ISSUE BRIEF

Immigrant and Refugee Health in North Carolina

Jeffrey Walden, Holly Sienkiewicz

The demographic composition of North Carolina has changed dramatically in the past three decades. Because of trends in immigration and refugee resettlement, our state is more diverse than ever before. Immigrants and refugees in North Carolina face unique challenges within the health care system, as well as increasing political and social pressures. Although often discussed as a homogenous group, newcomers comprise a varied mix of peoples from many cultures. The ability to connect across cultural barriers remains a key point when working with these populations. Despite myriad backgrounds, practice recommendations do exist when working with refugees and immigrants, and clinicians and other health care providers should adhere to these standards when working with these underserved individuals.

Presently, more people are forcibly displaced worldwide than at any other time in recorded human history. By the end of 2015, we reached an historic high of 65 million displaced people, the largest number since World War II [1]. In 2018, we surpassed that mark with an unprecedented 68.5 million displaced people throughout the world according to the United Nations High Commissioner for Refugees (UNHCR) [2]. Concurrent with these unprecedented numbers, nativist movements throughout much of the developed world have intensified, resulting in a decline of the number of immigrants and refugees admitted through legal channels [3]. This trend has been most pronounced throughout parts of Europe and the United States.

Immigrant and Refugee Policy in the United States and North Carolina

The US immigration system is extremely nuanced in its terminology and how it refers to specific types of immigrants, although politicians often use terms interchangeably when it is not appropriate nor factually accurate to do so. Such is the case with the terms "refugee" and "asylum seeker." The 1951 Convention Relating to the Status of Refugees defined a *refugee* as someone 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 of the country of his nationality and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" [4]. Refugee status is not granted automatically but determined only after a strict vetting process involving dozens of international organizations and federal agencies. All refugees entering the United States arrive legally. Subsequently, an *asylum seeker* is someone who states that he or she is a refugee, "but whose claim has not yet been definitively evaluated" [5]. The requests for sanctuary from individuals in this group have yet to be decided. Individuals seeking asylum in the United States may or may not have entered the country with a valid visa. *Immigrants* are also outside their country of origin and typically seeking permanent residence, but have left for opportunities such as work, education, or for family reunification [6]. Many immigrants have also been persecuted in their countries of origin and/or fled violence, but that violence does not necessarily meet the criteria for refugee status (eg, gang violence from drug cartels). Immigrants may or may not have documentation authorizing their stay in the United States.

Immigration to the United States predates the nation's formal founding and has included both forced migration—African slaves bought to work plantation crops and Chinese immigrants brought to build the western railways being two examples—and voluntary migration. Anti-immigrant sentiment is not new to the country either: Jews fleeing Russian pogroms were denied entry to the United States in the late 19th and early 20th centuries, and anti-Irish sentiment in the mid-1800s led to riots in northern US cities. A detailed history is beyond the scope of this paper; however, our country's history of refugee resettlement is a relatively recent phenomenon beginning in 1975 when the first Indochinese refugees arrived in the United States. Congress quickly realized that it needed more formalized procedures to address ongoing refugee crises, thus establishing the Refugee Act of 1980. Every year since, the executive branch has set presidential determinations establishing the maximum number of refugees eligible for admittance. Historically, the Refugee Admissions Program maintained bipartisan support with admission goals consistently set between 70,000 and

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Address correspondence to Holly Sienkiewicz, UNCG Center for New North Carolinians, 915 W Gate City Blvd, Suite A, Greensboro, NC 27403 (holly.cnnc@uncg.edu).

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90,000 refugee arrivals [7]. The ceiling has been as high as 231,700 in 1980 and prior to the current administration had never been lower than 67,000, the ceiling set in 1986. The number of refugees arriving to the United States has varied substantially from 207,116 arrivals in 1980 to a low of 27,110 in 2002 [7]. None of the 9/11 terrorists were refugees; however, the attacks resulted in a temporary moratorium on refugee resettlement and revamped security procedures and background checks.

In 2011, the Syrian crisis began to unfold, significantly increasing the number of displaced persons throughout the world. Five years later, the Obama administration increased the ceiling to 85,000 refugees, including 10,000 Syrian refugees. The Trump administration reduced the ceiling, or goal for refugee admissions, dramatically in fiscal year 2018 to 45,000 and again in 2019 to just 30,000 refugee arrivals for the year, the lowest numbers in the nearly 40-year history of the program [7]. In addition to slashing the number of arrivals, refugees from Muslim-majority countries have decreased dramatically since the Trump administration's inception of Executive Order 13769, the so-called "Muslim ban" [8], which disallowed entry for any refugees or immigrants from seven predominantly Muslim countries—regardless of their visa status or business relationships with the United States. After multiple challenges, a revised executive order was upheld on June 26, 2018, by the United States Supreme Court and currently remains in effect, effectively barring all entry of individuals from Iran, Libya, North Korea, Somalia, Sudan, Syria, and Yemen, as well as some Venezuelan officials (Iraq was in the original executive order but was removed from the revised list) [9].

Immigrants have also been targeted by this administration through policies pushing to end Deferred Action for Childhood Arrivals (DACA), forcibly separating families at the US-Mexico border, and proposing changes to public charge regulations [10, 11]. These policies (and attempted policies) have left many immigrants and refugees in this country in a perpetual state of confusion and fear over the possibility of being separated from their families or deported due to changes to immigration enforcement [12]. This "violence of uncertainty" has led to decreased used of vital health services, increased bullying of children and xenophobic crimes against adults, and fear for families' safety [13].

Providing Care to North Carolina's Immigrant and Refugee Population

The demographic composition of North Carolina has changed dramatically since the 1980s, a time when residents were largely black or white. As of 2017, 7.8% of the population was foreign-born and 9.5% Hispanic or Latino, most likely an under-reported percentage [14]. As of 2017, immigrants—including refugees—comprised more than 10% of the population in the urban counties of Durham (13.9%), Guilford (10.2%), Mecklenburg (15%), and Wake (13.3%) [14]. North Carolina consistently ranks 10th in the United States for the number of refugees resettled. In 2015 over 3,300 refugees made the state their home with most resettling to Durham, Guilford, Mecklenburg, and Wake counties, among others. The following year, arrivals totaled just 2,200 and only 1,100 refugees arrived in North Carolina in fiscal year 2018.

Prior to admission to the United States, refugee applicants are processed overseas by US authorities in a vetting process that can take up to 24 months [15]. Applicants for immigrant visas or refugee status undergo a medical examination by a panel physician using CDC-established guidelines. This examination's purpose is to identify any medical condition that might cause a significant public health danger to the United States [16]. After arrival in the United States, CDC recommends refugees receive a domestic screening evaluation, with detailed guidelines available [17]. Not all newcomers are refugees, of course, yet ensuring that all of these potentially vulnerable populations receive appropriate care should be a priority among health care providers in North Carolina.

To this end, in this issue of the *North Carolina Medical Journal* (NCMJ) we explore themes pertaining to immigrant and refugee health, focusing on issues relevant to practicing health professionals in our state. North Carolina has long been a haven for those seeking political asylum and freedom from persecution [18]. The prospect of job opportunities and a better life due to the state's rich agricultural industry and the presence of public universities (including historically black colleges and universities [HBCUs]) lured others [18, 19]. With this background, North Carolina has a strong history of providing for newcomers, whether formally settled refugees or otherwise. In her invited commentary, North Carolina's state refugee health coordinator, Jennifer Morillo, describes the screening all refugees must undergo [20]. These screening protocols and recommendations provide valuable tools to help integrate refugees into the American health care system while also providing continuity between screenings and physical examinations performed both abroad and domestically.

One of the struggles many newcomers face is that of accessing general care beyond the initial screening. By definition many of these newcomers—especially refugees—have experienced past trauma in their lives, often at the hands of government officials or other related entities. Such ordeals make refugees and other immigrants more hesitant to seek care, as they may distrust anyone in a perceived position of authority, such as health care providers or other clinicians [21]. Gaps in health care coverage, transportation issues, and an inability to access adequate language and interpretation resources also pose difficulties for newcomers trying to find medical, dental, or mental health care. On the provider side, language barriers and concern about encountering less common disease states can make clinicians hesitant about working with refugee and immigrant populations.

Many newcomers face comparable obstacles while

exhibiting similar levels of resilience. In a sidebar, Taye Gonfa, a former refugee from Ethiopia and soon-to-be fully licensed practicing physician, describes his particular journey [22]. Gonfa's detailing of life in a refugee camp and his ability to find work and start a family through resettlement proves remarkable. Several following articles detail analogous challenges, as well as the ability of newcomers to overcome them. Although resilience is often framed from the perspective of the individual, the article by Mohammed et al demonstrates that community-wide efforts at both local and state levels can provide a more systems-based approach to managing resilience [23]. Over the past year and a half, dedicated pediatricians have formed a working group to promote better health and well-being for immigrant families. The recently-formed North Carolina Pediatric Society (NCPS) Committee on Immigration works to advance policies that will better support families in obtaining equity in health care, while also addressing the social factors that affect access to care by directly advocating for policies that positively impact all children's well-being, no matter their country of origin [23].

Unfortunately, despite such efforts, some governmental policies directly subvert the well-being of children. In a related sidebar, pediatrician Shruti Simha examines the effects upon newcomer families of family separation stemming from the Trump administration's "zero tolerance" policy for those who "illegally" enter the United States [24]. (Beyond the political and human rights issues of prosecuting individuals who have yet to commit a crime, coming to the border to request asylum is a longstanding legal tradition enshrined in national and international law.) We know that long-term stress and trauma have toxic effects on children's neurological development, leading to lifelong consequences [25]. Unfortunately, fears of separation occur not just along our national borders. Such fears over separation from sudden deportation can limit access to public benefits, regular health checks, and pose ongoing stressors on families, establishing "climates of fear and mistrust" among immigrants that discourage, whether willfully or otherwise, interaction with any public service provider [21].

Beyond the threat posed by adverse governmental policies, immigrants and refugees are also at high risk of becoming victims of human trafficking. Maura Nsonwu of North Carolina State University outlines definitions of the term and provides specific examples of those who have been trafficked [26]. The number of people who have been trafficked is likely under-reported at both the state and federal levels for a variety of reasons, yet we know that the number is steadily increasing due to a confluence of factors including better documentation and increasing awareness. Of concern is North Carolina's rank at eighth in the nation for reported trafficking cases. As Nsonwu advocates, approaching this issue from a public health perspective may serve as a better way to further increase awareness of trafficking while also more appropriately assisting victims [26].

As highlighted previously, a patient's primary language often serves as one of the greatest limiting factors to accessing care. This should not be the case. The Civil Rights Act of 1964 decreed that no person should be discriminated against based on his or her race, religion, or country of origin [27]. In the latter instance, an individual's language stands in as a proxy for nationality. As such, all clinicians and health care systems that receive federal funding must provide appropriate language services to their clients and patients [28]. Despite this, persons with limited English proficiency (LEP) often still struggle to access appropriate language services. Best practice in language services extends beyond the already well-known maxim that family members should never be used as interpreters. In her article on this topic, Cynthia Mejia of the University of North Carolina at Greensboro Center for New North Carolinians outlines some of the training interpreters must go through, the various types of interpretation with which both patients and clinicians may interact, and potential means of overcoming some of the common barriers in interpretation—finances being a major one [29].

Immigration and resettlement issues do not end once individuals or families have crossed the border. Finding adequate health care, as mentioned above, remains a major concern, but so does finding work. North Carolina remains a highly agricultural state and finding workers to respond to agricultural seasonal demands can be challenging. Farmworkers provide a great deal of labor to our state yet remain an underserved population. In their article on this topic, Lambar and Thomas describe the various types of farm work immigrants perform and the health risks they may encounter because of their occupation [30]. The authors further detail that, despite potential funding sources, farmworkers are yet another newcomer group that struggles to access appropriate care. Opportunities to reach this population—whether through use of health science students to engage with and care for them, expansion of transportation support, or expanded insurance coverage—could work to bridge some of these gaps [30].

For both refugees and immigrants, integration into a new society can prove challenging. Acculturative stress is a major issue for newcomers, as is providing proper care for their families and children. Although refugees—by definition of their past ordeals—remain at high risk for developing mental health conditions such as post-traumatic stress disorder and mood and anxiety disorders, immigrants may benefit from what has previously been termed "the healthy migrant effect," which posits that those with good mental health may be more likely to navigate the highly bureaucratic process of immigration to the United States [31]. That said, the health of migrants to the United States is known to deteriorate over time [32] and the data behind any such supposed benefit remains weak [33]. Furthermore, US-born children of first-generation immigrants have rates of mental health conditions comparable to the general population

[25]. Still, the difficulties posed by potential past trauma, loss, and resettlement can still challenge the resilience of immigrants, and should remain a priority for those providing care to newcomers.

Along with integration, Sharon Morrison of the University of North Carolina at Greensboro discusses the difficulties that may arise for newcomers when their experiences of illness and disease states differ from those of their clinicians [34]. Traditionally based explanatory models—beliefs and attributes patients may have about the etiology of their illness—have the potential to drive a wedge between patient and clinician whenever these models differ from those of Western-trained medical practitioners. In her article, Morrison details an example of how using paraprofessionals from similar backgrounds of patients can lead to better health outcomes while bridging this potential cultural divide. By adopting the term "provider-community" partnerships, rather than the traditional provider-dominant patient relationship, she highlights the degree to which an individual's cultural background influences his or her worldview [34].

Building relationships for outreach among newcomer populations remains a theme as Namak and Kirk detail in their piece highlighting some of the other issues faced by mothers and children arriving in this country [35]. Arab Muslim women, who make up a growing population in portions of our state, face many of the same issues discussed thus far, such as differences in language, culture, and health from what most Western clinicians are used to. Yet, as new or soon-to-be new mothers, these women also face challenges obtaining maternal health care, often stemming from disparities in social status and cultural misunderstandings of health care providers [35]. Other reports have documented health disparities among minority women and mothers, especially African-American women [36, 37]. Without ongoing support, Arab Muslim mothers may increasingly face similar difficulties, plus the dual dangers of isolation and fear.

Finally, we look at one specific case of a clinic working to benefit some of these newcomers, and how the clinicians who work there have overcome some of these specific challenges. Through a focus on intercultural competency, the Durham clinic El Futuro works to provide mental health services to Spanish-speaking patients, many of whom are immigrants [38]. Because such an innate stigma often exists in many individuals' home countries against seeking care for mental health conditions, the clinicians at El Futuro work through community-based settings to help patients gain functional ability and make clinical improvements [38].

Many of us became involved in the work of caring for newcomer populations before political changes brought the health and well-being of refugees and immigrants to society's forefront. We plan to continue treating these patients even if the topic becomes eclipsed by some other ongoing crisis. The difficulties posed by increasing migration worldwide will not be ending any time soon. Ongoing warfare, environmental changes wrought by a warming climate, and political concerns over newcomers entering our country will continue to make this an important and timely topic to address. Health care clinicians can provide a level of security and trust for immigrant and refugee patients that is otherwise lacking in today's political climate, and—as demonstrated by the NCPS Committee on Immigration—have the opportunity, if not obligation, to engage in immigration policy [23]. We in the field of health care must be willing to meet these challenges, and the articles contained in this month's journal provide several ways to do just that. NCMJ

Jeffrey Walden, MD director, Cone Health Family Medicine Refugee Clinic, Greensboro, North Carolina; assistant professor of family medicine, Department of Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
Holly Sienkiewicz, DrPH director, University of North Carolina at Greensboro Center for New North Carolinians, Greensboro, North Carolina; board member, Association of Refugee and Immigrant Service Professionals, Greensboro, North Carolina.

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