Forced Migration
Public Health During Crisis

Healthcare Policy
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Dear Readers,

We are pleased to bring you the January 2017 edition of the NPHR. In this issue we focus on access to health for victims of forced migrations, a timely and imperative conversation in light of current global events. Forced migration can be precipitated by diverse events ranging from environmental emergencies such as tsunamis or earthquakes, to economic crises, political conflict and full-scale war. Despite the diverse drivers of displacement, one element remains constant; displaced populations endure genuine fear for their health and safety as they seek shelter and opportunity to begin their lives again elsewhere.

We began with a fundamental premise that access to health is a human right for everyone, everywhere. However, many migrants, particularly those for whom an emergency precipitated their flight from home, find themselves with severely limited access to health services. Their plight is further confounded by economic, legal, and cultural factors often inherent in the refugee status. Thus, we asked: what unique health needs do the victims of forced migration face; what infrastructures exists to ensure their right to basic health; and how can these resources be improved upon?

To better understand these challenges, our authors highlight the physical and mental health needs that displaced populations experience. These articles investigate policies, infrastructures, and resources essential to refugee access to health, particularly in relation to critical state actors: Lebanon, Syria, the United States, and Greece. Finally, we review the potential role of education as an important tool to both promote refugee health and rebuild communities.

We hope you find the following articles as moving and enlightening as we have. In this time of growing world-wide nationalism and protectionism, these articles speak to the clear benefit the international community gains by extending our hands to the most vulnerable as well as to the risk we take if we insist on shutting them out.

The NPHR Editors-in-Chief,
Osefame Ewaleifoh and Claire Vernon
Cover Artist Statement

I was originally drawn to Anna Maitland’s article on health care policy for migrants due to the visual challenge it posed, and my own interest in learning more about migration and refugee healthcare access. Healthcare policy can be a challenge for anyone to navigate, but when you are moving through multiple countries, or creating policy for people who have been displaced the challenge multiplies. In many places during refugee travel, simply having access to mental and physical health care is rare. It’s important that the article defines the term “refugee,” and then helps the reader understand the refugee experience. My illustration helps to portray this struggle, and how overwhelming it can feel. Hopefully it will inspire new policy and new movements to help refugees gain access to the care they need and experience some comfort and support as they travel from their homelands.

Ashley Ulm is a Chicago-based medical illustrator. She was born and raised in Cincinnati, Ohio, where she attended Miami University and earned a Bachelor of Arts in Zoology in 2011. She then worked at Cincinnati Children’s Hospital in Asthma Research before joining the Master’s program in Biomedical Visualization at the University of Illinois at Chicago. Through Biomedical Visualization, Ashley and her colleagues are able to communicate complex medical and scientific topics to a broad range of audiences. In her free time, Ashley is often reading, relaxing, or enjoying good food with good friends.
The Consequences of Untreated Trauma: Syrian Refugee Children in Lebanon

By Maria Hawilo, JD

In Janine di Giovanni’s reporting on war in Syria, she tells of a graveyard worker named Mohammed, and his 4-year-old redheaded son. Mohammed works in a former park turned graveyard in a Syrian neighborhood in Aleppo. With his 4-year-old son by his side, Mohammed digs graves for corpses ravaged by war. When di Giovanni worries about the impact on his son, Mohammed tells her that he did not expect the carnage to affect his son; that “death is like life.” Yet, death in war is different. And no 4-year-old child nor grown man can escape its brutality.

The war in Syria began with peaceful, anti-government demonstrations in March 2011. The government answered by turning peaceful protests into violent massacres. Armed opposition groups rose up in response, and the country was quickly engulfed in a civil war. The war continues to rage and the extent of its damage will not be understood for years. It is clear, however, that the war has had devastating consequences both for Syrians inside the country, and those who have fled.

The Syrian war continues into its sixth year. By now, the numbers have become part of our collective psyche. Nearly 500,000 people have been reported killed. Approximately 6.3 million Syrians have been displaced internally while 4 million more have fled the country as
refugees, many of them dispersed across the Middle East. By some counts, more than half of this displaced population are children.

The United Nations has called the Syrian conflict one of the worst humanitarian crises of the modern era. By now, the short-term consequences for the survivors, particularly the children, of this horrific conflict have become apparent: Syrian children are living with life-altering injuries, including amputations, spinal cord injuries, and whole body burns; the impact of malnutrition is now felt within and outside Syria's border; children have become increasingly vulnerable to insanitary and contaminated informal settlement environments. The war has also devastated families economically, forcing many children and adolescents to leave school and become providers for their families.

Added to these more observable problems, the stress of war followed by the trauma of displacement has led to an epidemic of Syrian refugees with mental illnesses and trauma-related disorders. International agencies currently provide aid in the form of food and cash assistance, but very little has been done to ensure that the mental health needs of these traumatized people are met.

Without a concerted public health response to this crisis, Syrian refugees—particularly children—will suffer the consequences of untreated trauma in the years to come.

This paper concerns itself with the consequences of trauma on refugee children in Lebanon. In the first section, I describe the impact of exposure to violence on children and adolescents. As a means of comparison, I review research focused on children in the United States. Next, I focus on Syrian children in Lebanon and their experience of violence and displacement. Finally, I explore how our evolving understanding of trauma and the effects on children refugees give rise to a public health crisis and a call to action: effective interventions that address the mental health needs of a traumatized population of children must be implemented. Such interventions are critical to reduce the risk of increasing violence and delinquency and to preserve the opportunity for eventual asylum and citizenship status outside of Syria.

**Research on Exposure to Childhood Violence**

Children are more likely to be exposed to violence and crime than are adults. In the United States, juveniles and young adults face violence as victims at twice the rate of the general population. In 2008, the Office of Justice Programs undertook a comprehensive, nationwide survey to assess the incidence and prevalence of children's exposure to violence. The survey, which measured exposure to violence for children ages 17 and younger to both community violence and direct victimizations, found that children become more vulnerable to increasingly serious types of violence as they grow older. That is, children who were exposed to violence at a young age were more likely to personally experience additional violence as they aged. It also tracked the cumulative effects of exposure to violence over time. In the United States, nearly 1 in 10 children was exposed to five or more different types of violent episodes through the years. Understanding the progression of violence and the cumulative effects of exposure to violence are necessary in order to create effective interventions. Studies confirm that exposure to violence has damaging consequences for the well-
being of young people and their capacity to function in the long-term. Exposure to at least one episode of violence significantly increases one’s chances of experiencing other types of violence. For instance, a child who experienced physical abuse was five times as likely to experience sexual victimization. Exposure to such violence often causes trauma, in which an event or a series of events is experienced by an individual as physically or emotionally harmful or threatening. Trauma, in turn, typically harms a person’s functioning and well-being.

Events related to war or persecution are characteristically traumatic. Refugees and asylum seekers experience significant traumatic events, including war, torture, violence, and forced migration. Refugees and asylum seekers “report high rates of pre-migration trauma, and therefore of trauma related mental health problems.” A traumatic event can lead to generalized anxiety, sleeplessness, and nightmares in the short-term, and neurological and behavioral dysfunction, including juvenile delinquency and criminal behavior, in the long-term. In fact, according to a study conducted by researchers at Canada’s Western University, refugees have a 27% higher risk of suffering from psychotic disorder compared to non-refugee immigrants.

The correlation between unaddressed trauma, and juvenile delinquency and crime has long been studied. Importantly, delinquency and victimization—that is, exposure to violence—are widespread among children and young teenagers, ages 10-17. The data is concerning. Boys who experience both delinquency and victimization report greater numbers of victimizations than boys who are victims of violence but have not engaged in delinquent behaviors. Relatedly, boys who experience both delinquency and victimization report a greater degree of delinquent behavior than do boys who have engaged in delinquent behavior but have not

“Sometimes I dream,” she says, “I dream I am carrying a dead man. And when I look at the children living here, I feel like they have lost their hearts.”
been previously victimized. Furthermore, delinquency correlates with higher rates of past victimization and higher rates of delinquent behavior.

For boys, an increase in victimization and delinquency occurs between ages 13 and 14, while for girls that increase occurs between ages 11 and 12. This group of victim-delinquents must deal with additional adversities, including higher rates of mental health syndromes.

Though the majority of those who suffer from trauma will overcome it, people who fail to overcome trauma tend to be those already burdened by psychological issues, including trauma suffered as children.

Early interventions may be effective in decreasing the risk of delinquent behavior and future criminality, particularly when interventions target young people with mental health symptoms who experience high rates of victimization or exposure to violence. Accordingly, identification of the most vulnerable population of children and teenagers is necessary for effective intervention.

**Syrian children in Lebanon: Experiences of violence, war, and displacement**

In a country smaller in size than the state of Maryland, more than 1.5 million Syrian refugees now call Lebanon home, at least temporarily. Of the approximately 4 million Syrians seeking refuge outside of Syria, Lebanon has the highest per capita numbers of displaced Syrians. Nearly half of the Syrian refugee population in Lebanon are younger than 17. Syrian refugees in Lebanon now comprise one in four of the population in Lebanon.

Despite a growing awareness of the impact of trauma on youth, there is a lack of funding, research, and infrastructure for mental health care in Lebanon. The influx of refugee families has depleted resources in an economy whose resources were limited already. According to one estimate, 170,000 local Lebanese have been pushed into poverty by the Syrian crisis. In every imaginable sector, Lebanon has suffered the consequences of the rapid influx of an ever-growing refugee population. In 2013, the World Bank undertook an analysis of the impact of Syrian conflict on Lebanon; the findings were stark. The World Bank estimated that in 2014, Gross Domestic Product in Lebanon would decrease by nearly 3% points, a loss of approximately US $7.5 Billion. The World Bank also concluded that unemployment had doubled as a result of the crisis and that there had been a sizeable degradation in the access to and quality of public services, including crowded health facilities, deterioration in the water supply, and overburdened schools.

The international community has contributed both in cash and in other forms of assistance, including provision of services. Much has been written about the shelter, assets, education, and health needs of the Syrian refugee population in Lebanon. Yet, little attention has been focused on assessing the psychological needs of the young refugee population. Though there is certainly anecdotal evidence and at least one survey supporting evidence of trauma reported by family members of Syrian children, a focused study has not been conducted on this population.

Before seeking refuge in Lebanon, many Syrian children were exposed to the violence of conflict. Potentially traumatic events continued as the war in Syria progressed. For instance, recruitment of children
as child soldiers and as participants in the war in Syria has increased since the beginning of the conflict. Families of children in Syria described seizures of children by armed forces from homes and schools. Reports of direct violence, including child rape, have also increased with the acceleration of the war.

In 2014, United Nations investigators reported grave violations against children committed by all parties to the conflict in Syria. In particular, children as young as 12 have been recruited for combat and supporting roles; they have been arrested, detained, and tortured for their perceived or actual association with the opposition; they have been killed and maimed by heavy shelling and aerial bombardment, shootings at close range, and summary executions; they have been subject to sexual violence, including young boys detained in facilities by government forces; they have been attacked indiscriminately in schools and hospitals, where children reported witnessing schoolmates shot dead while running away from government forces; and they have been abducted for ransom or as a form of pressure on relatives.

Undoubtedly, the violence these children have witnessed has contributed to severe traumatic reactions. Children exposed to such violence speak the language of trauma. According to a UNICEF qualitative survey of Syrian refugee children in Lebanon, Fatima, a ten-year-old Syrian refugee, described her experience of war as follows: “Sometimes I dream,” she says, “I dream I am carrying a dead man. And when I look at the children living here, I feel like they have lost their hearts.” Marwan says, “I dream that someone is coming to kill me, to eat me… So I decide to keep my eyes closed, and stay inside, so nothing bad will come.” The families of these young children reported symptoms of known trauma including inability to sleep, bedwetting, nightmares, and withdrawal. In one refugee camp, nearly a third of the displaced children are terrified of bombings, kidnappings, and killings. And, unsurprisingly, in that same refugee camp where a third of the children suffer from untreated trauma, a third also display unusually aggressive behavior and engage in self-harm.

The majority of the refugees arriving from Syria experience some form of distress as a result of their exposure to war. Children arriving in Lebanon then experience additional, psychologically damaging trauma as a result of displacement and the living conditions prevalent in informal settlements. For instance, a study conducted in 2014 described the impact of displacement on refugee youth in Lebanon. The study focused on those aged 15-24 who had been living in Lebanon, for some period of time, with the average respondent living in the country about 16 months. The study found that the trauma of displacement was further exacerbated by exploitation, communal tension, and increased domestic violence.

Specifically, the study found that Syrian refugee children in Lebanon live in distress and general insecurity, are trapped in a self-perpetuating cycle of violence in public and private spaces, and are unable to escape or break the cycle of repeated exposure to violence. The experience of war in Syria has resulted in a significant increase of children with mental illnesses including anxiety disorders, depression, post-traumatic stress disorders, and developmental problems. Notably and of concern, most Syrian refugee youth in Lebanon describe themselves as feeling depressed, anxious, or afraid most of the time. Psychological distress of Syrian youth in Lebanon is experienced across age groups and geographical areas, as a result of displacement, shared and uncomfortable living conditions, and being subject to physical and sexual violence.

Moreover, Syrian refugee youth do not feel safe in Lebanon. About half of those asked agree that they have “not once felt safe since I came to Lebanon.” Additionally, as a result of an increased economic burden and the loss of supportive social networks, Syrian refugee families in Lebanon have experienced increased intra-family tension resulting in an increased exposure to violence.

“Unsurprisingly, in that same refugee camp where a third of the children suffer from untreated trauma, a third also display unusually aggressive behavior and engage in self-harm.”
“The magnitude of the mental health crisis facing a generation of refugee children and teenagers cannot be overstated.”

Given the cumulative reports of trauma, it is unsurprising then that 17 percent of Syrian refugee youths describe contemplating suicide often while 36 percent describe contemplating suicide sometimes. Psychologists and doctors who treat Syrian children in Lebanon report that these children are impacted by symptoms of phobia, hysteria, night terrors and regression in development. Finally, even 3 years ago an estimate by a crisis group concluded that one-fifth of refugees required help with psychological disorders. A review of the literature further supports the association between torture and other potentially traumatic events with the increased risk of mental illness, particularly depression and post-traumatic stress disorder among populations exposed to mass conflict and displacement.

Untreated, young people suffering from mental illness-related trauma and forced displacement may begin acting out in reckless and violent ways that bring them into contact with the criminal justice system. As noted above, research from the United States suggests that repeated exposure to violence is associated with higher rates of delinquent behavior and higher rates of continued victimizations. In a study of jail inmates exploring the relationship between trauma and violence, 96 percent of those incarcerated reported experiencing a traumatic event. Witnessing serious violence predicts perpetration of violence. Historically, for instance, after major wars, crimes among combat veterans increase. Indeed, one study found that almost half of all Vietnam veterans suffering from post-traumatic stress disorder had been arrested or in jail at least once. Trauma survivors, many of whom have been exposed to repeated acts of violence, may resort to self-destructive behaviors which can lead them to commit crimes. Interventions that fail to address the mental health needs of children exposed to multiple episodes of violence will result in greater rates of delinquency and negative behaviors.

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A Call to Action: the trauma experienced by Syrian refugees in Lebanon must be addressed as a public health concern

The magnitude of the mental health crisis facing a generation of refugee children and teenagers cannot be overstated. The psychological distress and “the legacy of early childhood trauma” is sobering, and it will continue to lead to increasingly worse outcomes both for those suffering and for citizens of the host community. As the war continues and Syrian refugees become a more permanent reality in Lebanon, the international community must consider broadening the mandate from simply providing assistance in the form of food, cash, and short-term medical needs, to long-term mental health interventions.

As with trauma rates, traumatic stress reactions vary considerably. However, it is clear from even the little research conducted to date that the cumulative trauma experienced by Syrian refugee children in Lebanon has caused traumatic stress reactions in children and young adults. The international community must do more to address this crisis now given the prevalence of the mental health crisis facing Syrian refugee children, the psychological distress they suffer, and the impact of trauma on their future prognosis and on the host community.

As a public health matter, there are a number of concerns arising from untreated significant trauma in children and adolescents. In the short-term, depression and other forms of mental illness often act as barriers to other social determinants of health and economic stability. Moreover, untreated trauma and exposure to violence increases an individual’s risk of further victimization. Reports of unrest, danger, and increased rates of domestic violence are unsurprising for refugee children who have been exposed to the violence of war then the uncertainty of displacement. To be clear, there are many causes for the increase in intra-family conflict but past victimization and exposure to violence left untreated are among them.

Assessments focused on the psychological distress of Syrian refugee children and adolescents and the response to such trauma would benefit both the Syrian refugees and the host community. To speak of a “lost generation of children” is certainly devastating, yet, the increased risk of suffering from mental illness coupled with untreated trauma could result in more than a lost generation of children.

Indeed, the impact of untreated trauma and cumulative trauma may lead to an increased risk for delinquent and criminal behavior with consequences for both future perpetrators of crime and future victims of crime.

1st, more research must be conducted to assess accurate rates of trauma and subsequent mental health problems of refugee children and adolescents in Lebanon.

2nd, in addition to conducting surveys and interviews focused exclusively on psychological trauma and mental health disorders of the Syrian refugee population, more must be done to assess the impact of such distress on the lives of the Syrian refugees. Most importantly, research analyzing rates of victimization and responses to such victimizations has not been conducted despite being a necessary component of effective interventions.

3rd, given the association between the rate of delinquency and the number of times an individual is victimized, there is a need for more research focused on the rate of trauma and any resulting delinquency in the refugee settlements and outside of them.

4th, effective interventions require identifying the population of children and teenagers most vulnerable to the impact of cumulative trauma.
More must be done to understand this link, particularly in the international context, but, as a preliminary matter, analysis of aggressive and delinquent behavior and the rates of both within and outside of the settlements must be undertaken to understand the scope of the problem.

Further, to the extent that certain vulnerable populations of Syrian refugee children and adolescents engage in delinquent and criminal behavior, opportunities for permanent settlements and asylum both in Lebanon and in other countries will decrease. Criminal records act as barriers for those seeking asylum and citizenship. In the United States, for example, the government may legally detain non-citizens without a bond hearing and then deport them for criminal violations, including minor violations.46

The example of Southeast Asian refugees fleeing after the Vietnam War provides a sobering reality of the potential impact of untreated trauma. After the Vietnam War, more than a million refugees from Vietnam, Laos, and Cambodia settled in the United States. Compared to other Asian immigrant groups, refugees from Southeast Asia suffered from trauma and poverty. Many of these refugees were children born in refugee camps or in their home countries during the war. And, as a result of stringent immigration policies, immigrants from Southeast Asia are three to four times more likely than others to be deported for old convictions and nonviolent crimes they committed when they were young.47 Other countries, such as Germany, have similar laws making it easier to deport migrants who commit crimes.

As Katrina Dizon, an immigration rights worker, told reporter Teresa Wiltz, “Restricting support for these traumatized communities only leads to the growth of an increasingly marginalized population.”48 Without adequate mental health interventions, we may be relegating young refugees in Lebanon and elsewhere to statelessness. To find a solution that will ultimately include a permanent home, whether in Syria or abroad, the international community must make efforts to ensure that the untreated mental health epidemic experienced by Syrian refugee children and adolescents will not lead down a preventable path of delinquency and crime and statelessness.

The numbers are overwhelming. The war in Syria rages. The children of Syria suffer. There is a very real need to intervene and to intervene now by identifying the population of children most at risk to the impact of trauma and providing long-term mental health treatment to those children.

“Restricting support for these traumatized communities only leads to the growth of an increasingly marginalized population.”

How to help:

**Hope for Syria**
Divides donations among 9 non-profits including HIAS and Islamic Relief USA. Groups focus on relief in Syria as well as resettlement aid in the USA.

**InterAction**
Non-profit organization whose website contains filters for donors to locate charities for specific issues like refugee encampent.

**International Rescue Committee**
Highly regarded group currently working on setting up a reception center on the Greek island of Lesbos to aid refugee efforts.

**Sources**
“How to help in a Global Refugee Crisis”, NYT, 2015

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A Path to Mental and Physical Health Care for Syrian Refugees in the United States?

By Anna Maitland

The United Nations High Commissioner for Refugees (UNHCR) asserts that as of the end of 2015, there were 16.1 million registered refugees worldwide, with 4.9 million of those being Syrian.

As the largest UNHCR registered refugee population, displaced Syrians face extreme and ongoing physical and mental health insecurity. Countries hosting large Syrian populations living in camps, urban environments, and tent cities such as Lebanon and Jordan report overstretched and already inadequate health infrastructure, with many people surviving on only the barest minimum of health access. For the average Syrian refugee, it is not uncommon to face a range of poverty and malnutrition-related health issues prior to resettlement. Further, depression and post-traumatic stress disorder (PTSD) are common, with host countries reporting that over half of Syrian refugees are in need of psychological support while only approximately 5% receive services.

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For the average resettled refugee or asylee, accessing health in the United States involves navigating:

- language barriers
- a complex and confusing health care system
- different health care customs and beliefs
- discrimination

Displaced from insecure health environments, and often chosen for resettlement because of a heightened vulnerability or illness, resettled Syrian refugees or asylees can arrive with experiences of extreme trauma that impact both their physical and mental health. While mental health and depression among this refugee population has reached staggering rates, the difficulty of navigating the US health system only further isolates, marginalizes, and traumatizes people in need of holistic health services. Given these issues, health care providers and social services in the United States have a duty to build better protections for this refugee population, including improving their access to health care through more programs, greater support, empowerment and choice-based accompaniment, and a deeper understanding of their prevailing needs.
What do we mean when we say refugee?

According to the UNHCR—the only international inter-governmental organization mandated to ensure refugee protection—a “refugee is someone who has been forced to flee his or her country because of persecution, war, or violence.” The 1951 Convention relating to the Status of Refugees further defines the term as applying to “any person who … owing to [a] well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.” Only 145 countries have signed the Convention.

The vast majority of refugees apply for status upon arrival in a contiguous or nearby country to their country of origin. If a host country has domesticated laws on refugee status, individuals and families apply using the asylum or other refugee status-determination avenues enshrined in law. Otherwise, UNHCR conducts a refugee status determination, and if the applicants meet the qualifications, they are given temporary refugee identification/proof of recognition by UNHCR. Where a refugee resides is country-dependent as are the health, work, and other benefits available to them. The most common image this conjures is one of UNCHR-run camps that have restricted access to work and public services, with UNHCR and partners providing most of the basic needs like access to primary health care, education, and food. However, some countries, like Lebanon, have prohibited camps, opting instead for refugees to live in urban environments and unofficial ‘tent cities’. In countries receiving fewer refugees, the assistance may be far more extensive. Most people determined to be refugees in the countries surrounding Syria have no path to permanent status in the host country, as asylum is rare and very hard to obtain. Instead, there is the expectation that one day they will be able to either safely return to their country of origin or be resettled by UNHCR to a country that will allow them to seek permanent status. Given how few refugees are resettled each year, this expectation is not likely to be met.

“Most people determined to be refugees in the countries surrounding Syria have no path to permanent status in the host country, as asylum is rare and very hard to obtain.”
Refugees include individuals recognised under the 1951 Convention relating to the Status of Refugees or its 1967 Protocol, the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa, or those recognised in accordance with the UNHCR Statute. The refugee population also includes individuals granted complementary forms of protection or those enjoying temporary protection.

Asylum-seekers are individuals who have sought international protection and whose claims for refugee status have not yet been determined, irrespective of when they may have been lodged.

Internally displaced persons (IDPs) are people or groups of individuals who have been forced to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights, or natural or man-made disasters, and who have not crossed an international border.

Stateless persons are defined under international law as persons who are not considered as nationals by any State under the operation of its law. In other words, they do not possess the nationality of any State.

Others of concern refers to individuals who do not necessarily fall directly into any of the groups above, but to whom UNHCR extends its protection and/or assistance services, based on humanitarian or other special grounds.

Refugee resettlement occurs when an individual or family has been granted refugee status and meets a number of criteria for ‘resettlement’ to a third country that has agreed to accept a predetermined number of refugees. Each year, a small number of nations make a public commitment, setting out the number of refugees they will accept for the purpose of resettlement. Less than 1% of all registered refugees are afforded this opportunity.11

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Refugee resettlement in the US

The United States has signed onto the 1967 Protocol Relating to the Status of Refugees, which incorporates the key provisions of the Refugee Convention. The Legislature domesticated parts of the Convention into law via the 1980 Refugee Act and the Immigration and Nationality Act, which closely follows the language of the Convention. In 2015, the United States resettled 66,500 registered refugees comprising approximately 60% of resettlements worldwide. Only 1,682 of the total number of refugees resettled to the United States in 2015 were Syrian. The US agreed to resettle 85,000 refugees in 2016, of which 12,486 have been Syrian.

“Resettlement to the US comes with some basic benefits: time-limited housing, employment counseling, and time-limited health care...”

Refugees seeking resettlement undergo a thorough and time-intensive vetting process. It begins with UNHCR conducting a refugee resettlement determination to identify and refer those that meet US-listed criteria to the US Refugee Admission Program (USRAP), where they undergo more interviews and extensive background checks. This includes the collection of biodata and biometrics, security screenings with the FBI, Department of Homeland Security, and national intelligence, review of all documents, and interviews with associates. For Syrians, a second enhanced screening with DHS occurs along with further vetting. This process can take anywhere from 18 to 24 months, and for Syrians who are under heightened scrutiny it can take even longer.

Resettlement to the US comes with some basic benefits: time-limited housing, employment counseling, and time-limited health care services, among others. Three US departments oversee the resettlement process. The Department of Homeland Security is initially tasked with clearing the refugee (and family) for resettlement. Afterwards, the State Department Bureau for Population, Refugees, and Migration helps the resettled person(s) settle in a new city through one of nine voluntary resettlement agencies. Finally, the US Department of Health and Human Services Office of Refugee Resettlement (ORR) allocates the funding for the benefits and assistance provided to resettled refugees including all medical help. This funding goes to the voluntary resettlement agencies—responsible for the first 30-90 days of transition, from orientation to connecting the refugee with a local resettlement agency—and to the local, much smaller resettlement agencies that refugees use to navigate the ORR-funded state welfare services.

The United States federal government provides “$925 per refugee to cover the costs of housing, household goods, food, and pocket money for the first 30 days.” After this, the refugee may be eligible for public benefits. For the first 8 months, most refugees receive Refugee Medical Assistance, after which some may be eligible for Medicaid. Additional assistance by the state is covered by the federal Cash and Medical Assistance program and Refugee Health Promotion grants, which among other things provides medical assistance to unaccompanied minors and up to 8 months of additional support such as Medicaid. ORR also provides targeted grants to agencies conducting
health literacy and emotional wellness services.\textsuperscript{27} States may also decide to supplement this federal government offer with longer housing benefits or earlier eligibility for public benefits.\textsuperscript{28} In contrast to refugees, asylees arrive in the US without refugee status and often with time-limited travel documents such as a student, tourist, or business visa or even without any form of documentation.\textsuperscript{29} The asylum process is essentially a request for the adjudicating authorities to find that they qualify as refugees in contrast to UNHCR doing so abroad. In 2014, there were a total of 121,200 asylum claims in the US\textsuperscript{30}—but only 23,533 asylum grants.\textsuperscript{31} Of this number, 4\% were Syrian, or approximately 941 people. The asylum process is very slow, with existing backlogs resulting in a three to six year delay for the resolution of an asylum claim.\textsuperscript{32} During this time, asylum applicants are not eligible for any federal public benefits and they are not eligible to receive employment authorization until their asylum application has been pending for 180 days. Many rely on the support of friends or family, and many—especially those who enter without a visa—are detained for a portion of the time pending the asylum decision. Asylees do not receive the same government benefits as resettled refugees, however, once they receive asylum status they are eligible for 8 months of Refugee Medical Assistance or Medicaid, along with some of the other benefits received by resettled refugees.\textsuperscript{33}

\section*{Refugees and Health}

The very process of becoming a refugee can cause physical and mental health issues. By definition, a person classified as a refugee is presumed to have, at the very least, been subject to fear and insecurity in their home country and, at the worst, suffered torture and inhumane circumstances. As a result, refugees tend to have a shared narrative of forced displacement from their homes and communities in response to violence and/or the fear of violence, and often have stories of unsafe and harrowing journeys to only moderately safer conditions. Refugees include the sick, the elderly, and the mentally or physically incapacitated—few if any of whom receive targeted services at their destination.

Health issues in camps and urban settings can range from poverty to malnutrition-related diarrhea to proximity-driven skin infections. Many easily treatable diseases go untreated in the face of seemingly insurmountable barriers to health care access. The World Health Organization reports core concerns of upper respiratory tract infections, diarrhea, and skin conditions.\textsuperscript{34} Malnutrition and lack of sanitation both in transit and upon arrival to a refugee’s destination contribute to a proliferation of respiratory infections and diarrhea as well as resilient and difficult to treat diseases such as multi-drug resistant tuberculosis; the WHO reports that refugees are at an increased risk of developing
tuberculosis while simultaneously having reduced access to effective treatment.\textsuperscript{35} Syrian refugees are no exception to this narrative. Displaced from their homes after months or years of constant bombing, threat or realization of violent assault, chemical attacks, and starvation, displaced Syrians often face incredibly dangerous journeys in pursuit of safety.\textsuperscript{36}

With limited, if any, health care provision, many children do not receive vaccinations. \textbf{Three out of every 10 Syrian children are estimated to be unvaccinated}, leading global health practitioners to worry about the resurgence of diseases such as polio.\textsuperscript{37}

Mental health is widely reported as one of the biggest issues faced by refugees, with medical studies reporting PTSD and depression ranges of 10-40\% and 5-15\% respectively in Syrian refugees.\textsuperscript{38} Syrian children are at even higher risk: 30\% report experiencing violence, and 79\% have lost a family member.\textsuperscript{39} Before, during, and after ‘flight,’ a displaced person may suffer malnutrition, exposure to illness and the environment, physical and mental abuse, rape and pregnancy, etc.\textsuperscript{40} For many, the threat of sexual and gender-based violence is a constant source of additional trauma. A recent CARE assessment found that 28\% of Syrian households fled out of fear of sexual and gender based violence and that it remains a key issue for safety in refugee camps.\textsuperscript{41}

For the less than 1\% of refugees who are resettled globally each year,\textsuperscript{42} some of the primary health care barriers may be mitigated—however, for most, mental and complex health issues remain unaddressed. For the millions of asylum applicants globally each year,\textsuperscript{43} both mental and physical health barriers are often acute,\textsuperscript{44} with few health care options and a number of factors such as homelessness, detention, and lack of status exacerbating pre-existing issues.

Many of the Syrian refugees arriving in the United States are resettled because they were in need of urgent medical care or part of a vulnerable group. Even those who are not relocated due to acute health needs or extreme insecurity can have special medical and mental health needs as a result of the traumatic experiences before and after becoming a refugee.

\“Health issues in camps and urban settings can range from poverty to malnutrition-related diarrhea to proximity-driven skin infections.\”

A recent report shows that over 50\% of refugees in Germany have trauma-induced depression.\textsuperscript{45} In addition, almost all Syrian refugees leave behind close family and community ties, which do not end upon arrival in a new country, placing considerable stress and responsibility on those who have been relocated.\textsuperscript{46}

Once in the US, refugees face linguistic, cultural, and economic burdens, often compounded in the health services sector. Many refugees find themselves unable to bridge the health culture and linguistic barriers that come with trying to access health services.\textsuperscript{47} Thereby, they are left in the difficult position of trying to navigate trauma and transition. The set-up is also disempowering, further alienating people from use of available services. While refugees are eligible for Medicaid based on their financial need, it can be difficult to navigate and has limited mental health assistance.

Refugee assistance agencies, often overstretched, are working hard to address the many mental health needs while also helping to respond to alienating health care services and conflicting health care traditions. In response to a lack of adequate options, agencies and refugees have worked together to develop more empowerment and needs responsive approaches. Some resettlement agencies and volunteers—many of whom are resettled refugees themselves—
As the Syrian refugee population in the US increases, so too does the need to ensure adequate and appropriate physical and mental health services. With too few trauma services and complex health systems, people who need help are facing strong barriers to access. Resettlement services remain underfunded and overburdened. Chicago is a prime example, where none of the six ORR identified resettlement agencies in the area focus solely on resettlement, and none have a specialization in health services. With Chicago politics continuing to shut down mental health services to populations at large, it is no surprise that it is even more difficult for refugees to find affordable and targeted trauma services.

Accompaniment and assistance in navigating new health systems, culturally appropriate counseling and health services, and trauma-centered mental health approaches need to be increased. Great examples are being rolled out by organizations across the United States, but with limited funding and limited health personnel, they remain insufficient. Further, refugees must be able to access assistance at all levels of health care, not just via specially targeted volunteer service provision. More emphasis must be placed on mental health services and assistance for those seeking health care through the Medicaid and Medical Assistance Program. But, perhaps, the starting point needs to be encouraging and facilitating the role that medical providers have in ensuring that basic services are afforded to these survivors—starting with learning how to navigate the complex health cultures that refugees bring with them and ensuring that they do not have to make this difficult transition isolated from the health care they need.
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3. 4.9 million displaced Syrian’s have registered as refugees with the UNHCR, although estimates put that number far higher. The current number of Palestinian refugees is higher, but they register under a different framework overseen by the United Nation’s Relief and Works Agency.


9. Many Arab countries have not signed the Convention; this includes Lebanon, Jordan, and Turkey. See https://www.loc.gov/law/help/refugees/legal-status-refugees.php and http://www.unhcr.org/en-us/protection/basic/3b73b0d63/states-parties-1951-convention-its-1967-protocol.html. This means they have limited asylum and refugee legislation, if any, and often look to UNHCR to determine refugee status. For the purpose of brevity, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)—which covers Palestinians refugees in certain countries, though not all—is not discussed here.

10. In a growing rejection of decade long refugee camps, several countries such as Lebanon have refused to allow UNHCR to build camps, instead allowing for tent cities and larger urban integration of refugees, while others such as Kenya have begun to dismantle long existing camps, with little clarity on where the displaced will go.


13. Particular social group includes sexual orientation and gender identity, women and girls at risk (usually domestic violence and early marriage situations), and other groups with specific legal and physical protection needs.

14. Every resettlement country has different approaches to resettlement and the rights, privileges, and assistance provided. Canada, for instance, gives resettled refugees limited housing assistance, income assistance for up to one year, and the option to apply for a loan to help cover the costs of transition (see http://www.cic.gc.ca/english/refugees/outside/settle-assist.asp). Similarly, Brazil provides up to 12 months of housing and basic expenses, as well as employment and language training (http://www.unhcr.org/4e2d622713.pdf).


19. This number was reached in fewer than 12 months (http://www.nytimes.com/interactive/2016/08/30/us/syrian-refugees-in-the-united-states.html?_r=0).

20. An applicant may include their spouse and children under the age of 21 in the request to resettle. This complex issue can involve legal conflicts such as custody and formal adoption, as well as conflicting traditional and formal laws such as polygamy or informal marriages.


continued:

24. The US government settles refugees across the US—if they have family, they are often settled near those family members, otherwise a number of factors including country of origin and which states that have agreed to host larger populations determine where a person is placed. States can state a preference for more refugees. North Dakota, for instance, accepts the largest number of refugees per capita in the US, arguing that this as an opportunity to grow as a state. States cannot refuse to host refugees, as was demonstrated in 2015 when a number of Governors threatened to refuse Syrian resettlement. These states can, however, make the process slow, difficult, and complicated (http://www.inforum.com/news/3853303-north-dakota-leads-nation-refugee-resettlement-capita).


27. With the Affordable Care Act, many refugees who would have no longer received health insurance after the first 8 months became eligible for more affordable, self-paid options going forward.

28. There has been a lot of talk about the cost or “burden” of refugees. The ORR allocated 1.56 billion USD in 2015, almost 1 million of that towards unaccompanied minors crossing the Mexico-US border. Refugees are required to pay the US back for their flights, and studies have found that refugee populations actually help to create more jobs and can be a cost-positive group for host countries. The biggest cost of resettlement is actually on the front end, where we have unusually long and onerous screening processes. https://www.washingtonpost.com/news/the-fix/wp/2015/11/30/heres-how-much-the-united-states-spends-on-refugees/

29. Most persons seeking asylum must have a visa in order to board a plane to the U.S., thus in most cases those arriving without documentation of any sort arrive via boat or border. Border and Patrol Services are required to ask individuals if they have a fear of return before placing them in deportation proceedings. If the answer is yes, the person is often placed in detention pending bail (usually reliant on having family in the US), a credible fear interview, or in some cases, a determination of asylum or removal.


31. This does not mean that everyone else was denied. Huge backlogs in US asylum proceedings mean that the majority of applicants in 2014 will not have their cases heard for 2-5 years.


44. http://rsw.sagepub.com/content/early/2016/02/16/1049731516630384.refs


The Public Health Crisis in Greece | Lacing the walkways in the Athens airport are banners with images of white-washed villages and aqua blue waters. Scrawled across an image of the 2,500-year-old Parthenon are the words “Live your myth in Greece”. This is the Greece that tourists see. Despite the raging economic crisis the façade continues to be upheld, but beneath those beautiful layers of sun and sea you find a nation that has been pushed to the brink in more ways than one.

Six years into the economic crisis, this small country of 11 million people is reeling with the consequences of austerity measures. International attention on Greece tends to focus on economic conditions resulting from the 323 billion euros Greece owes to the banks,\(^1\) the 25% unemployment,\(^2\) or the thousands of refugees washing up on its picturesque beaches. Staggering as these numbers are, they fail to capture the extent to which the crisis has affected the everyday lives of Greeks, especially with respect to the impacts on their health. To meet austerity measures imposed by the European Union, Greece has made **budget cuts of nearly 50% to health care**, which include social welfare programs and publically funded pharmaceutical spending.\(^3\) This harsh economic policy, in conjunction with a nearly 40% reduction\(^4\) in household income, has lead to a prolonged humanitarian crisis with reductions in access to healthcare and medications, resurgence in diseases of poverty, food insecurity, and dramatic increases in mental health issues.

By Nelly Papalambros
Shifting financial burden from the government to the people

While far from perfect, the pre-crisis health care system was founded on a socialized medicine model. No health insurance? No problem. After the economic crisis began, several changes to the healthcare model were implemented to reduce government spending including reducing public insurance coverage and spending on pharmaceuticals. This has shifted the financial burden of health from the government to the people, resulting in increased patient fees for doctor’s visits and increased cost of medications. Under normal economic conditions, people might have been able to absorb the increased costs. However, a 25% contraction of the economy has resulted in the widespread inability of the population to access healthcare and afford medications.

In a northern Peloponnesian city surrounded by olive groves and a deep blue sea, Dimitris Tsiotos, a young pharmacist, has watched the effects of the crises unfold over the last few years. Pharmacies are small family-run enterprises, something not often seen in the United States since the birth of mega corporations like Walgreens. The Greek government controls drug prices and has significantly reduced these prices in an effort to cut costs. While this may seem to be a win for the consumer, the drug companies have started to pull out of the Greek market. The consequence, Mr. Tsiotos says, has been widespread drug shortages as drug companies seek higher paying markets and medications are resold out of the country.

Pharmacists are relying on an informal bartering system to find medications for their patients. Pharmacists are also dealing with the new requirements adopted by drug companies that demand upfront payment for medications. Coupling prepayment requirements for drugs with delays in insurance reimbursements has created an unsustainable model for both pharmacists and patients. With salaries and pensions severely reduced, 7 in 10 Greeks say they don’t have the money to pay upfront for medications. Greece has always been community oriented. People often live in the same town their entire lives, and therefore an honor system has always existed. The honor system has been exacerbated by the crisis. “If an elderly woman comes in to see you for her monthly anti-hypertensive medication, but she doesn’t have the money to pay, what would you do? Do you send her away? Of course not,” Mr. Tsiotos says. This vicious cycle puts financial pressure on pharmacists and their clients, ultimately degrading the quality of care and access to needed medications.

© Nelly Papalambros

Dimitris Tsiotos in his pharmacy in the Northern Peloponnesian city of Patras

“Greece has always been community oriented.”
A decline in the health of the population

Beyond the increased cost of medications, the economic crisis has directly impacted individual health through increased levels of stress and the resurgence of poverty-related illnesses. Likewise, indirect impacts manifest as severe reductions in public health spending and new restrictions on social services. While previously there were long-term unemployment benefits, current changes mean unemployed individuals receive free health benefits from the state for only one year. Chronically high unemployment, 50% for ages of 25-39, has led the number of uninsured individuals to climb from half a million in 2008 to almost 2.5 million by 2014.

“Patients who should be seen by a doctor when symptoms first appear are waiting until the last minute and heading to the emergency room, where they can be seen for free.”

Reduction in insurance coverage has resulted in patients no longer seeking routine preventive care. “Patients who should be seen by a doctor when symptoms first appear are waiting until the last minute and heading to the emergency room, where they can be seen for free” pediatrician Dr. Dimitris Papalambrou explains. “There is an overburdening of the emergency room and patients are not getting the individualized care that they need.” Dr. Papalambrou has seen a substantial reduction in the number of his patients over the course of the last 6 years. Despite this decline in his business, he doesn’t turn away desperate clients who cannot afford the healthcare they need for the same reasons as Mr. Tsiotos: these are people who have been part of his community for decades. In Greece, pharmacists can prescribe all medications aside from narcotics (e.g. opioids) without a doctor’s prescription. As the crisis rages on, Dr. Papalambrou knows patients are getting medications such as antidepressants or antibiotics directly from pharmacists, and worries about the consequences of over-prescription and lack of follow-up on serious conditions when patients are not being properly evaluated by a doctor.
The reduction in healthcare professional wages resulting from cutbacks has lead to unexpected shortages in the healthcare workforce. Due to a lack of stable work, small private practice physicians are disappearing, particularly in more rural areas. Half a million people have emigrated from Greece since the start of the crisis. Among those seeking security elsewhere are an estimated 20,000-25,000 Greek doctors who have left for countries such as Germany, the UK, and Sweden. The exodus of doctors has left hospitals understaffed and rural areas without new doctors to replace those who are retiring. The unexpected paradox is an increase in need for low-cost services with fewer doctors available to provide those services.

The shortage of doctors in conjunction with cuts in social welfare programs has profoundly impacted public health. There has been a reemergence of malaria and tuberculosis cases and a spike in new HIV infections in intravenous drug users from only 15 per year in 2009 to 484 per year. Such an emergence of diseases of poverty is not common across developed nations, and it underscores how tightly the health of nations is tied to economic stability. If either is not kept in check, a “snowball effect” can occur where increasing disease burden requires increases in public spending but also reduces the ability of people to be happy, productive members of society. This then prevents the economic development necessary to devote public spending to fighting disease, and disease increases further. Perhaps even more striking than the resurgence in disease is the spike in mental health concerns. As described by author David Stuckler in "The Body Econmic: Why Austerity Kills, “recessions hurt [well-being], but austerity kills”. This sentiment is showing itself across Greece. Increased rates of depression and anxiety have been attributed to economic hardship. Greece had one of the lowest suicide rates in the world, but since the end of 2009 suicides have increased 45%. At the same time there have been substantial cuts to mental healthcare. From 2011 to 2012, there was a 20% reduction in spending, and then another 55% reduction one year later. The decreased spending caused a hiring freeze for mental health practitioners and closed clinics and psychiatric hospitals nationwide. For the hospitals that remain resources have dwindled, there are caps for inpatient stays, and staffing hours have been reduced. Once again, there is an increase in need for mental health services but a reduction in the public expenditure to ensure that those needs are met.

Poor nutrition and hunger is hard to imagine in a country known for its healthful Mediterranean diet. Greece boasts a sprawling landscape of fig and pomegranate trees surrounded by crystal clear waters teeming with fish. Yet, in 2013 UNICEF reported that in lower income households more than a quarter of children are malnourished. For the first time since World War II, there is increased infant mortality and low birth rates due to poor nutrition and lack of access to prenatal care. Even more telling of the impact of the economic crisis, the NGO Dianeosis found recently that 15% of the population lived in extreme poverty, up from 2.2% in 2009. These numbers come to life in the mid-size city of Patras. Mrs. Piyi Zapanti is a volunteer for the Hellenic Red Cross in Patras.

An estimated 20,000-25,000 Greek doctors [...] have left for countries such as Germany, the UK, and Sweden.
Access to care for refugees

Given all of the health and economic issues currently facing Greece, it begs the question of how the crisis has affected Greece’s ability to support refugees. As is often the case, the people most affected are those with the least means, and this includes the refugees currently waiting out their fate in Greece. Refugees have some unique health needs when first entering the country, but those who are now long-term residents face many of the same barriers to health care as Greeks. While there has been an outpouring of support from local residents, barriers reduce refugee access to healthcare beyond basic first aid and triage, including access to mental health services.

The UNHCR estimates some **850,000 people landed** on the shores of Greece from Turkey in 2015, mostly on the idyllic sunburnt islands of Kos, Chios, and Lesvos. Of those arriving almost **28% were children**, more than half were Syrian, with the rest being from Afghanistan, Iraq, and other neighboring countries. There was a severe lack of government infrastructure and resources to provide temporary housing and to meet refugees’ basic needs. After all, the refugees arrived on the shores of tiny tourist havens with only a few hundred residents—not the expansive metropolis of Athens. During this time, humanitarian aid was focused on emergency response: search and rescue,

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**SPOTLIGHT: REFUGEES IN GREECE**

- **56,500** forcibly displaced people in Greece
- **20,600** asylum-seekers from unknown or variable countries of origin
- **9,500** additional refugees and asylum-seekers from Syria
clean water, ready-to-eat food, and emergency medical treatment upon arrival. Small NGOs and local residents provided what support they could; fisherman dragged half-sunk dinghies to shore while shopkeepers rushed to the beaches with towels and water. For this response, the Greek islanders were collectively nominated for the Nobel Peace Prize. When media attention brought the refugee crisis in Greece to the world stage, international outrage ensued and an outpouring of support led to establishment of larger NGOs and an influx of financial support to the critical islands in the Aegean. All the while in mid-2015 the European Banks were pressing Greece for loan repayments, capital controls had been put in place, and the government was in turmoil. Given Greece’s financial trouble, many refugees were eager to move on through Europe’s open borders to countries where employment or education opportunities were more likely, and many did move on before long-term support such as housing, education, food, or healthcare was needed.  

Then in a twist of events, the Northern Balkan countries closed their borders in early March 2016. Since this announcement there has been a massive drop in the number of new refugees entering Greece from 2,200 per day in February to 120 per day in April 2016. The government is now faced with shifting from emergency services to long-term services for those people effectively trapped in Greece until the asylum or resettlement process takes place. 

The UNHCR estimates 57,000 refugees are currently in debt-strapped Greece needing long-term solutions for health and well-being. Greece has become an accidental host for the refugees and has been tasked with ensuring their safety and livelihood. In a beautiful Mediterranean landscape such as Greece, it is easy to think that it isn’t the worst place to be trapped for a while. Unfortunately, the government lacks the resources and perhaps even the energy for ensuring long-term solutions for these refugees. Where to house so many refugees? How will they get access to healthcare in an already strained healthcare system? Major NGOs such as The Hellenic Red Cross and Médecins Sans Frontières are providing basic medical needs, prenatal care, and vaccinations at refugee camps. Long-term camps have been setup in old military compounds, tent cities, hotels, and even resort towns. Outside funding remains meager, and aid pledged at the beginning of the refugee crisis has dwindled. Given the financial circumstances, a surprising amount of humanitarian aid has come from Greeks making small contributions. In northern Greece and on the islands near some camps, local residents cook lunches with beans and vegetables and march them to camps to supplement the army-rationed microwave meals. Volunteers in the port city of Patras, often people who have been unemployed for years, give what they can in the form of soap, diapers, or hand-made blankets. Residents give hand-made crochet blankets...
that have been in families for generations. When asked how they feel about giving up something sentimental, there is a resounding answer: “we know what it is like to be a refugee and they need these things more than we do.” The majority of Greeks have family members who were once refugees after the 1923 Treaty of Lausanne forced the absorption of some 1.2 million ethnic Greeks into Greece from Turkey. Whatever the reason, it is clear that Greeks have come out in droves to support the refugees in any way they can.

“[Local] residents give hand-made crochet blankets that have been in families for generations.”

While help from locals has eased some everyday needs of refugees, it cannot possibly be enough to meet the ever-increasing long-term needs of those stranded at government-run camps. There have been reports of unsanitary conditions, overcrowding, and a lack of access to clean water or nutritional food. The International Medical Corps (IMC) recently conducted an extensive survey of several of the organized camps across Greece, including Thermopilis, Katsika, Nea Kavala, and Varia. Some of the most common stressors reported by camp residents included poor food quality provided by the army, crowded conditions, the presence of mosquitoes and lice, isolation of the camps from larger towns, and difficulties accessing secondary health care. Specifically, the difficulties in accessing healthcare were due to a lack of transportation to clinics or specialists, a lack of translators, and having to use savings to see private doctors. Some of these refugee-specific issues echo the reductions in coverage, lack of resources, and lack of doctors that face the Greeks, in a public health system stretched too thin.

An important but often overlooked need of refugees is access to mental health services. The World Health Organization and United Nations estimate that anxiety disorders and depression can double in the context of a humanitarian crisis. Findings from the IMC report support this idea, as both men and women expressed sincere concerns for their psychosocial well-being. Commonly mentioned issues included apathy, fear and uncertainty, depression, sleep disturbance and nightmares, suicidal thoughts, maternal depression, and the inability to care for and feed children. Parents expressed additional concerns regarding a lack of psychosocial support for children with developmental disabilities (e.g. autism, ADHD), behavioral difficulties, bedwetting, and other mental health issues such as PTSD. Given all of these mental health and psychosocial needs it is unfortunate that mental health support is on the back burner. Of the four camps surveyed, only one had a specialized psychiatrist and psychologist and none of the camps had community psychosocial support and outreach. One positive note was that all four camps had some form of “safe space” activities geared towards children. For what little mental health services there are, there is very little clinical follow-up or monitoring of medication use for a particularly vulnerable population. Fragmented care results in most cases going untreated, a common barrier to mental health care faced by Greeks and refugees alike.
Conclusions

The public health crisis in Greece serves as a warning that economic stability and public health are tightly intertwined. Even the most apparently stable social and health care systems could be only a few turns from devastating humanitarian crisis. In the case of Greece, government efforts to meet austerity measures through cuts in healthcare spending have had startling costs for the Greek people and for the refugees trapped there. Mass exodus of healthcare workers and rampant drug shortages have reduced access to health services. Meanwhile austerity has increased chronic stress, mental health needs, poverty, and poor nutrition. While refugees have unique issues and certainly increased need, their needs cannot be met by a health care system and an economy that cannot provide for the country’s own citizens. The international community must recognize that successful resettlement of refugees hinges on ongoing support of host countries. Behind the sunny blue-sky tourist billboards and disheartening economic statistics are citizens going about their everyday lives, each fighting their own private battles. Despite this, many of these people offer hope even in the most difficult of circumstances. Whether it is providing medications to people who cannot afford them, treating sick infants, or donating family heirlooms to refugees, there is no gesture too small.

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All quotes were translated from Greek to English.

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To Learn is to Rebuild

By Jacquelyn Pavilon

Washington, DC, February 2017 - Seven-year-old Sami* puts a toy gun to his younger brother’s head. He play-shoots his other siblings as they cower to the ground. Pulling out a phone, he points to a photo of a soldier: this, he says, is who he wants to be when he grows up. Sami* has seen nothing but war for most of his life. While his past is already written, his future is not.

With upwards of 65 million people displaced worldwide, trauma is not an exceptional case; it is an epidemic. With limited international resources and emergencies on the rise, aid for refugees often only addresses what is viewed as necessity. Yet in the whirlwind of providing food, finding shelter, and filling out documents, the most detrimental aspect of the refugee experience is often overlooked: the psychological component. Fleeing war, oppression, and persecution, refugees—especially children—are at high risk for psychological trauma. Amidst seemingly endless uncertainty, education can provide protection and stability both to children and adults alike.

“Making a life transition like this, moving continents, leaving everything, and coming to a place where no one seems to want you would be hard enough on anyone, but it is all the more difficult for us after what we’ve seen, what we’ve been through. We are already fragile. Breaking out into tears is a daily occurrence for months to a year upon arrival,” said Amira*, a Syrian refugee living in Italy and former aid worker who has faced ISIS four times and was abducted once.
Sadly, the trauma the refugees face is a three-tier trauma and does not end when they escape. First, there is the trauma that arises in conflict; second, the trauma of the journey; and finally, the trauma of not being accepted into their new community. According to Amira, the mental effects of the alienation and rejection she experienced in Italy were just as traumatizing, if not more so, than what she experienced in Syria.

“No one says hello,” she said. “After a year and a half of living here, no one has replied to my hello.” In fact, even after obtaining legal refugee status, she decided, willingly, to return to Syria.

“I’d rather return and contribute to my home community and risk dying, than stay in a community where I am idle and cannot do anything or know anyone,” she said.

Worldwide, over half of those who experience the trauma of displacement are children. One of the greatest consequences of this is that they find themselves out of school. Sami is among them. In emergency situations, psychosocial support and education are often secondary and fall onto the list of "long-term goals," with other more urgent forms of aid taking priority.

The average length of displacement is 17 years. That is, on average a refugee waits 17 years before being resettled, repatriating, or integrating into their country of arrival. Without education, 17 years can devastate an entire generation. Yet the benefits of education are not merely long-term, they initiate the healing process.

Approximately 4 million Syrian children are out of school as a result of the war, 250,000 of whom are in Lebanon. While war cannot be undone, its after-effects can be ameliorated through education and support. The Jesuit Refugee Service (JRS) educational center in Jbeil, Lebanon serves nearly 500 Syrian refugee children, including providing psychosocial support to children through Peace Education classes.

All of the children at the center have been touched by war, with mortars and bombs a daily risk. Some children have experienced violence in the home, and most currently live in unsuitable or overcrowded homes.

“When the children first arrive to our center, their 'bad behavior' is a direct result of the trauma they have experienced,” said Majed Mardini, a Syrian teacher at center. Many children could not access education in Syria, primarily in the villages, as various armed groups occupied the schools. It has been over five years since the war started in Syria. Thus, some children are out of school for years; others never had the opportunity to start.

“The most important thing,” he says, “is that we start to support the children psychologically.” “They need more than a traditional education,” Mardini continues. Moral- and conduct-education takes precedence. All of the teachers play a double role as social worker. “Many of the kids don't know how to be in school. We teach the kids how to behave, how to interact with one another, but most importantly, how to like one another”

Catherine Mora, another teacher at the center recalls the change she’s seen in the students: "The children used to fight when they played,” she recalls. “It was all they knew. When they arrive to us, they're basically starting from scratch, but after only six months, they no longer do so. Rather, they play with each other. Sometimes I see them playing 'English class' at recess, where one is imitating the student and one is imitating me as the teacher. When I see this, I feel their progress.”
Even now in Lebanon, the children live an uncertain and transient life. Children move with their families, transition to new schools, start working or even get married. “You may see them today, you may not see them tomorrow,” says Syrian refugee and English teacher at the Jbeil center, Catherine Mora.

In the same home as Sami is five-year-old Sabeen*. Through the crack in the door, the JRS home visits team can see her hiding under a blanket crying. “She is sad because she misses her cousins who left here to try to reach Germany. We don’t know if or when we’ll see them again,” the mother explains.

In the midst of such a transient life, schools create safe spaces and stability for the children who left everything behind. Simply having a class can help create structure to ground students and provide them with the support they need to cope with their past and present situations. “The children are happy [at the center.] When you tell the children it’s vacation time, they are so sad. They don’t want vacation. School is the only place they have fun, the only place they’re at peace. They don’t want time at home, because time at home may mean time in the street,” Mardini explains.

According to those in the field, young children can recover from trauma relatively quickly. Like their youthful bodies, their minds similarly heal faster. “Children are resilient,” said Gassian Tenekejian, center principal. “They can bounce back even faster than adults, but we have to help them do so.”

Over 50 percent of refugees worldwide live in urban areas and thus are not isolated from the communities to where they have moved. They are moving into existing neighborhoods, existing economies, and existing public schools. Thus, the stable community structure that schools create helps to build bridges to the new community and break down barriers and prejudices. Being in school facilitates integration, so children do not have to face the extreme alienation and xenophobia like Amira did.
Sustaining services.

Education gives refugees the tools they need to rebuild not only themselves but also their communities. Despite the fact that the United Nations recognizes education as both a basic and enabling human right, only 50 percent of refugee children have access to primary education, 25 percent to secondary education, and less than one percent to tertiary education. Within the global epidemic of trauma as it relates to displacement, the lack of education turns these individual psychological problems into a societal one.

The manner in which refugees deal with childhood trauma directly correlates to how they cope with and manifest that stress in adulthood. Research suggests school interventions can effectively address post-traumatic stress symptoms that refugee children experience and help them build secondary resilience. Teaching local languages to help develop social networks, facilitating the formation of social groups and friendships, and making local information available all help alleviate the stress of forced migration.

As of now, education comprises only 8.6 percent of aid services provided worldwide. The process of rebuilding communities and reconciliation is a marathon, not a sprint, yet aid money is disproportionately applied toward the ‘hot and trendy’ crises. What happens when the ‘hype’ surrounding a crisis fades?

Chad is an example of a protracted crisis where this is happening. Thirteen years ago, “Save Darfur” was ringing in everyone’s ears, but now over a decade later, Sudanese refugees still find themselves displaced in Chad, with waves of new arrivals coming over the past three years. However, in 2013, UN aid to Chad was cut by forty percent.

AGENCY SPOTLIGHT

The United Nations High Commissioner for Refugees (UNHCR)

Created in December 1949 following the end of WWII, The United Nations High Commissioner for Refugees (UNHCR) is the premier agency for refugee support. Headquartered in Geneva Switzerland, the UNHCR is a program of the United Nations and serves both at the request of local governments or the UN itself. According to the United Nations General Assembly the sole mandate of the UNHCR is to provide, on a non-political and humanitarian basis, international protection to refugees and to seek permanent solutions for them. Included here is a listing of UNHCR funding sources, regional priorities and unmet needs.

<table>
<thead>
<tr>
<th>Select UNHCR Unmet Refugee Needs 2015</th>
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<td>Psychosocial Support</td>
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<td>Child secondary education</td>
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<td>Core relief items</td>
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<td>Shelter support</td>
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UNHCR Funding Sources 2015

Regional Fund Allocation 2016
Since the cuts, schools are stripped to the bare minimum. Some classes have a 200:1 student-to-teacher ratio. Schools can no longer provide food for the students and are lacking many supplies. Many students drop out because they cannot stand the school day in the 115°F (45°C) temperature without food.

“Since the budget cuts, our classrooms are in bad shape. We prioritize keeping children in school but we’re in need of almost everything: water buckets, food, scholastic materials, bathroom doors, hygiene materials, blackboards, desks, floor mats, etc.,” said Adam Khatir Ibrahim, Director of the JRS Dorothy school, Goz Beida camp, Chad.

Schools are in dire need, and refugees in dire need of education. Yet even where budgets are cut, displaced students everywhere affirm their commitment to learning. Many say that it gives them hope.

“The students have not only mastered English grammar, but really learned to think critically. We watch Ted Talks on various topics each week. It gives them a glimpse of the outside world and allows them to think differently. Last week we analyzed a poem. All of these activities allow them to think of different realities, of a different future, possibly outside the camp. Their education brings them out of the mentality that, because they’re refugees, they can’t attain anything. It gives them hope,” a JRS Adult English Teacher in Goz Beida camp Chad explains.

The arch of psychological and societal trauma is steep and wide, but the solutions for healing must start at day one in emergencies and continue on for decades, even when crises fall off the radar. JRS Arabic teacher and refugee from Darfur, Hiba* tells it straight:

“If people are educated, they’ll understand life, how to manage themselves, even through the most difficult situations...”

*Names have been changed.

Jacquelyn Pavilon is a first year PhD candidate in the Department Economics at Georgetown University. In 2014, she began work in the Communications Department at the headquarters of the Jesuit Refugee Service in Rome, an organization with the goal to accompany, serve, and advocate for refugees across 45 countries and all faiths. As the International Communications Coordinator she traveled to various countries to report on the situation of refugees. In 2015-2016 she helped launch a $35 million campaign called Mercy in Motion specifically commissioned and endorsed by Pope Francis to provide 100,000 additional refugees with education by 2020. She plans to focus her research on labor and migration.

REFERENCES:
Early education as a path to long term health in refugee and displaced populations

By Osefame Ewaleifoh

Providing high quality education for refugees and displaced populations might not be the most urgent public health priority in the short-term; however, a counter intuitive investment in high quality education might be the most prudent public health investment to guarantee sustained positive health outcome in the long-term.

THE GLOBAL REFUGEE CRISIS IN HISTORICAL CONTEXT

In the last 30 years there have almost constantly been at least 8 million refugees adrift every year.¹ This trend peaked in 1990 at which point there were 17.4 million refugees globally (1/350 people).¹ Over the following decade the number of global refugees and internally displaced populations declined significantly to a record low of 8.6 million people in 2005. Sadly this steady decline in global refugee populations was short lived, interrupted by a new wave of natural disasters and geopolitical conflicts culminating in the Arab Spring by early 2011.¹ Thus, whereas only 8.6 million people were identified as refugees in 2005, by 2015 this number had increased to 15.6 million people—once again approaching the 2-decade high of 17.4 million globally displaced.

According to a recent UNHCR report, if the current displaced populations around the world were a country, they would form the 21st largest country in
The growing trends in refugees and displaced population have been driven by geopolitical forces such as wars, but also by climate change, a factor that promises to become an even bigger driver of migration and displacement in the years ahead. Even more distressing, recent data suggests a growing population of refugees are stuck suspended in a state of “protracted displacement” that extends over 20 years in camps—neither returning home nor getting absorbed into new communities. Together these realities raise the question: what happens to health needs of refugees stuck in camps for months or years? More specifically, what interventions might be employed to promote short- and long-term health outcomes among refugees and displaced populations? The answers to these questions might provide insight on how to both manage the current crises and prepare for future need.

The refugee experience is changing. Increased volume of refugees and duration of their displacement has revealed the inadequacy of existing health access frameworks, which were designed primarily to meet short-term settlement health requirements. Here, I examine the potential role of an education-centered model in promoting access to health and improving long-term health outcomes in refugee and displaced populations around the world. I ask three central questions: first, what role if any does education play in promoting health outcomes in refugee and displaced populations? Second, what institutions and infrastructures currently exist to promote health outcomes in refugee and displaced populations? Finally, looking forward in the light of current and predicated migration trends, I examine the role of education in innovatively promoting health access and outcomes in refugee and displaced populations.

“According to a recent UNHCR report, if the current displaced populations around the world were a country, they would form the 21st largest country in the world.”
THE NECESSITY FOR LONG-TERM HEALTH ACCESS

A person is designated a refugee when he or she “is outside the country of his or her nationality, and is unable to or...is unwilling to avail himself of the protection of that country” due to a “well-founded fear” of persecution, but not all forcibly displaced persons are refugees.

According to the UNHCR, a protracted refugee situation is one in which 25,000 or more refugees from the same nationality have been in exile for five or more years in a given asylum country. The estimates of this definition are conservative, because irrespective of how long a group has been in exile it will not be counted as “protracted” if the group size is fragmented in different regions and thus less than 25,000. Still, by this conservative estimate in 2015, the UNHCR estimated that some 6.7 million refugees, 41% of those under UNHCR’s mandate, were in a protracted situation. Specifically, this report suggested that of the 32 protracted refugee situations at the end of 2015, 23 have lasted for more than 20 years. The conflict in the Syrian Arab Republic, which entered its sixth year in 2016, has been the single biggest driver of global refugee populations in the last three decades. Concurrent with a growing wave of global nationalism and resistance to the refugee resettlement effort, the proportion of protracted refugees is expected to grow.

The growth in protracted refugees raises new demands for long-term health services. Currently, the overwhelming majority of health services provided during refugee crises focus on emergency and short term care. These services concentrate almost exclusively on infectious diseases, malnutrition, and sanitation and, to a limited degree, child and maternal health. The goal of these services is simple—to reduce “refugee emergency kills” that result from the sudden mass exodus of refugees, such as those that occurred following Rwanda in 1994 and most recently Syria. However, while reducing refugee emergency kills remains important, the growing trend in protracted displacement raises new “long-term health challenges” much beyond simply preventing infections or treating war injuries among refugees. Although the full impact of protracted displacement on refugee health outcome remains to be carefully examined, a recent global burden of disease multination analysis of the 22 countries in the Mediterranean implicated in the Arab spring and related conflicts observed that since 2013, there has been a clear shift in main causes of death from communicable to non-communicable diseases in the region. This study notes an increase in mental health disorders including addictions. Most noteworthy, this study documents a steady decline in life expectancy in the region (by 6 years for males and 5 years for females) perhaps attributable to the continuing war and protracted regional instability. In light of the reality that most refugees will experience protracted displacement before resettlement (if and when that occurs), perhaps it is time to re-think our approach to refugee health. Future health priorities must go beyond simply emergency care and infection control in search of new strategies to promote long-term health and wellness among refugees.

“...The conflict in the Syrian Arab Republic, which entered its sixth year in 2016, has been the single biggest driver of global refugee populations in the last three decades.”

RECOMMENDED READINGS

A Hope More Powerful Than the Sea
by Melissa Fleming

The story of Doaa, a Syrian refugee, and her plight as she voyages from her native Syria. Fleming is the director of communications for the UN Refugee Agency, recently spotlighted by Humans of New York in her efforts to put a face to the refugee crisis.

Aging with Grace
by David Snowdon

This book follows the landmark “Nun Study” which was one of the first studies to draw a link between education and healthy longevity.
UNIQUE HEALTH CARE CHALLENGES OF DISPLACED POPULATIONS

Conflicts and natural disasters frequently lead to some degree of health concern, and beyond this, forced displacement and the refugee experience are highly associated with trauma and other health-related conditions. The health-related needs of refugees are often complex and multi-factorial, and these factors might be further complicated by genetic, socio-economic, and geopolitical factors. To better understand the individual factors that might influence health outcomes in displaced populations the health experience continuum of displaced populations can be categorized into three temporal divisions: pre-flight, in-flight, and post-flight phases of displacement. Pre-flight factors are pre-existing factors in the community such as poverty, unemployment, infectious disease outbreaks, or lack of preventive services that existed before the migration occurred. Pre-flight factors might or might not be of significant impact depending on their duration, how precipitously living conditions changed, and what event precipitated flight. In cases where wars and civil unrest led to flight, the pre-flight phase might be hallmarked by significant physical and psychological trauma. Next, the actual process of relocation can lead to health challenges, particularly among vulnerable groups such as children, the elderly or otherwise infirm. The health challenges associated with refugee relocation can stem from the mode, duration, or specific context of transport. The impact of relocation process has been most studied for the refugees from Vietnam who escaped the fall of Saigon on boat, some of whom continue to suffer significant psychological struggles related to their escape decades later. Finally, post-flight factors that determine health outcomes can range from access to basic initial needs such as housing, food, water, and sanitation to more complex factors like asylum status, permission to work, and access to local health resources. Collectively, factors from each of these three phases affect the physical and mental health outcomes of refugees.

Psychosocial evaluations of displaced populations around the world show that refugees consistently exhibit significantly higher rates of mental health impairments than non-refugee populations. Mental health impairments in refugees have been specifically associated with severe anxiety, post-traumatic stress disorder (PTSD), depression, and
existential dilemmas.\textsuperscript{10-12} It is important to note that not all refugees present with mental health impairments and that some presentations take time to manifest. A longitudinal study estimating the prevalence of mental illness among Guatemalan refugee communities in Mexico 20 years after the resolution of initial conflict and relocation showed that 12\% fulfilled the criteria for PTSD, over half (54\%) had anxiety symptoms, and more than a third (39\%) had symptoms of depression.\textsuperscript{13} This study is among others in suggesting that mental distress among refugees might present immediately or might occur years after the initial flight experience.

While mental health in displaced populations have been more extensively studied due to the traumatic nature of forced displacement, a retrospective Lancet study in 2002 showed that “displacement increases the Crude Mortality Rate (CMR) to at least double normal baseline rates in the population before any displacement activity.”\textsuperscript{14} Specifically, this study showed that camps that were close to the border or region of conflict, or had longer travel times to referral hospitals had higher CMRs than those located further away or with shorter travel times. Additionally, camps with less water per person and high rates of diarrhea had higher CMRs.\textsuperscript{14} The displacement-associated increase in CMR has been attributed to malnutrition, measles, a lack of sanitation, malaria, diarrhea, and acute respiratory infections.\textsuperscript{15} Beyond these acute increases in CMRs, sustained conflicts, forced migration, and protracted displacements have also led to an increase in the incidence of chronic diseases, one example being diabetes.\textsuperscript{4}

To be clear, much success has been achieved in providing emergency care to internally displaced communities by such organizations as the UNHCR; however, much of this work has centered on “Band-Aid” relief. This current emergency health care strategy might be ill-suited for the challenge posed by the growing displaced populations’ shift towards protracted displacement. Given the growing interest of education as a social determinant of health outcome, I propose a role for education in delivering and improving health outcomes among displaced and refugee populations. If education is indeed a core social determinant of health outcome, it could prove invaluable in delivering positive health benefits to the displaced and dispossessed victims of forced migration.

THE CASE FOR EDUCATION AS A PROTECTIVE SOCIAL DETERMINANT OF HEALTH

In 1973, Kitagawa and Hauser published a cross-sectional study focused on understanding how mortality outcomes are driven by differential measures of socioeconomic status such as education in the United States.\textsuperscript{16} This landmark study found substantial differences in mortality by education level for both white men and women showing that overall, persons with less education had higher levels of mortality.\textsuperscript{16} Follow-up longitudinal studies found that mortality differentials by educational attainment remained after controlling for other socioeconomic factors such as income, employment, and marital status.\textsuperscript{17,18} These studies provided the earliest empirical evidence for the relationship between education and health outcome, and were further confirmed by U.S census data in 1999 that showed the age adjusted mortality rate of high school dropouts ages 25 to 64 was more than twice as large as the mortality rate of those with some college education.\textsuperscript{19}
Education and health outcome: the evidence

Extensive studies have been conducted to gain insight into the relationship between education and health outcome. In 1991, Snowdon and colleagues began following 680 nuns born before 1917 as part of the now famous “Nun Study” — a longitudinal study of aging and Alzheimer’s disease. The goal of the experiment was to determine how early childhood factors influenced health outcomes later in life. Once admitted into sisterhood, all sisters had essentially the same meals, health insurance, and living conditions. Importantly, this allowed researchers to better control for later life exposures that might impact health outcome, and created room to study the impact of early life experiences. The most seminal finding of this study was that the greatest predictor of health outcome was earlier life education. Specifically, sisters who had received any education before entering the sisterhood had much better health outcomes later in life than those who had no education. This study indicated that the protective impact of education suggested by Kitagawa and Hauser was more complicated than simply the result of higher income or better access to health resources, and that it was more directly connected to elemental tenets of education such as numeracy and literacy.

Follow-up studies have reinforced the role of education in predicting and influencing health outcomes. These studies revealed that the 30% drop in lung cancer following the 1963 surgeon general’s pronouncement on cigarette and lung smoking was almost exclusively attributable to behavioral changes among those educated to at least high school levels. Parallel and analogous studies show that following widespread knowledge on the preventable nature of HIV with condoms, the greatest drop in new infection rates were among the educated.
MODELS: HOW DOES EDUCATION IMPROVE HEALTH OUTCOME

Increasingly, it is evident that education improves long-term health, but how precisely does education improve health outcome? Two primary models have been proposed for how education can influence health outcome: the exogenous and endogenous models. The exogenous model for the impact of education posits that obtaining an education provides more income, places one in a higher socio-economic class, in a wealthier neighborhood, and different social settings which collectively serve to promote better healthy behaviors and outcomes. Still, the results from the Nun Study and other longitudinal health access study suggest the impact of education on health outcome might be significantly more complicated and interesting than the simple presence or absence of more resources. These studies support a role for the endogenous model, which posits that the knowledge gained through education is itself responsible for improved health outcomes.

The endogenous model of education and its impact on health outcome

The inadequacy of exogenous factors such as socio-economic status (SES) and income to fully explain the education–health correlation has led to the “endogenous model” for educational impact on health outcome. This model is anchored in the theory that health outcome is affected by the process and products of education. Specifically, this model proposes that education imparts essential life skills and learned effectiveness that enhances an individual’s quality of life. Endogenous benefits of education include both cognitive benefits such as literacy and critical thinking, and non-cognitive benefits like self-control and impulse regulation. This is possible because education helps one develop the capacity to find out what needs to be done and how to do it, and develops habits and skills of self-direction. Furthermore, education improves health because it “increases an individual’s effective agency, enhancing a sense of personal control that encourages and enables a healthy lifestyle.”

Research suggests that the process of education “intentionally engages the receptive capacities of children imbuing them with knowledge, skills of reasoning, values, socio-emotional awareness and control, and social interaction that help them grow as engaged, productive, creative, and self-governing members of a society”. It is worth noting that this process of education occurs both within and outside the walls of a formal classroom educational process. Beyond thoroughly establishing that education has positive health outcomes, the health benefits of the health benefits of education are even greater among the poor, minorities, and less privileged.”
education are even greater among the poor, minorities, and less privileged. Thus, if education policy were to be re-interpreted as health policy, vulnerable and underprivileged communities could benefit the most from its equalizing impact. 24, 25, 27, 28

It is becoming increasingly evident that education improves long-term health not just by increasing wealth, but because it increases an individual’s effective agency; it enhances a sense of personal control by increasing the stock of one’s competencies, general and specific knowledge, and personal and social attributes. Education thus increases one’s ability to function successfully within market and nonmarket environments—a valuable attribute for effectively managing one’s health and accessing care—making it a particularly potent tool to empower vulnerable and high health risk communities like refugees and displaced populations. 23-25

THE UNHCR MANDATE FOR EDUCATION IN REFUGEE COMMUNITIES

Given the documented health benefits, what can be done to promote access to education among refugees and displaced populations where potential constraints to education access exist? Specifically what legal frameworks, infrastructures, innovations, and policy tools have been used historically to promote education, and how can these tools be redeployed to promote long-term, education-based improvements in access to health in displaced populations?

Currently, the foundational framework driving the rights of displaced children to education include the Article 22 of the 1951 Convention relating to the Status of Refugees, which states that signatory states “shall accord to refugees the same treatment as is accorded to nationals with respect to elementary education…. [and accord] treatment as favorable as possible… with respect to education other than elementary education” (UNHCR, 2010c). Furthermore, in the UN Convention Rights of the child, Article 28, signatory States are directed to:

“(a) Make primary education compulsory and available free to all;
(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
(c) Make higher education accessible to all on the basis of capacity by every appropriate means;
(d) Make educational and vocational information and guidance available and accessible to all children;
(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

This article continues, outlining that discipline should occur in a “manner consistent with the child’s human dignity”, and that international cooperation should be encouraged to promote modern teaching methods in addition to scientific and technical rigor. Article 29 expounds upon the need for education to be of high quality, stating that “the education of the child shall be directed to: (a) The development of the child’s personality, talents and mental and physical abilities to their fullest potential” 29

The UN conventions on the rights of the child provide an essential foundation for both the educational right of the child and the right to wholesome, healthy development. This convention is particularly important for refugees today because of its binding character, participation rights, and comprehensiveness, which collectively committed all signatories to protect the rights of children—including the right to education. 30
A well-characterized hallmark of forced displacement is its corrosive impact on local education systems. The violence in Syria is a case in point: in 2009, before the current conflict began, 94 per cent of Syrian children attended primary and lower secondary education; by June 2016 only 60 per cent of children did so, leaving 2.1 million children and adolescents without access to education. The situation is not much better for Syrian refugees in neighboring countries. In Turkey, only 39% of school-age refugee children and adolescents were enrolled in primary and secondary education, 40% in Lebanon, and 70% in Jordan; this suggests nearly 900,000 Syrian school-age refugee children and adolescents are not in school. Globally it is harder to identify precisely how many refugee children are deprived of basic education. Still, estimates range upward from 1.7 million, and those who are receiving educational services find that the content and the quality vary drastically. Depending on their asylum status, displaced children might or might not receive education, as immigrants and undocumented refugees are often left unreached unless they are fortunate enough to find NGOs offering educational aid. Legal status matters a great deal as access to education is not universally guaranteed, especially for children with irregular status. Furthermore, migrants with irregular status may avoid formal schooling for fear of being identified, and detained or deported, a complication that further limits these children’s access to education opportunities.

Beyond asylum status, language education policies also influence the education of refugees. Proficiency in the language of instruction profoundly affects educational outcomes. Studies show that migrants who speak the language of instruction at home perform better than those who do not, making appropriate language of instruction essential to improved refugee educational outcome. In addition to system-level drivers like asylum status and language policy, school-level factors like access to kindergarten and early childhood education enrollment have been observed to be essential for migrant student performance and positive outcome. Finally, the presence of migrant teachers and the responsiveness of curriculum to the migrant experience have been found to positively correlate with enhanced education outcomes for migrant children. Promoting access to health in refugee populations through education is a complex and multi-factorial challenge and will require a concerted coordinated interagency effort. Still, in light of the overwhelming need for a long-term strategy towards refugee access, an investment in education might be an ideal place to start.

**STRATEGIES TO PROMOTE REFUGEE HEALTH THROUGH EDUCATION**

According to a recent UNHCR review by Sarah Dryden-Peterson, “while education is one of the highest priorities of refugee communities, at present there is little evidence of tangible organizational commitment or capacity by UNHCR to guaranteeing the right to education for refugee children and young people.” Even more, the UNHCR is not currently recognized as an actor in the education arena by other players in the field, including Non-Governmental Organizations (NGOs), scholars, and other UN agencies. An education-centered strategy to promote health outcomes among displaced populations must achieve a few objectives to be truly effective.

1. **1st**, it must target young migrant children as early as possible to bring them into the education pipeline.
2. **2nd**, it must focus on developing core cognitive skill such as numeracy, literacy, critical thinking, and abstraction, as well as non-cognitive skills such as organization and self-regulation. The development of these skills must be prioritized over the acquisition of diplomas or other formal attainments, although the latter are not of themselves undesirable.
3. **3rd**, the school curriculum and administration must be innovative yet sensitive to the needs of students from displaced backgrounds.

**OBJECTIVES**
Innovations to promote education among refugees must integrate refugees into national education systems, which will require optimizing current educational infrastructures. To achieve this aim, we must encourage investment in teacher training that cultivates high quality skills related to both pedagogy and content, and there must be a recognition of the connections between education and conflict in all education policy and planning. Since most local government and state actors are unlikely to have the capacity to pursue these aims, close partnerships between local Ministries of Education, Ministries of Health, and UNICEF must be prioritized to strengthen national education curricula for the benefit not only of refugees but also host communities. Promoting long-term refugee health outcomes through prioritizing refugee education can only be achieved through a concerted, interdisciplinary partnership, as no single agency or state alone possesses the capacity to meet this growing need.

**IN SUMMARY**

In “A Framework for Public Health Action: The Health Impact Pyramid,” Frieden writes, “Interventions that address social determinants of health have the greatest potential public health benefit”. Education is fundamental among social determinants because it is foundational to the development of new members of society—children and youth—and it bridges the gap across socio-economic inequity. In this context, effective teachers become facilitators of long-term health benefits and education policy becomes in itself a form of health policy. Thus, while education as a means of public health intervention might remain difficult to define and evaluate, its impact—particularly in high-need communities such as refugees and displaced populations—can be cumulative, formative, and transformative, both for the individuals who experience it and for the society it recreates.

**Osefame Ewaleifoh** is a PhD/MPH student at Northwestern University and a co Editor-in-chief of the NPHR.

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