants become more comfortable and confident in navigating U.S.

life. John, a resettlement agency coordinator, explains how practical the classes are from applying for financial assistance programs to “we try to make sure they have realistic expectations”. Many of the participants considered these classes valuable in educating them about the healthcare system in the U.S. and other practical aspects of American life: “I had a three day class in the resettlement agency... during which they taught us different things like how to write a check [and] some cultural issues. [they told us] when you get sick, where should we go: for which conditions one should go to the emergency room, when to use Urgent Care, and which conditions to [go to the] outpatient clinic. They all emphasized that we try to avoid 911 in case it is not an emergent scenario. Overall, that was good”.

(Hashem, Afghan SIV holder)

Aside from classes and financial assistance, access to language was another critical practical facilitator. Interpersonal relations and the quality of patient care is enhanced by providing certified interpreters; however, lack of in-person interpreters can be a challenge as described earlier in the Barriers section. Interpreters who are culturally competent and skilled in the Afghan languages and dialects were a valuable asset for care providers as they functioned as cultural mediators and could help identify nuances in body language, tone, or eye contact which would be overlooked and literally lost in translation when using tele-interpreting services.

“Every time we go to the clinic, Physician asks us if we require interpreters. If we ask for it, they will easily call an interpreting agency, choose the language and in less than five minutes, they will provide a Farsi interpreter. However, not all Farsi interpreters speak our Afghan dialect, so it is not ideal, but it is certainly helpful”.

(Akbar, Afghan SIV Holder)

Provider rapport

All the refugees deemed provider-patient rapport highly satisfactory, such as by sharing positive recollections of encounters with physicians, nurses and staff at their refugee health

clinic and describing providers compassionate and empathetic. This degree of positive provider rapport facilitated refugees’ interactions with other staff in the healthcare system. As one recently resettled refugee stated:

“We really like the staff and doctors and nurses in the clinic. They all smiled at us, very kind, very polite. They took time to explain everything to us...”.

(Asmah, Afghan SIV holder)

Continuity of care

Continuity of medical care in the U.S. was also perceived as a major facilitator to health care for refugees who reported varying levels of exposure to continuity of care. Continuity of care includes, but is not limited to, use of an universal electronic health record system for refugees, social work services, establishing referral pathways in the health system, coordinating for a case workers to accompanying refugees and asylum seekers, communication/coordination /collaboration with other services, co-delivery of services, flexibility of primary healthcare system, and specialized services. As Hussam, a former doctor explained, “Back in Afghanistan, we still do not have Electronic Health Records in most places. For example when we go to a primary care doctor, they give us a diagnosis and prescribe some medications. They chart old-fashioned paperwork. If referred to a different facility or doctor, other facilities sometimes do not exactly know what treatments were done or may have no electronic access to the previous facility. It is very good that in America the referral system is very good and they have access to our records and this facilitates the continuity of care and makes everyone on the same page”.

(Hussam, Afghan SIV holder and medical background)

Overall, the care available in the U.S. was perceived as high quality. Notions of high quality health care were so strongly held among refugees that the majority of participants expressed this view even before having experienced their first interaction with the primary care physician. For example, Isaad, a refugee

who was a healthcare worker in Afghanistan explained:

“One clear benefit of health care services in the U.S. compared to the ones in Afghanistan is that patient care is well-focused and well-attended. It is a step by step physical examination and para-clinical work up...”

(Isaad, former healthcare worker)

DISCUSSION

Existing literature describing refugees' experiences interacting with the health care system in the U.S. is limited [16]. Also there is little research that applies a transformative paradigm [1] to investigate health providers' cultural competency to deliver efficient and culturally relevant care to such populations. The transformative paradigm was a beneficial philosophical underpinning for this study's analysis of barriers and facilitators Afghan refugees experience when interacting with the U.S. healthcare system, as the paradigm's epistemology brings to the forefront the key understanding that marginalized voices should be included in the research process. The following discussion of the implications and use of this data is framed in terms of recommendations (Figure 1), which are rooted in the participants' suggestions and organized here within a social-ecological framework and which we illustrated with quotes from participants.

Individual level

At the individual level, data suggests that empowerment can be capitalized to help support the wellbeing of refugees [15, 9, 17]. Refugees can be empowered by building their self-efficacy, English proficiency, and environmental mastery [17]. Improving individual self-efficacy will also lead to elevated levels of empowerment and increased levels of wellbeing [17]. Many refugees resettled in the US arrive with a history of trauma and Post Traumatic Stress Disorder (PTSD). These adversities can have negative impacts on an individuals' self-esteem that can hinder their self-efficacy. One female refugee who works as a medical interpreter highlighted the importance of

self-efficacy by explaining:

“Then you feel like you are inferior and we shouldn't feel that. And I think, In order to change their behavior. They need to learn. It's again it's education. And so they need to learn that a person's value. Is not dependent on their money or on their looks on their right where they are born or where they were raised. We All have, Tremendous value. We are all equal. We are all Part of this universe to be what we are. We all have value”.

(Farzaneh, Medical interpreter and Afghan refugee)

Interpersonal level

The interpersonal level is also an important factor in accessing healthcare. Recommendations focus on building the capacity of healthcare providers and the healthcare system; this includes employing culturally competent providers, providing in-person interpreters, and fostering cultural humility among healthcare staff. Below is an explanation of these various interpersonal recommendations rooted in the data.

Cultural competent providers

Providers need to receive more comprehensive training to develop their cultural competence in serving refugees [18]. One case worker highlights how there is a need for cultural competency among current providers saying: *“I don't think a lot of health care providers are aware of you know who they are. Even with other refugees they're not very, I don't think, at least I don't think they are very culturally sensitive or knowledgeable that they are refugees, these are their rights. So, more awareness is needed”.*

(Case worker from Refugee Resettlement Agency)

Some care providers are unfamiliar with their patients' various cultures and how culture is a framework for beliefs about occupation, gender norms, and social expectations. One key informant illuminates this issue of competence and how the provider plays a key role in helping shape the patient's experience:

“See them, examine them, of course they can.

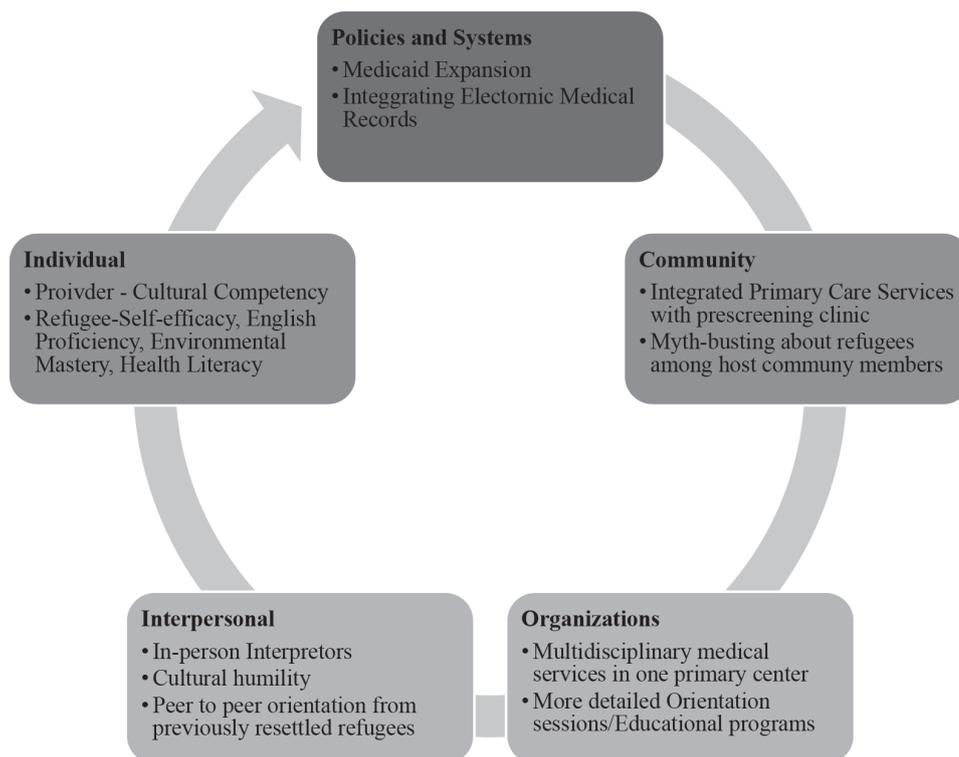


Figure 1. A socio-ecological model of factors influencing Health Care access among recently resettled Afghan refugee based on participants recommendations.

There's a certain attitude that the physician can have to make the patient comfortable to share their information. Of course, that's obvious. But other than that, I think the most important thing is educating them about the health system in the United States".

(Shuhrah, a journalist and refugee advocate, working in a Refugee Resettlement Agency)

In-person interpreters

Interpersonal relations and the quality of patient care can be enhanced by providing skilled in-person interpreters [19–21]. Culturally competent and responsive interpreters can help providers facilitate care between physicians and their patients [19, 21] and can also help the healthcare system avoid extra costs encumbered by poor translation [20]. Fazen, explains how miscommunication causes frustration due to a lack of understanding regarding linguistic nuances:

"...In this case, [the] Iranian translator conveyed to the physician [that the] Afghan patient has a history of high blood pressure when in reality it is

not, it is just "high-stress." In the end of the day, occasions like that, not only cause confusion for the doctor, but may cause frustration for the Afghan patient. Sometimes I felt helpless, and just gave up elaborating my medical conditions".

(Farzaneh - Medical Interpreter from Afghanistan)

Cultural humility

Cultural humility overlaps with the other interpersonal level recommendations (for example, interpreting and humility of care staff). Humility is a soft skill often overlooked in the medical profession although it can help enhance patient experiences, promote active listening by staff, and overall help health care workers provide better care [22, 23]. Holly an academic researcher highlights the importance of humility:

"I've heard some of the old school versus the new school [medical providers] say that the newer trainees get trained in the very technical things and they know how to run tests and read things and do, but they don't know how to just listen and

hear what the person is saying instead of what they expect. The thing about working cross-culturally is what you expect is almost never what you're going to hear if you listen. And that takes time and patience and being interested, not needing to be the smartest person in the room".
(Holly- Academic Researcher)

The notion of humility intersects not only with colleagues but also how providers work with interpreters. Alyssa a key informant and mental health provider, highlights the connection here:

"Many people focus on the cultural competency of the providers, but cultural humility is also a key-factor when interacting with refugee clients... So 'like tell me about the situation in your country right now.' You must do your research but then be open to their particular issue, how they regard it, what they see as the source of their concern. Why, what do they attribute, what they're experiencing to, whether it's a mental health issue or medical issue, what do they attribute it to? And what do they think can help them?"
(Alyssa, Mental health provider for refugee patients)

Cultural humility requires an interpersonal stance that is other-oriented with the goal of encouraging personal reflection and growth around culture in order to increase service providers' awareness. This is in contrast to cultural competence; the provider should be aware and ready to learn from this individual with a focus on their specific individual experience and not only by avoiding generalizations to it, but also not expecting them to be your informant.

Organizational level

At the organizational level, which includes efforts within local health departments and refugee resettlement agencies, the data suggests that access is facilitated when programs ensure that education of healthcare services remains available. Refugees demonstrated an overall lack of awareness in how to navigate and utilize the health care settings. Educating the recently resettle refugees when to use dif-

ferent resources like ED vs Urgent Care vs Primary care service is essential. Informing about in-network versus out of network providers in the context of the refugees' health insurance program is also necessary. Refugees were suspicious about discussing personal information and did not trust the health care system. Refugees were particularly distrusting of the HIPAA Privacy and Personal health information rights. Considering the fact most participants expressed concerns about sharing their mental health concerns with their providers due to fear of consequences, more effort must be undertaken to educate refugees about the health system and their privacy rights. Increasing Afghan refugees' education and awareness of American society is critical in building their self-efficacy and ability to navigate the health system. Pedagogy techniques such as peer-to-peer training prove to be more effective than training provided by individuals' perceived as outsiders. Thus, more collaborative and culturally responsive training by caseworkers and Afghan gate keepers or 'insiders' is recommended. Health education for refugees should especially include the topics of patient rights and privacy, in addition to how to navigate the health system. Health education sessions would be best held in spaces that reduce the logistic barriers for families. This issue is clarified by one key informant:

"The only way is health education; health education at home and any kind of informal education at home or in the clinic that gives them more information".
(Farzaneh, Medical interpreter and refugee from Afghanistan)

Community level

As data demonstrated that one of the barriers to access was perception, it is apparent that myth busting would be a feasible recommendation to remedy the situation. Busting the myths regarding refugees and how they are perceived by locals can facilitate community integration [8, 24]. Myth busting education within the community can be more effective by employing peer-to-peer pedagogy [8, 25].

Media and tactful messaging can improve the host community's awareness and understanding of the incoming refugee community. Myth busting is critical since many Americans and even researchers and care providers are not aware of the complexities of the refugees' immigration status. Some people may perceive refugees as being uneducated, permanently reliant upon social assistance systems, and using the locality's resources without making any contribution to society. However, most refugees, especially those who possess SIV cards, are actually well educated and served American troops and/or the US mission for at least one year within respective war zones [26]. These refugees have backgrounds in medicine, education, diplomatic service, and other skilled fields. During the war they functioned as interpreters, informants, and guides for American troops. In fact, this very commitment to serving the U.S. government is what made it unsafe for them and their families to remain in Afghanistan as one key informant highlighted below. By educating the host community about the origins and culture of refugees, the myths that promote marginalization of refugees can be busted.

"[The] SIV application is very time-consuming and complicated with a lot of hoops and barriers. That is why it takes 2 years... I think the immigrant advocacy groups use the word "extreme vetting" as these people are vetted more than one could imagine. They really go through a gigantic process to get here. This is why the majority of Americans do not even know what is a Special Immigrant visa holder versus a refugee or asylum seeker".

(Shuhrah, Journalist and advocate for refugees)

Policy level

At the policy level two main things can be done to improve access to healthcare. First, electronic medical records (EMR) systems need to be improved to streamline continuity of care for refugee patients. Second, Medicaid coverage and thresholds should be expanded in order to reduce the barriers to wellness. Although refugees can extend their Medicaid coverage upon meeting the requirement, the-

re is constant fear of losing coverage among all the interviewed participants. Eight months is not enough time to establish one's self as financially independent in a new country; therefore, Medicaid benefits should be extended beyond the eight month coverage period as one participant explained:

"All recently resettled Afghans that I know are constantly afraid that if they work a little extra hours to better serve our families' financial needs, then they have to be concerned about going beyond the [income] cut-off of \$3K per month, which may culminate in losing their Medicaid coverage and their benefits may be revoked. If I was the policy-maker I would extend Medicaid coverage and increase the cut-offs for household income".

(Muhamad, Afghan SIV holder)

CONCLUSION

Recommendations to improve Afghan refugees' health experiences in the U.S. were rooted in the data, and discussion of these recommendations was organized within a socio-ecological framework. There are many people like the refugees and SIVH participants, who supported the U.S. military during the conflicts and war in their countries. These individuals put their lives and their family's lives' in extreme danger to aid the U.S. forces, which often forced them to flee their homes in search of safety. Refugee's had to abandon everything that was known in their homeland and work to rebuild their lives from scratch facing barriers and drawing strength from facilitators to create a new future in a new country.

Although the number of SIVH from fiscal year 2017 to 2018 dropped dramatically, and even more so with the current administration [7] service providers need to remain vigilant and ensure they provide high quality care to this deserving population. Specific focus is needed to inform the health system about the unique needs of the Afghan refugee community resettled in the U.S. This refugee group is not included among the Centers for Disease Control and Prevention Refugee Health Profiles available publicly to brief health care providers on appropriate services for diffe-

rent refugee patient populations [27]. After the events of September 11th, 2001 and the U.S.'s involvement in the war in Afghanistan, the current administration [7], the U.S. healthcare system has an increased responsibility to promote successful resettlement of this population, which includes appropriate health services [28].

Future implications

The present study provides important implications for future research. Future investigations may determine if these findings are confirmed in other refugee communities. Given the limited literature on this population, more research needs to be done to gain a better understanding of the community to address potential sub-optimal health outcomes and

under-utilization of health services within the Afghan refugee community throughout the states. Future investigations may utilize a transformative [1] approach, which is not only culturally responsive, but it also applies a critical approach to understanding a phenomenon. By using a transformative methodology and a socio-ecological framework practitioners can focus on bolstering health influencing facilitators, while working to design new initiatives which are culturally responsive and research-informed. Intentional aims to identify facilitators to health care accessibility and health-promoting community attributes could better frame this refugee population as active agents in their health care process instead of passive users of the health care system.

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