

# Health Needs Assessment Report for Afghan Refugees of Summit County

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Summit County Public Health Department

The purpose of this needs assessment is to determine what are the perceived and expressed healthcare needs of Afghan refugees. Noted barriers such as language, transportation, and cultural understanding of healthcare system have prevented refugee groups from receiving sufficient and quality healthcare, increasing their likelihood of acquiring mental and physical injury and illness. This document contains cultural information about Afghan refugees, descriptions describing the barriers to care, methodology of data collection, results of data collection, and recommended next steps for program planning and educational outreach. Results revealed three major themes of healthcare needs are access to care, and understanding how the American healthcare system works, and lack of knowledge. Based on the results, it is clear that Afghan refugees would benefit from increased support with transportation and learning English, means to address non-healthcare related barriers, and printed/video resources for non-literate refugees. Lastly, assisting women open their own childcare business near other refugees can address barriers concerning childcare and training community advocates and religious leaders with mental health first aid training can further reduce barriers to mental health care.

## **Table of Contents**

<b>Introduction .....</b>	<b>1</b>
<b>Literature Review .....</b>	<b>1</b>
<b>Research Question .....</b>	<b>17</b>
<b>Methodology.....</b>	<b>18</b>
<b>Results .....</b>	<b>21</b>
<b>Discussion .....</b>	<b>25</b>
<b>Recommendations .....</b>	<b>27</b>
<b>Acknowledgements .....</b>	<b>28</b>
<b>Work Cited .....</b>	<b>29</b>

## **Introduction**

The Islamic Republic of Afghanistan had a history as a prospering nation and a major trading hub between Europe and Asia.<sup>1</sup> In the 20<sup>th</sup> century and onward, the country experienced multiple wars, political instabilities, and natural disasters. These events created thousands of refugees in two major waves. Prior to the Syrian refugee crisis, Afghanistan produced the world's largest number of refugees.<sup>2</sup> The main objective of the report is to discover the perceived and expressed needs of Afghan refugees are when receiving healthcare in Summit County. The needs assessments also examines a brief history, cultures and religion, languages, a health profile, health beliefs and customs, the immigration process, and barriers to care. Lastly, the methodology, results, discussion, and recommendations are discussed.

## **Literature Review**

### **Brief History**

The history of Afghanistan can be traced back to almost two millennia. Interactions with different civilizations and ethnicities contributed to several historical events and shaped a great deal of the Afghans' many cultural identities. In the 20<sup>th</sup> century, political strife contributed to the modern refugee migrations. In 1919, Afghanistan attained its "independence" from the British after multiple attempts of colonization.<sup>3</sup> From 1921 to 1979, Afghanistan heavily allied itself with the Soviet Union and was the first country to recognize the Soviet government.<sup>1</sup>

The Soviet Union invaded Afghanistan, and started the Soviet-Afghan War on December 24, 1979.<sup>4</sup> Rebellling forces, collectively known as the *Mujahideen*, received financial assistance and weaponry from the United States in order to drive the Soviets out. After Soviet troops withdrew in 1989, a series of civil wars continually broke out between rebel militant forces and the Afghan government. The Soviet-Afghan resulted in the first major refugee wave of Afghans to nearby Pakistan and Iran or to the United States, Canada and Europe.<sup>5</sup> In 1992, the rebel forces overthrew the government and declared Afghanistan an Islamic Republic.<sup>2</sup> This caused

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<sup>1</sup> (Central Intelligence Agency, 2015)

<sup>2</sup> (United Nations High Commission for Refugees, 2015)

<sup>3</sup> (Robson, Lipson, Younous, & Mehdi, 2002)

<sup>4</sup> (Khalidi, 1991)

<sup>5</sup> (US State Department, 2013)

particularly chaotic period since no formal government was in place. The Taliban rose to power in the early 1990s and acted as a political religious force in Southern Afghanistan.<sup>6</sup> Initially, the Taliban were well-received for restoring order to the previously ungoverned country but then radically changed the way of life for many Afghans by imposing harsh and rigid interpretations of religious edicts.<sup>2,5</sup> The Taliban also gave refuge to Osama Bin Laden, a supporter of the Mujahideen during the Afghan and Soviet War. He was also granted cultural protection for guests of the country. When the war ended, Bin Laden increasingly gained followers and pushed for a holy war against the United States. After the September 11<sup>th</sup> attacks, the United States demanded his surrender. The refusal to surrender Bin Laden led to the US-Afghan War, which lasted from 2001 to 2014.<sup>7</sup>

The US- Afghan War resulted in over 90,000 war-related deaths and over 100,000 injured.<sup>8</sup> Even after the war ended, stability still has not reached the country. Two major terror attacks occurred in the summer of 2016, one month apart.<sup>9,7</sup> The culmination of multiple wars and political instability forced droves of Afghans to evacuate into neighboring Pakistan and Iran, creating the second wave of refugees. Afghan refugees currently face mass repatriation by both the Pakistani and Iranian governments.<sup>10,11</sup> Aside from the aforementioned countries many Afghans resettle in Germany, the United States, and Australia.<sup>12</sup> In the United States, Fremont, California has the largest Afghan community, followed by Northern Virginia, New York, and Florida.<sup>13</sup>

## **Religion and Cultures**

Both religion and culture play a strong role in the identity of the Afghan people. Allegiance to tribe and family come even before allegiance to the nation.<sup>3</sup>

The largest ethnicity in Afghanistan is the Pashtuns, comprising 38% of the country's populations.<sup>3</sup> The Pashtuns are recognized for their ability to thrive in harsh geographic terrains,

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<sup>6</sup> (Matinuddin, 1999)

<sup>7</sup> (Tyler, 2001)

<sup>8</sup> (Watson Institute of International and Public Affairs, 2016)

<sup>9</sup> (Rahim & Windrem, 2016)

<sup>10</sup> (United Nation High Commission for Refugees, 2016)

<sup>11</sup> (Human Rights Watch, 2013)

<sup>12</sup> (Stichs, 2016)

<sup>13</sup> (Stannard, 2009)

their marksmanship, and their strength in battle. They are usually acknowledged for driving out the British and the Soviet Union.<sup>3</sup> Additionally, Pashtuns are well known for their strong emphasis on religion and deep appreciation for oral poetry. A code of ethics for how a Pashtun should live and interact with his or her environment is called “Pashtunwali”. Pashtunwali embraces concepts such as bravery, endurance, protecting women and children, protection of property, hospitality, and the protection of guests.<sup>3</sup> Since Pashtunwali has guidelines for nearly all aspects of life, most will identify as Pashtun before identifying as an Afghan. The Pashtuns almost entirely speak the language of Pashto, one of the official languages of Afghanistan.

Tajiks, originally from Iran, are the second largest ethnic group and comprise of the largest group of Afghan refugees in the United States.<sup>3</sup> Tajiks are recognized for speaking Dari, a language very similar to Farsi. They are also known as “*Farsi*” or “*Farsiwan*” since “Tajik” used to be depreciatory. However, “Tajik” is now an acceptable term to identify this group.<sup>14</sup> They are known for being devout Muslims, having a strong work ethic, and extreme hospitality towards guests.<sup>3</sup> Tajiks also comprise the highly-educated and wealthier of Afghan citizens, giving them great influence in political and social issues.

Following the Pashtuns and Tajiks, Hazaras are the third largest group. They are one of the original Central Asian ethnicities.<sup>3</sup> While most of the Hazaras speak Hazaragi, other Dari-speaking groups can easily understand and communicate in this dialect.<sup>15</sup> Most Hazaras are Shia Muslims, compared to Tajiks and Pashtuns who are mainly Sunnis. Unfortunately, the distinction between the groups has led to prejudice and discrimination against the Hazaras.<sup>11</sup> The Hazaras have assimilated to Pashtun and Tajik cultures in order to blend in with the other groups, but are generally very independent. They are a sedentary people, living in highland areas as farmers or shepherds.<sup>16</sup>

Aside from Pashtuns, Tajiks, and Hazaras, Afghanistan is home to many more ethnic groups. Each ethnic group, while having similar cultures, are still vastly different. Ethnic identity is a strong factor in the way Afghans see themselves and others. It is critical not to apply a “blanket culture” to Afghans as if they are a homogenous group.

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<sup>14</sup> (Dames, Morgenstierne, & Ghirshman, 1999)

<sup>15</sup> (Encyclopaedia Iranica, 2016)

<sup>16</sup> (Latham, 2015)

Despite the many ethnic groups in Afghanistan, one of the unifying aspects is religion. Nearly all Afghans are Muslim, with 90% identifying as Sunnis and 7-19% claiming they are Shia.<sup>1</sup> Islam is a central part of Afghan life and can take precedence over cultural differences. Health care providers, resettlement staff, and interpreters should keep this in mind while assisting Afghan refugees with their transition to America.

## **Languages and Communication**

Pashto and Dari are the official languages of Afghanistan but it is not uncommon for Afghans to speak multiple languages.<sup>1</sup> Many can speak at least two dialects comfortably. Additional national languages include Uzbek, Arabic, Turkmen, Pashayi, and the Nuristani dialect.<sup>2</sup> Illiteracy is a widespread problem in Afghanistan. The literacy rate for Afghanistan in 2015 was 38.2%. Men have higher literacy rates of 52% while women have a considerably lower rate of 24.2%.<sup>1</sup>

Nonverbal communication is very important keep in mind when interacting with Afghans. It is common to see displays of affection between people of the same sex (such as hugging, kissing on the cheek, or holding hands) as it indicates friendship.<sup>17</sup> Eye contact is another concept of communication which differs. Many Afghan men and women will not make direct eye contact with individuals of the opposite sex since direct eye contact appears “bold” or immodest.<sup>18</sup> It is important to keep cultural context in mind. For example, an Afghan female refugee may have resided in a large city, with a career and higher education, may be accustomed to interacting with men and shaking hands with opposite sex. However, it is best to let the refugee make the first move when it comes to greetings. Care providers should observe their body language and nonverbal communication in order to comfortably interact with Afghan women. Non-Afghans should understand that Afghans will stand closely when communicating with people, which may conflict with the concept of personal space. The close interaction is meant to show that people are paying attention and are interested in the other person. It is not as common to see this close interaction between men and women. Putting one’s hand to their chest is a respectful and appreciated manner of greeting someone of the opposite sex.<sup>12</sup>

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<sup>17</sup> (Government of Canada, 2014)

<sup>18</sup> (Office of the Refugee Health Coordinator of Arizona, 2016)

Getting angry and using a raised voice towards an Afghan is highly frowned upon since public rebuking will cause an individual to lose face. It is important that tone of voice is moderate and clear when speaking to an Afghan.<sup>12</sup> Afghans, as a whole, are very polite and formal, especially when addressing individuals they don't know well. They will use professional and formal titles when addressing others and may not stop doing so with people whom they believe are in a higher station than they are. Praise and compliments are always deeply appreciated and can foster more trusting relationships but it is important not to excessively flatter the individual either. By saying the Islamic phrase MashAllah (or Praise be to God) after a compliment or praise, Afghans will be much more receptive and trusting towards care providers and resettlement agency staff.<sup>12</sup>

### **Family Structure**

In general, Afghan family and societal culture is patriarchal. The oldest male in a household, often the husband's father, makes the major decisions on anything which can impact the family.<sup>19</sup> Multigenerational households are the norm in Afghanistan and it is also common for extended family members to reside in a household, such as unmarried aunts and uncles.<sup>3</sup> Although there are stereotypes about Afghan women not having respect, mothers are considered a vital and critical entity of the family unit. It is common for women to be in charge of the household and childrearing while men are the breadwinners of a family. Though, it should be remembered in bigger cities such as Kabul, many women go to universities, have jobs, or have financial independence.<sup>15</sup> Afghan male refugees, mainly from rural areas, may have trouble adjusting or accepting when their wives leave the home to work.

Elderly Afghans may have trouble adjusting when their adult children, specifically daughters, are not home to care for them. With increasing numbers of Afghan women are working outside the home in America, elderly relatives are left unattended. Most are unable to speak English or drive, making it difficult to socialize with others.<sup>20</sup>

Children are expected to show proper respect and manners towards anyone older than themselves. Besides their mothers, children are generally brought up by multiple women in the

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<sup>19</sup> (Norwegian Afghan Committee, 2016)

<sup>20</sup> (Brown, 2009)

household, including aunts, older siblings, cousins, and their grandmother. Though adults can be very indulgent and affectionate towards children, corporal punishment as a disciplinary method is common along with not fussing over children when they get hurt. <sup>21</sup>

Marriage is one of the most important life events in Afghan culture. Most marriages are typically arranged but in the larger cities, men and women choose their spouses. However, this is not to say that arranged marriages cannot be harmonious or happy contrary to Western thought and understanding.<sup>13</sup> Afghans commonly marry young and have many children. While child marriages exist, the trend is decreasing as international sanctions are taking place. Polygamy is also socially and religiously acceptable so long as wives are all treated with respect and have equal status among one another. Each wife (up to four wives are Islamically permissible) is entitled to money and has recognized legal status by the Afghan government. However, polygamous marriages are becoming less common and done only in rare circumstances.<sup>13</sup> In the United States, the other wives may be introduced as sisters since it is understood polygamy is illegal in many Western countries.

### **Health and Healthcare Profile**

The Ministry of Public Health (MoPH) in Afghanistan, in recent years, has made many efforts to restructure itself after long periods of war and instability. The MoPH describes its mission to “improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality health services provision, advocating for the development of healthy environments and living conditions; and the promotion of healthy lifestyles”. <sup>22</sup>

Unfortunately, the health profile for Afghanistan is one of the lowest in the world. According to the United Nations Human Development Index (UNHDI), Afghanistan ranks at 171 out of 185 countries.<sup>23</sup> Life expectancy for men and women was approximately the same at 60.5 years in 2012. <sup>24</sup> The top three leading causes of death in Afghanistan are lower respiratory

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<sup>21</sup> (Giger & Davidhizar, 2002)

<sup>22</sup> (Ministry of Public Health e-Government of Afghanistan, 2011)

<sup>23</sup> (United Nations Development Programme, 2015)

<sup>24</sup> (UNICEF, 2013)



infections, ischemic heart disease, and diarrheal disease.<sup>25</sup> Conflict and violent deaths were in the top ten causes of death for Afghan adults in 2012 and has reportedly increased, based on the report data.<sup>27</sup>

Previously, Afghanistan was described as “one of the worst places in the world to be pregnant” in 2002.<sup>26</sup> In that year, the maternal mortality rate was 1,600 per 100,000 live births. Conditions such as war, displacement, travel restrictions on women placed by the Taliban, and poor infrastructure have all lead to the exceptionally high maternal mortality rates.<sup>36</sup> However, the United Nations Population Fund (UNPFA) has praised country health officials for improving OBGYN services and training programs for midwives. While the maternal mortality rate is still high, it decreased considerably and is now 400 per 100,000 live births.<sup>27</sup> In 2002, the nation only had 467 midwives but in ten years, more than 4,600 midwives are actively working. Fertility rates amongst Afghan women are high. Afghan women may bear an average of 5.22 children in her life time.<sup>1</sup> Family planning is a priority goal by the MoPH. When evaluating factors that predicted increased contraception use a study conducted amongst married women of child-bearing age (12-49) showed the strongest indicator of contraceptive use was age.<sup>29</sup> Older women were more likely to use a contraceptive, compared to younger. Other indicators included place of residence, education level, and media exposure to contraceptive use. Women who resided in urban areas, had higher education, and increased exposure to mass electronic products, such as cell phones or television, indicated higher usage and intended use of contraceptives.<sup>28</sup>

Childhood mortality in Afghanistan was the second highest in the world.<sup>29</sup> However, much like maternal mortality rates, under-5 child mortality has decreased. In recent years, the nationwide child mortality rate has reduced from 87 deaths per 100,000 to 55 deaths per 100,000.<sup>30</sup> The leading cause of death for children under-5 or less isn't precisely known but is described as “other causes”.<sup>27</sup> It is possible that this cause of death is related to malnutrition or starvation. In 2014, 55% of children were stunted in growth from a lack of nutrition.<sup>31</sup> In 2015,

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<sup>25</sup> (World Health Organization, 2015)

<sup>26</sup> (UNICEF, 2002)

<sup>27</sup> (United Nations Population Funds, 2015)

<sup>28</sup> (Reyer, Osmani, Osmani, & Hamajima, 2015)

<sup>29</sup> (UNICEF, 2016)

<sup>30</sup> (Watt & Khan, 2016)

<sup>31</sup> (Central Statistics Organization and UNICEF, 2012)

the United Nations of Assistance Mission in Afghanistan documented civilian casualties reached a new high and cite conflict-related violence is a leading cause of death for children in Afghanistan. Child mortality had risen from its previous count in 2014 and reported 430 children civilian casualties.<sup>32</sup>

Oral health is becoming an increasing concern for Afghan refugees. Many refugee children have never received a conventional toothbrush or used fluoridated water and or toothpaste.<sup>33</sup> However, more research is needed about oral healthcare on Afghans, including attitudes and perceptions on the importance of oral care to Afghans.<sup>34</sup> New refugees should be referred to a dental clinic sooner after their arrival.

Common diseases found in the Afghan population are intestinal nematodes and iron-deficiency. Iron deficiency anemia is the leading cause of disability as well, along with lower back and neck pain and conflict.<sup>35</sup>

Afghan refugees are especially at risk for mental illness. In the past decade, the MoPH of Afghanistan has made mental health care a priority cause after data showed 16.5% of adults reported suffering from some mental trauma.<sup>36</sup> Mental health care is greatly needed and is continually expressed by care providers and resettlement agency staff. Psychotic disorders such as schizophrenia are rarer in Afghans. However, conflict and instability has plagued Afghanistan for almost four decades, resulting in increased rates of post-traumatic stress disorder, depression, anxiety, and psychosomatic illnesses among the Afghan refugee population.<sup>36</sup> Health care providers should also watch for substance abuse disorders, mainly alcoholism. While alcohol is forbidden to Muslims and is not legally sold in Afghanistan, many Afghan refugees may begin drinking in the United States and can develop addiction to alcohol as a coping mechanism.<sup>36</sup> There is a strong likelihood mental health concerns are underreported. Mental health is heavily stigmatized, though some conditions such as anxiety are recognized (worrying may cause illness).<sup>35</sup> It is important for care-providers and resettlement agency staff to recognize that Afghan refugees could discuss their mental health terms in psychosomatic terms (complaining of

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<sup>32</sup> (United Nations Assistance Mission in Afghanistan , 2015)

<sup>33</sup> (Cote, Geltman , Nunn, Lituri, Henshaw , & Garcia , 2004)

<sup>34</sup> (Keboa, Hiles, & Macdonald , 2016)

<sup>35</sup> (Institute for Health Metrics and Evaluation, 2015)

<sup>36</sup> (World Health Organization, 2016)

headaches, weight loss or gain, tiredness). Afghan refugee youth are highly vulnerable to mental illness and may manifest it in anger or withdrawal.<sup>35</sup> Elderly Afghan refugees are a high risk group for mental health disorders, mainly with anxiety or depression. This is most often the case when they are no longer being attended to by adult children or are left alone at home during the day. They may also not accept Western medicine or treatments and will prefer to use homeopathic or traditional Afghan remedies, including treating somatic symptoms related to mental illness.<sup>3</sup> However, the need for mental health services has been recognized. Groups such as Afghan Mental Health Project or the Afghan- American Women's Association work strongly to promote mental health wellness, answer questions about mental illness, teach cultural competency to healthcare providers, advocacy, outreach, referrals, and resource provision.<sup>37</sup>

Domestic violence is a large concern among the Afghan refugee population. In Afghanistan, traditional gender roles are strongly adhered to in which males are the main authority. Violence against women and women's rights are controversial issues in Afghanistan. In a report conducted by Global Rights, approximately 87% of Afghan women experienced domestic violence at least once in their lifetimes.<sup>38</sup> However, this statistic may be underreported in that many women may feel afraid to tell anyone of the domestic violence or domestic violence may not always be interpreted as illegal. The latter reason is demonstrated in a 2012 UNICEF survey, in which 92% of the women participating felt domestic violence was justifiable for reasons such as leaving home without telling their husbands, neglecting children, arguing with the husbands, refusing sex, or burning food.<sup>39</sup>

Afghan parents also use corporal punishment when disciplining children, though it can be construed as child abuse by non-Afghan health care providers and refugee resettlement agencies. Many Afghan refugees are mistrustful of American healthcare systems because of the cultural differences in regards to women and children.<sup>3</sup> Refugees may have heard stories of children being removed from homes or women experiencing further domestic violence after they "told on" their husbands. It is advisable for healthcare employees and refugee resettlement agencies approach the subjects of domestic abuse carefully to avoid confusing or frightening the women. Male Afghan refugees may perceive this as insulting and withdraw his participation or efforts to

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<sup>37</sup> (Afghan Coalition, 2016)

<sup>38</sup> (Global Rights Partners for Justice, 2008)

<sup>39</sup> (Clifton, 2012)

assimilate. The Cultural Orientation Center suggests that women can subtly be told the issue of domestic abuse is not private and there are resources they can turn to without “getting in trouble.”<sup>3</sup>

### **Health Beliefs and Customs**

For Afghans, health and hygiene are of paramount importance. In a study examining the health of Afghans, participants claimed good health could be achieved through eating well, exercising regularly, getting enough rest, and staying warm.<sup>40</sup> Afghans also believe living within the accordance of Islamic teachings about cleanliness (such as washing after using a toilet, practicing personal hygiene, and washing before the five daily prayers), is strongly linked to good health. Afghans take different approaches to what causes an illness. One belief centers on illness being God’s way of testing individuals and family. Friends, family members, and acquaintances of the sick should pray, fast, or give charity to facilitate a painless and swift recovery.

Another cause of illness is the work of supernatural entities called *jinns*. Since the majority of Afghans are practicing Muslims, many believe jinns (a non-human being made of smokeless fire) can interfere with the health of humans. For example, it was once thought epilepsy came from being jinn possession.<sup>40</sup> It is important not to dismiss or scoff at Muslim patients for thinking this. Care providers and staff members of resettlement agencies should suggest a patient consult an imam (an Islamic religious leader) about this to allay concerns.

A concept called “*nazar*” also contributes to illness or injury. *Nazar* translates to “gaze”, or is colloquially known as the “evil eye”. *Nazar* is thought to be the result of envy or someone with ill intentions who wished poorly upon another person, leading to a misfortune like becoming sick or getting hurt. Or, *nazar* can be caused unintentionally when an individual is praised excessively.<sup>40</sup> This can be prevented when a compliment is attributed to God. A common scenario could be a doctor praising a small child effusively for being well behaved or cute. Though the intention is not to harm, Afghan parents might say the phrase “*MashAllah*” which means “Praise be to God” or deflect the compliment to prevent *nazar*. Many Afghans will wear blue stones or beads in amulets or charms to prevent *nazar*. Care providers or resettlement

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<sup>40</sup> (Lipson & Omidian, 1992)

agency staff members should keep in mind this jewelry is sensitive for Afghans and removing it might cause some discomfort or anxiety.<sup>40</sup>

While there are a lot of spiritual factors related to illness, Afghans do staunchly believe in natural causes of illness such as dirt, wind, or cold weather. Very traditional Afghan medicine looks closely at humoral imbalances such as “hot” or “cold”.<sup>40</sup> Whatever the imbalance is, specific food or traditional herbs are used to treat the illness. Western medicine is highly respected and a profession in the medical field is admired and sought after.

In general, Afghans will use both traditional and Western clinical treatments and in no particular order. Mild illnesses such as headaches, colds, and fevers are usually treated at home with traditional methods or over the counter medicines while more severe illnesses are referred to doctors.<sup>40</sup>

There is a “cultural disconnect” between care providers and Afghan refugees. Healthcare expectations are vastly different from Afghanistan and America so patience and understanding is critical to reduce miscommunications or misconceptions.<sup>40</sup> Many Afghans have been described to “interrogate” doctors about their credentials, visit multiple doctors for the same condition, or share medicine with family members or friends. Afghan women will also ask for female-only physicians, especially when seeing gynecologists or when receiving physical examinations. If interpreters are in the room, female interpreters will be asked for if personal health matters are discussed. Sometimes, Afghans can withhold health issues, due to concerns of being gossiped about in their community, loss of face, or being seen as “weak”. Healthcare providers can reassure Afghan patients of confidentiality and even interpreters are not at liberty to discuss a patient’s medical history outside of the doctor’s office.<sup>40</sup>

Healthcare providers should be aware of the cultural communication styles of Afghan patients since it can be construed as insincere. Patients will accept treatment plans more out of respect than from agreement.<sup>40</sup> It is important to note that Afghans do not like to directly be told “no” when requesting something and from this, Afghans will not say “no” explicitly to a healthcare provider. Some healthcare providers have expressed frustration in getting health information out of Afghan patients due to how Afghan patients may answer questions. Afghans will likely describe a health condition or answer a question almost in a story format rather than

providing succinct information. Afghans find giving “short” answers comes off as rude and or disinterested.<sup>40</sup>

## **Immigration Process**

To date, approximately 9 million Afghans have been affected by national crises.<sup>41</sup> The United Nations High Commission for Refugees (UNHCR) claimed there were 2.7 million Afghan refugees and Afghanistan was the second largest source country of refugees in 2015.<sup>2</sup> Afghan refugees are usually hosted by a first-asylum nation before coming to the United States or a European country. Pakistan and Iran take the largest number of Afghan refugees, with Pakistan taking 1.6 million of the refugees.<sup>18</sup> The similarity between many Afghan and Pakistani cultures results in many Afghan finding the cultural transition less difficult. In recent years, relations between Afghanistan and Pakistan have become strained from violence along the Afghanistan-Pakistan border. Pakistan also experiences political instability, natural disasters, increased unemployment, and an energy crisis which contribute to residential hardship in the country for both citizens and refugees. In 2014, the Taliban executed a terror attack on the Army Public School in Peshawar<sup>42</sup>. After the attack, more than 33, 000 Afghan refugees had been repatriated to their home country when resentment and suspicion towards Afghan refugees arose.<sup>43</sup> However, the Pakistani government is now allowing for a visa extension of Afghan refugees into 2017.

Similarly, Iran also accepts a large percentage of Afghan refugees. In January 2014, the UNHCR cited Iran hosted 840,158 refugees.<sup>44</sup> Unfortunately, Afghan refugees also face mass deportation from Iran. Afghan deportees expressed they faced torture and abuse from the Iranian police. The government denied these claims and justified the deportation as a way to ease the economic burden.<sup>45</sup> In 2010, widespread demonstrations were held in Afghanistan against Iran for mistreatment of Afghan citizens after six were executed and 4,000 to 5,000 refugees were jailed.<sup>46</sup>

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<sup>41</sup> (Internation Rescue Committee, 2016)

<sup>42</sup> (Saifi & Botelho, 2014)

<sup>43</sup> (Goldstein, 2015)

<sup>44</sup> (European Resettlement Network, 2013)

<sup>45</sup> (Alisa Tang, 2007)

<sup>46</sup> (BBC News, 2010)

Much like Pakistan and Iran, Turkey has been taking Afghan refugees since the late 1970s. In Turkey, Afghan refugees do not have access to legal employment. Additionally, Afghan refugees who do not have a residence permit cannot leave whichever province they are currently residing in without governmental permission.<sup>47</sup>

If Afghan refugees are unable to find employment and/or reside in cities in their first asylum nation, they will be sent to live in camps along the country borders. The Kungi camp, located along the Afghanistan-Pakistan border, is in abysmal condition.<sup>48</sup> Eight to twelve people live in a small tent together, which increases the risks of contracting infectious diseases. Women are forced to go to the woods when using the bathroom while men use one communal toilet. Malnutrition is a common condition faced in the camp due to the scarcity of food and water. The major causes of death which refugees are most at risk for in camps include, but are not limited to, diarrheal diseases, measles, acute respiratory infections, malaria, and malnutrition.<sup>49</sup> Sexual assault and/or rape are also frequently experienced in resettlement camps but little reproductive or sexual health clinic services are available to mitigate adverse effects. Resources to improve conditions are scarce and often, the camps are often in distant locations from hospitals or other healthcare facilities where better care is available.<sup>50</sup>

Residing in first-asylum nations like Pakistan and Iran are resulting in mass repatriation or violence against Afghan refugees, many are now looking to Europe, Australia, or the United States as a place of new residence.

Afghan Coalition, a non-profit community group working with Afghan refugees in in the United States, conducted a survey to create an overall picture of the Afghan refugee experience in California. Their findings indicate the average age of individuals who have just left Afghanistan is about 30 years. Of the participants in the survey, only 24% could speak English fluently. The survey also indicated that ¼ of the participants were unable to read in Pashto, Dari, or English. Additional results showed an 11% unemployment rate for Afghans between ages 18-64.<sup>51</sup> In terms of health insurance, Afghan refugees have similar health coverage to the US adult

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<sup>47</sup> (The Economist, 2015)

<sup>48</sup> (Shah, 2008)

<sup>49</sup> (Toole & Waldman, 1997)

<sup>50</sup> (Rutta, et al., 2008)

<sup>51</sup> (Younos, et al., 2008)

population. With the adult population, at least 86% of adults had some form of health insurance coverage in 2008, resulting from an increase from 2007.<sup>23</sup> Seventy-three percent had Medi-Cal insurance but it is not specified if the refugees had this coverage after the first 90 days of their arrival. Rates of insurance may be different in 2016 due to the Affordable Care Act and Medicaid expansions.

### **Health Screening Process**

The International Office of Migration offers the largest amount of Migration Health Assessments. In 2014, the Office reported completing close to one third of a million assessments for seventy seven countries.<sup>52</sup> The overall process includes a panel of physicians who conduct a medical screening, review of patient medical history, preventive or curative treatment, counselling and health education, and preparing of medical reports from the screenings. The initial screening looks for cases of tuberculosis, sexually transmitted diseases/illnesses, Hansen's disease, HIV/AIDS, and mental health disorders with harmful behaviors. These cases are considered as "Class A" and prohibit refugees from travel until they no longer pose harm to others.<sup>24</sup> Class B conditions are "physical or mental abnormalities, diseases, or disabilities serious enough or permanent enough to be considered as substantial departure from normalcy" and are highly recommended to receive follow up treatment soon after arrival to the United States.<sup>53</sup> Examples of Class B conditions, include but are not limited to, inactive or latent tuberculosis, treated syphilis, other sexually transmitted diseases, treated Hansen's disease, sustained and/or full remission of substance abuse, and sustained history of non-harmful behaviors of mental health disorders.<sup>54</sup>

In regards to vaccinations, refugees are not required to meet vaccination requirements with the exception of children attending school (those schools may require vaccinations in order to attend). When refugees apply for Legal Permanent Resident status, then they must comply with vaccination requirements.<sup>26</sup>

### **Barriers to Care**

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<sup>52</sup> (Migration, 2013)

<sup>53</sup> (Centers for Disease Control and Prevention, 2015)

<sup>54</sup> (Centers for Disease Control and Prevention, 2016)



During the period in which Afghan refugees are utilizing health care services, there may be several barriers to attaining appropriate and adequate care.

One of the primary obstacles which may interfere with obtaining healthcare services is the difference in language. This can be particularly difficult if a refugee has been advised to schedule an appointment and the scheduling department may not speak the same language or access an interpreter. For the appointment itself (if a resettlement agency makes one for them), a translator will be required to translate health questions and assist the Afghan refugee with understanding and answering questions. Some Afghan women may feel discomfort in answering reproductive and or sexual health questions to male interpreters. Conversely, male interpreters may also be reticent in asking personally intimate questions to women and girls. While same-sex translators can be provided, this may not always be feasible.

Another immediate barrier to healthcare is transportation. There may not be a reliable transportation service for a resettlement agency to use for the refugees or the services may be too costly, such as a taxi cab. Public transportation such as buses or trains may be intimidating for new refugees, especially if the refugee is unfamiliar with using public transportation or reading scheduling and route maps.

Under the umbrella of healthcare expectations, use of mental health services is low among Afghan refugee populations due to differing cultural contexts of mental health or stigma.<sup>38</sup> It has been noted in Afghan refugees, conversations with therapists is not a preferred treatment method. Most Afghans, if comfortable seeking mental health care, will likely request medication over meetings with therapists.<sup>35</sup>

The emphasis on privacy is deeply ingrained in Afghans. Yet, it can be a barrier to care.<sup>36</sup> For many Afghans, family matters or disclosing any information that could potentially shame or dishonor a family unit are not to be discussed with anyone. This could also explain the low utilization of mental health services among this refugee population. For example, Afghan refugees may not want to talk to Afghan psychologists since there is a fear of judgment or being gossiped about to other Afghan refugees in their social circle.<sup>44</sup> It has been suggested to refer Afghan refugees to Iranian or Pakistani psychologists since language and or culture are similar enough for them to engage with.<sup>44</sup> Care providers can also reassure Afghan refugees that

interpreters will maintain confidentiality and not share the information they learn during translations but physicians are required by law to disclose any abuse they learn of to proper authorities.

Lastly, the concept of health insurance may not be familiar to Afghan refugees. Health care prices for medications or other services may appear very high which discourages refugees from utilizing services. While most refugees are given Medicaid or other government assistance to pay for treatment, transportation, and other necessary healthcare costs, it may not be available after a certain period of time. After expiration, many Afghan refugees may not know where to get insurance again and assume they must pay out of pocket.

## **Research Question**

The question this study raises is what are the perceived and expressed healthcare needs of Afghan refugees who have resided in Summit County for three months or longer? The purpose of this question is to gather information from Afghan refugees on their healthcare experiences in Summit County and to create or maintain health programming and services that are sensitive and beneficial to the needs of the group.

## **Methodology**

In order to best examine the complex attitudes and beliefs of the Afghan experiences getting health care in Summit County, a focus group was held with six Afghan refugees and a community advocate from the Islamic Society of Akron and Kent. Focus groups appeared to be the most appropriate method of gathering information since this population had not previously been studied for needs assessments in Summit County. Additionally, focus groups are a useful data collection method which looks closely at the “why” of a participant response. Rather than interviewing separate individuals, a focus group can augment conversation in a group setting where multiple perspectives are offered and responses are built upon by other participant

opinions and experiences.<sup>55</sup> This can lead to richer and in-depth responses which may not have been evident in a survey questionnaire.

IRB approval was not needed on the grounds of “standard public health practice” To further minimize risks, assent forms were translated into Dari (the majority of Afghans in the focus group spoke this language) and read aloud by the translator assisting with the focus group. Participants signed the document or drew an “X” (if they were non-literate) to show they heard and understood the statement.

Participants were selected based on two major criteria. All participants had to be over the age of eighteen and had been residing in the United States of three months or longer. After the initial three months of residence, many refugees are generally no longer receiving assistance from refugee resettlement agencies. The recruitment process involved reaching out to the Refugee Committee Group of the Islamic Society of Akron and Kent’s (ISAK) community advocate. The community advocate selected a venue most accessible to the Afghan refugees and coordinated for a translator and the transportation.

The community advocate recruited five females and one male participant for the focus group. The discussion was limited to one hour in order to accommodate schedules and childcare needs. The focus group was hosted in the home of one of the participants.

As an incentive and token of appreciation, the participants and translator were given a gift and refreshments were provided. The focus group responses were electronically recorded and files were saved in a secured computer. The audio files were transcribed and all focus group data was destroyed after the completion of the report.

## **Themes**

Prior to the focus group, seven themes were discussed of which best illustrate perceived and expressed needs. To clarify, a perceived need was described with language that did not expressly use the words “I need” or “I want” but still appeared important to the speaker in the group either by repetition, tone of voice, or facial expression. Other indicators of perceived needs

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<sup>55</sup> (Evidence Base, 2006)

were through anecdotes in which the participant described an incident or situation which they found difficult or troubling. An expressed need specifically used language that indicated need or want (i.e. “I need”, “I want”, or “it would help”) when responding to a question.

The themes were selected based on best practice recommendations from Harvard Public Health Review Healthcare Recommendations for Recently Arrived Refugees: Observations from EthnoMed.<sup>56</sup> The themes are as follows:

- 1) Need for healthcare services and education
- 2) Need for cultural competency
- 3) Understanding the American healthcare system
- 4) Timeliness
- 5) Lack of knowledge on community services and resources.
- 6) Access to care (includes barriers such as language, transportation, distance, and or payment)
- 7) Other

Need for healthcare services and education includes but is not limited to need for health education, instructional classes on the American healthcare system, or specific healthcare needs such as screenings or home-visits. Health education classes can include but are not limited to education about healthy pregnancy or recognizing signs and symptoms of mental illness.

Cultural competency is defined as “the ability of providers and organizations to effectively deliver health care services that meet social, cultural, and linguistic needs of patients.”<sup>57</sup> Cultural competence can be illustrated through interactions with care providers and front desk staff, interactions with case management, provided with linguistically appropriate resources, and demonstrating cultural knowledge and context when speaking to refugees (i.e. allowing men or women to decide whether they wish to shake hands with the opposite sex). Since Afghans come from several ethnic groups and cultures, being aware and sensitive to Islamic lifestyle and practices may be helpful when interacting with Afghans as opposed to knowing all nuances and differences between ethnic groups.

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<sup>56</sup> (Jackson, et al., 2016)

<sup>57</sup> (Betancourt, Green, & Carillo, 2002)

Understanding the American healthcare system appears to be a broad theme but specifically examines whether newly arrived refugees understand appointment etiquette, use of preventative services, how health insurance works, or using in-network providers.

The issue of time can also be a deterrent for newly arrived refugees, especially with competing demands of enrolling children into schools, going to other government offices for benefits, English classes, case management appointments, healthcare needs may not be met simply because the time to go to appointments is not available.

Lack of knowledge is a selected theme due to many refugees not understanding what resources are available and or how to use them. While lack of knowledge could fall under other themes such as need for healthcare education or access issues, it focuses on specific concepts such as knowing what to expect in a doctor's office, local resources to assist with transportation and payment, or patient rights. Additionally, lack of knowledge can be illustrated through whether refugees know when to utilize emergency services and what to do in an urgent health matter.

Access to care has been discussed in previous sections of this assessment but this theme focuses specifically on transportation issues, payment, and language barriers. Lastly, the theme of "other" includes issues such as mental health needs and assistance with meeting non-healthcare related needs such as childcare assistance, educational needs, employment, or citizenship.

## **Analysis Methods**

Thematic analysis was utilized to examine the collected data. Themes were differentiated by color and then counted to see the frequency of themes. Multiple colors were used for the same statement if it applied to multiple themes. Explicitly stated needs were also considered as higher priority needs. All transcripts were coded more than once to check for accuracy and consistency for the themes detected.

## **Results**

Participants spoke for approximately 44 minutes and the questions were approved by the community advocate prior to sharing the questions with the focus group. Each theme will be discussed in order of prevalence in the focus group.

### **Access to Care**

The theme for access to care came up fifteen times in the transcript. Transportation and English were the two main barriers to care but also discussed lack of insurance or ability to pay for care even with health insurance. Compared to other refugee groups, Afghans did have cars but usually one per family and the car was often used by one person for the day, usually the main income earner. This made it difficult to reach appointments since they did not have access to a vehicle. Participants did discuss using the bus or having rides arranged through the local refugee resettlement agency but were aware the latter option was not always going to be available after case management services ended. Additionally, many of the Afghan participants discussed how in-network providers were too far from them to get their care. One example a participant discussed an instance when she had a prescription to fill her medication. She went to a nearby pharmacy who then told her it would have to be filled in different store but she ultimately did not get her prescription because the pharmacy was too far away.

In regards to payment, one participant told the group that she had a job but she was now earning more income and lost her Medicaid benefits. However, her insurance was not enough to cover the costs of treatment and care, namely for dental procedures. Language was also discussed as an issue but considerably less than payment and transportation. Many Afghan refugees acknowledged the assistance they received from interpreters but four of the six participants were illiterate in their own language and were unable to read in English either.

It was apparent in that participants were gravely concerned about not having assistance after the 90 day case period. The sentiment of not having enough help to get the healthcare needed was repeated by three refugees. The community advocate expressed he wanted to help eliminate this issue by taking the refugees and assisting them in doctors' office but he said he was not sure he was allowed to do this for confidentiality reasons. When a participant asked the local refugee resettlement for assistance with enrolling into the Health Insurance Open Market, she was told she could not be assisted because her 90 day case management period had ended.

The participant also lost access not only to pay for health insurance but to available resources which could have helped her with recovering her insurance benefits. She also did not receive any advice or suggestions on finding providers who would see her on a sliding fee scale or optional payment method.

### **Understanding the Healthcare System**

Afghan refugees displayed some knowledge and understanding on how to utilize healthcare services. For example, one participant discussed when she is ill, she tries to take home remedies or Tylenol first before calling the doctor's office. Since she is unable to speak English, she understood she needed to ask her case manager to assist her with making an appointment before going. The participants in this focus group knew, overall, where to get healthcare if their doctor was not available to them, such as going to the emergency department but did not say if their illness was clear grounds for using emergency services. One participant claimed she kept regular appointments with her doctor and understood what to do if the doctor's appointment could not be met.

However, there did seem to be a lot of confusion and lack of understanding when it came to insurance and payment. Based on the previous example a participant gave about getting her prescription filled, she felt she wasted a great deal of time going somewhere she wasn't supposed to go. If she had known, she said she would have made the appropriate arrangements to go the pharmacy further away ahead of time. Another participant who lost her health insurance did not know there was a penalty fee she would have to pay if she did not get coverage. The community advocate said that many refugees, not just Afghans, struggled with knowing the ins and outs of healthcare insurance and what it actually meant.

### **Lack of Knowledge**

Lack of knowledge was referenced nine times in the transcript. Afghan refugees were unclear about how to find community resources after their 90 day case management period ended. The participant who earlier spoke of losing her Medicaid insurance was advised to enroll for insurance but responded she did not know how to do it or know who could help her. She was also not told there are instructional resources which help individuals with the enrollment process.

Two participants also discussed how their doctors did not inform them or share any useful resources for them regarding assistance with insurance payment or health education classes. Afghan refugees also spoke about how they didn't make their own medical appointments and relied heavily on the local refugee resettlement to make it for them. One participant said, "If they don't make it for us, we can't do anything." In terms of treatment, one participant described how she was continually prescribed pills for pain she was having. She expressed the pills made her feel better but ultimately, she did not want to become reliant on the medication in order to feel better. The participant may not have realized she could ask for second opinions, seek healthcare from another provider, or have an active role in her treatment plan.

However, the community advocate did say there were Muslim doctors from a mosque who offered pro-bono medical services. He also talked about a free-clinic which took walk-in appointments but participants did not seem to be aware of this either. The Afghan participants did, however, know the local mosque and community advocate could provide support for them and were familiar with some community assistance when needed.

### **Cultural Competency**

Overall, the participants did not feel they were treated poorly by American doctors. All participants agreed they liked their doctors. However, the response towards opposite sex care providers was divided. Three of the female participants stated they had no problem with a male physician attending them. These participants stated they understood what the doctor intended to do. However, two of the female participants claimed they were a little shy but did not request a female physician since they understood the examination was for their health. However, all the participants preferred having same-sex interpreters. The community advocate explained that participants trusted and understood the doctor was treating them. However, participants expressed the interpreters were not providing treatment so sharing personal information made the women feel uncomfortable.

### **Timeliness**

Though timeliness did not seem to be a widely discussed issue, it did serve as a large problem for female participants who had small children. The time spent waiting for



transportation discouraged many refugees from their appointments. One female participant mentioned she had many children alone at home and going to the doctor's office was a challenge since she did not like leaving them unattended for a long period of time. The community advocate said that many Afghans do not have an issue waiting in the doctor's office because they are unemployed. However, there may be multiple tasks and other scheduled appointments participants may miss due to waiting for transportation to come pick them up. Overall, timeliness directly relates to transportation concerns.

### **Classes and Health Education**

In regards to learning about healthcare information, participants agreed they spoke among themselves to find out any information about health or asked their older children. When asked if their doctor provides any referrals for healthcare education or services, all participants said no. Participants, in general, were interested in seeking a healthcare class but were unsure if it was possible due to many not being literate in any language. When told accommodations would be made to assist those who were not literate, the participants were amenable. One participant asked if any such classes were available and if so, when could she attend.

### **Other**

Many participants expressed how there was only one person in their home who was able to work and for the number of people in their homes, one income was not sufficient. Others spoke about how it was difficult for them to find employment when they had several small children at home and were not yet ready to start school. Often times, many of the female participants were single mothers and did not have the means to arrange for consistent and affordable childcare. Another participant spoke about how she really wanted to enroll into university and get a degree but was afraid doing so would result in losing her job. She also discussed how the income in her home was limited, which additionally made it difficult to pay for schooling. Financial assistance and childcare needs were cited as two of the most pressing non-healthcare related needs

### **Discussion**

Afghan refugees have been settling in Summit County for approximately one year. Generally, they have been able to utilize some community resources through Islamic centers and refugee committees but on the whole, have been experiencing some issues with adjustment and transition.

Previous discussions with refugee resettlement groups have described the higher level of difficulty for Afghan women to adjust to American life. Many women are unaccustomed to leaving their home unaccompanied without men or have never left the home at all. This causes heavy reliance on refugee resettlement groups to assist them with basic living necessities, such as going grocery shopping. Acculturation to American culture will naturally take time but there has been a great deal of anxiety from Afghan women to utilize resources independently

In the focus group discussion, Afghan refugees did not discuss mental health concerns or issues but this concern still should be addressed. The literature suggests that Afghan refugees, namely the women, are especially at risk for mental health concerns. Single mothers, especially, are a vulnerable population for increased risks of depression and or anxiety. Or, women who have disabled or ill spouses who cannot work are equally at risk. Additionally, many of these women experience the “triple trauma paradigm”, which describes refugees experiencing three levels of trauma.<sup>57</sup> Many refugees will have lost family members, spouses, and have had their lives severely interrupted by conflict and instability. This is the first level of trauma but it expounds when they are residing in camps in their first-asylum nation. Food, water, and healthcare shortages can adversely impact overall health and women are especially at risk for sexual and gender based violence. Lastly, the third level of trauma impacts refugee women with adjusting to a new culture, finding employment, enrolling children into school, learning a new language, and running a household usually without assistance.<sup>58</sup> The lack of disclosure regarding mental distress could be attributed to multiple factors, such as privacy concerns or cultural perceptions of mental health, but it is critical to offer mental health assistance in a culturally sensitive manner.

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<sup>58</sup> (Weibe, 2011)

Lack of literacy served as a barrier which prevented participants from seeking additional assistance. The lack of literacy in English, Pashto, and or Dari made it difficult for participants to read forms, appointment cards, looking up information, and signing papers.

While Afghan refugees do have access to community resources for assistance, some refugees seemed reticent to ask for help. This may be traced back to refugees not feeling they have enough language skills to communicate with community groups. Or, refugees may feel embarrassed over their perception of being a burden on others. For example, when a female participant discussed not knowing how to enroll for insurance on the Open Market website, she did not readily agree to the community advocates suggestions and seemed hesitant to accept help from him. Refugees may be aware they need a lot of assistance and may, after a time, feel embarrassed or uncomfortable to continually ask for help. This demonstrates the goal to become self-sufficient but the volume of steps it takes to become acclimated to American culture can be very overwhelming and can result in not trying at all or withdrawing from the larger community.

One distinction of the Afghan focus group, compared to other refugee group was extended assistance from the refugee resettlement agency if their case was considered “extreme”. Extreme cases were usually those in which no one in the household could earn income or only one person earned. Three participants discussed how they were unable to find employment due to health issues and not having anyone else in their home old enough to work.

Another distinction with Afghan refugees was the short-lived or inconsistent community assistance from outside groups. Refugee resettlement groups have worked with other organizations who wanted to assist refugees but the volunteers lack proper training and guidance on effectively helping refugees. One participant described how she once had a volunteer from a community group helping her with transportation. The volunteer abruptly stopped helping her and never responded to any calls again. This left the participant feeling especially upset over her assistance being suddenly cut off and not knowing why.

## **Recommendations**

Based on the existing literature and focus group discussions, the following recommendations have been made. Recommendations are subject to change based on economic feasibility and programmatic logistics.

Afghan refugees have considerable barriers to overcome when receiving healthcare. Transportation and language are the main barriers which prevent refugees from receiving adequate healthcare. Transportation barriers can be addressed in a few ways. Healthcare facilities can apply for company discounts to use Lyft or Uber to arrange for transportation to take refugees to and from their homes. These transportation services can assist refugees with getting to and from appointments in a timely manner and are less expensive than using a taxi service. If participants feel uncomfortable with using either car service, they can enroll in the New Americans Driving Initiative. This local initiative provides driving education, preparation for the written exam, and a voucher to take the physical exam. The class also teaches refugees driving and parking etiquette along with providing information about insurance and car-seat safety. The class, however, meets once a week and may require significant payment to cover the costs of the program.

Since childcare needs were an obstacle to getting to appointments as well as finding employment, the Office of Refugee Resettlement (ORR) recommended teaching and certifying refugee women to become childcare providers in their home can assist with providing a job skill and helping other refugee women with childcare needs.<sup>59</sup> The ORR offers grants to different refugee resettlement agencies which can apply for to get the necessary funds to teach refugee women how to make sure their homes meet standards, obtain business licenses, and assist refugee women start home-based day-care centers. Refugee women who need childcare assistance may feel more inclined to trust women whom they already know with caring for their children and those who are not able to leave home can still work and earn income.

Based on cultural traditions of creating textile art, introducing a knitting circle or a quilt-making club for Afghan refugee women in a central location may assist with mental health trauma and networking. Textile arts can also be manufactured for an online store such as an Etsy shop and funds can be given to woman who created the craft. The craft-making circle can serve as a means of art therapy in which women can develop positive coping skills. By selling their crafts and earning income, women unable to leave the home can develop self-esteem by being able to provide for their children and having a marketable skill.

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<sup>59</sup> (Office of Refugee Resettlement, 2017)

Lastly, Mental Health First Aid (MHFA) is a much needed resource for Afghans. This training has shown improved recognition of signs and symptoms of mental illness, and increased referrals to mental health care providers, and decreased stigma of the mentally ill.<sup>60</sup> Mental Health First Aid Training can be first utilized by community advocates along with Islamic leadership in mosques. Culturally appropriate mental health resources has been developed by the Afghan Mental Health Project and many members provide information about mental health promotion, screenings, and community education, specifically tailored for Afghans. Reaching out to existing advocacy groups and utilizing their resources can spare time in program development and costs.

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<sup>60</sup> (National Council for Behavioral Health , 2015)

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