Syrian Refugees in the United States

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Refugees are a long way from home and fought quite tenaciously to get to their destinations. According to *Action Against Hunger,* 5.5 million refugees are from Syria, 2.5 million from Afghanistan and 2.3 million are from Sudan. According to an editorial in AJPH, refugees from Syria in particular have a longer road to normalcy and have needs that include"... the need to find paid work, transportation, and housing; deferred preventive care; pre existing medical conditions, particularly untreated diabetes and hypertension; and severe mental distress arising from great personal loss and a chaotic and dangerous flight from Syria." Syrian refugees had a long and often painful road to refugee status which corresponds with the story of many Refugees that we have seen in the past 10-15 years. However, this refugee movement is unparalleled because of the sheer number of people who are being displaced, whether internally, within their own countries, in the Middle East or the Western world. In my research I would like to discuss the needs of the newly arrived Refugee population, how the healthcare needs are being addressed and at the same time reveal where there is room for growth.

A refugee is, "...an alien who, generally, has experienced past persecution or has a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." A refugee can seek protection under the law while already in the country and asylum status while outside the country, under Section 207 of the Immigration and Nationality Act. In 2016, the US raised its number of Syrian Refugees accepted into the country to 10,000 after pressure from European nations to do more to help in the Syrian Refugee Crisis. In the 2020-2021 report, the US had pledged to resettle 15,000 refugees and process 290,000 asylum claims, catching up on the almost 1.1 million asylum seekers who are awaiting decisions on their acceptance. COVID-19 has delayed a lot of these refugees from being accepted into the country, but new legislation seeks to help these people who are desiring legal immigration. Refugee resettlement was put on hold from March 19th to July 30th,2020 due to the COVID virus. Moving into 2020, the United States actually led the world in the number of new asylum applications received for the years 2017, 2018 and 2019 and therefore is a highly coveted destination for many refugees.

The United States is a place where refugees come and receive help to restart their lives and have a new mandate to live in a freer environment with greater opportunities. However, due to the political climate, the Executive Branch of the United States in their 2021 report, determined that refugees from high risk terrorist countries would not be admitted to the United States unless under the strictest circumstances of persecution or

threat to life. These countries include Syria, Somalia and Yemen. Meanwhile, after the beginning of the Syrian Civil War, there are 5.6 million Syrian Refugees worldwide including European countries, 3.7 million in Turkey, 865,00 in Lebanon and 663,500 in Jordan.

Among other things, the United States has made several provisions for the healthcare needs of the Refugees. When refugees arrive they are enrolled in a Refugee Medical Assistance program for up to 8 months upon arrival. Within the resettlement period the refugee receives a screening assessment and will be provided with health and mental health services through the Survivors of Turture and Refugee Health Promotion grant programs. The families are required to have a medical exam within 30 days of arrival, resettlement agencies give 3 months of services and then the refugees are recommended to join a medical home. After the first 8 months, Refugees can go to the Marketplace under the Affordable Care Act and receive insurance coverage or receive insurance through employment like most Americans. There are currently 18,000 Syrian refugees resettled in the USA since the war began 10 years ago. Each individual has their own story, hardship and mental health strategy to help them go forward. Thus each refugee struggles".. with time pressures, linguistic and cultural adaptations and lack of continuity of care." There are high rates of mental health disorders due to traumatization while in flight from violent situations.

In a study done among 19 Syrian families in Cincinnati, Parents of the patients said that the trauma, "... affected their ability to remember medical advice and medical appointments for their children." The resettled patients said that they did not have the energy to learn new things or make decisions, even though it had been months since they resettled. This behavior affected their ability to care for their children. Parents also said that they missed many appointments and tests which ultimately delayed the diagnosis for their children. Ultimately, difficulty navigating the healthcare system, language barriers and the already overloaded health system makes it increasingly hard for these refugees to get the health outcomes they desired. Cincinnati is one of the non-traditional migration destinations and therefore there are many more barriers to healthcare than in other big cities in the United States.

When Mental Health underlies the refugee experience it can make it very difficult to integrate into the new society. The most common mental illnesses in the Syrian refugee population are Depression, prolonged grief disorder, Post Traumatic Stress Disorder and forms of Anxiety.In another study that questioned 25 Syrian refugees in the Metropolitan Atlanta area, patients stated that their difficulties in resettlement included language barriers, inability to pay living expenses and a lack of help from charity organizations. Among the patients who wanted to talk about their feelings, only 20%

sought mental healthcare and 60% felt the visit was helpful. However, the barriers to attending Mental Health appointments were similar to Cincinnati and were a mix between lack of information and access to transportation. These patients, many of which experienced traumatic events in the years leading up their resettlement, might be hindered from seeking help because of lack of resources.

As has been seen, much can be done to help America's newest refugees in the resettlement process. Several of the accounts of refugee frustration over the resources has to do with suboptimal medical care delivery. One solution to this problem is ensuring that all refugees are insured after their 8 months of coordinated care and then collocation of medical services in their placement area. According to McNeely, "...several communities have increased refugee's access to quality health services that span the full spectrum from preventative screening to management of complex chronic conditions." Placing all the services that migrants might need in one common location and allowing them to be followed over the course of the patients first 5 years in the US, may create better continuity and stability in healthcare delivery. The Philadelphia Refugee Health Collaborative has set up a weekly clinic and has relationships with specialists who agree to see refugees, have translation services and are collocated within refugee clinics. These clinics have selected staff that can help confirm patient appointments and provide case management to ensure that the refugees get the care that they need. Outside of the medical care, other community-based services are provided including community building and art therapy. This program also does multidisciplinary rounds on the refugees to make sure that all the needs are being addressed by the various caregivers. This ensures that no one is neglected. This program runs on the support of volunteer services so that stakeholders like government agencies can save on funds, but getting Arabic speaking volunteers might be a challenge.

Another program works by increasing the medicaid enrollment of the refugees so that after the 8 month medical benefits are terminated, refugees are already enrolled in medicaid if they apply. This same program, run by the T*he New Arrivals Working Group*, also helps arrange transportation services with the associated clinics. This service directly targets a problem that refugees mention throughout the literature. The *New Arrivals Working Group* started a convention that provides primary care providers with information on how to care for the refugee population. McNeely also recommended assembling key players like local, state and federal agencies to build capacity to provide better healthcare options for refugees. These types of meetings would be pointless without including frontline, community health and social workers who specialize in the Syrian population. Lastly, without additional funding to the work involved in refugee community management, there would be no special services for this group. No matter

how small the help, community programs need additional funds and support among the already settled Syrian populations in the United States.

Sometimes the United States can also look at what other Refugee host nations are doing. In Alberta Canada many Primary Care providers carry a great deal of knowledge about refugees and are taking a team based approach to their care. The medical providers,"... work very closely with the social workers and they're very instrumental in helping provide support, just resources, physical resources, but also trying to get the social support in place too." For example, one of the practice goals is to have "baby boxes" arranged for new moms that contain bottles, clothes and other things the baby might need in the newborn period. The care coordinators also arrange everything from labs, ultrasounds, specialist and follow-up appointments, to ensure that all the information is understood.

One plan that I believe can be enforced in the United States is better medical education at the Residency level about treating Refugees. The CDC outlines Physical and History Examination points, as well as a general overview of the most common diseases that affect the refugee population. In this body of information, residency and medical school educators can map out an adequate base of knowledge and communicate the need for these providers in almost every medical specialty. In the H& P section, the guideline firmly establishes the need for physicians to, "...set aside an adequate amount of time, create a trusting environment, and provide competent interpretation services to facilitate compassionate and culturally appropriate history acquisition and performance of the physical examination." This would help build awareness and capacity early in a physician's training. This plan would also involve recruiting doctors to practices that service refugees and in some cases encouraging physicians to become civil surgeons. Civil surgeons perform the medical exam that allows refugees to eventually become US citizens. Although this is a great help to refugees, a physician does not have to become a civil surgeon in order to help refugees. According to the AFP article the exam of a refugee can be performed by, "... a licensed clinician in the presence of an interpreter, if necessary." and can be done in a public or private health clinic or at the health department. The goal of qualifying physicians to do these exams is to increase the rate of Refugees who are receiving primary care so they access all health services they missed since their lives were forever changed by the Syrian War in 2011. This program could be improved by not only utilizing permanent medical homes but sending mobile clinics into neighborhoods that are heavily populated by Syrian refugees and set up medical, social and mental health services on a weekly basis. The mobile clinics can take responsibility for engaging patients into care and arranging interpretation, transportation, pharmacy and medication management services if needed. These services will likely require additional funding and assistance from the local, state and

federal agencies. Lobbyists might be able to convince Senators to increase funds to the implementation of the Immigration and Nationality Act, however, the problem of how this will be funded when the current healthcare system for Americans is already problematic. Also, because of travel restrictions, legislators may need to consider whether it is safe to open the country to this particular group, given concerns about terrorist activities among Syrian and other refugees.

In conclusion, The United States of America has taken specific steps to welcome refugees to our borders, orienting refugees to life in the US and providing a variety of medical services. However, each state government has its own way of fulfilling this obligation and not every Refugee clinic offers high quality care. The goal is to replicate the work done by some organizations who collocate medical, social work and mental health services. Providing interpretation and transportation services are key to maintaining continuity of care and helping refugees adapt to a new culture and a completely different medical system. If I were to design a plan to improve care to refugees I would start at the medical graduate level, by educating future primary care and specialty providers about treating patients who come from a completely different cultural context. Along with physician education, I would endorse legislation that would increase funding for Refugees so that more interdisciplinary refugee clinics could take form and replace outdated and inefficient models. As the United States seeks to now review all the refugee and asylum cases delayed because of COVID-19, my hope is that more Syrian refugees will be considered for resettlement so that men, women and children will finally begin the healing process.

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