Asylee Access to Refugee Health Screenings: Refugee Health Screenings Should Be Urgently Granted to Asylees in Washington State

Sefanit Ghezahegn

A thesis
submitted in partial fulfillment of the
requirements for the degree of

Master of Public Health

University of Washington
2016

Committee Members:

Deepa Rao
Aaron Katz

Program Authorized to Offer Degree:

Public Health

University of Washington

Abstract

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Sefanit Ghezahegn

Chair of the Supervisory Committee:
Professor Deepa Roa
Department of Global Health

This research is a policy analysis assessing the importance of health screenings for newly granted asylees in Washington State as both a tool for surveillance and a form of preventative care. This paper will go further and make preliminary recommendations that health screenings be granted to asylees as soon as they make a claim for asylum.

This paper will begin by giving an overview of U.S. asylum policy. It will then outline asylee eligibility for medical assistance. Later, it will describe the refugee health screening. This paper will also include a summary of stakeholder opinions surrounding refugee health screening, its purpose, and their perception of its importance. It will then provide examples of past and present interventions that addressed issues around asylee access to health screenings. Finally, I will make recommendations and discuss how these recommendations may play out today, as well as ways we may learn from the past.

Table of Contents

Table of Figures

Table of Tables

Introduction

The Institute for Economics and Global Peace (IEP) Index reports that the number of wars worldwide has been declining over the years (UEP). Despite this, the world has become less and less peaceful (IEP). Since 2008, 111 countries have had deteriorating levels of peace, this is mainly due to the rise of internal conflicts, the increase in terrorist activity, government instability, and ongoing global tensions (IEP). In the last two decades alone, there have been more than thirty-five civil wars, and an unprecedented amount of ethnic cleansing, and terrorization of populations (IEP). As a result, there has been an increase in the number of refugees, asylum-seekers, and internally displaced people globally (IEP). The United Nations High Commissioner for Refugees reports that there are approximately fifty-two million people classified as refugees, asylum seekers, and internally displaced people (UNHCR). Of the fifty-two million: one million of them are asylum seekers (UNHCR). However, this number is widely underreported, and not representative of all asylum seekers because it only includes those who have formally submitted an application for asylum (UNHCR).

> *Asylee: "legally defined as a person who flees his or her country and is unable or unwilling to return due to persecution or a well-founded fear of persecution. The persecution may be on the basis of race, religion, nationality, political opinion, or membership in a social group (CLIN)." – U.N. 1951 Convention & 1967 Protocols. This definition is in U.S. Immigration law in the Refugee Act of 1980.*

In the U.S. alone, there were 203,299 asylum applications between 2010 and 2014 *(See Figure 2)* (DOJ). In the U.S. there are two types of asylum seekers: affirmative, and defensive. An affirmative asylum-seeker is an individual who enters the United States and files for asylum without ever being detained, or without having contact with Immigration and Customs Enforcement (ICE). Affirmative asylum seekers file their application with United States Citizenship and Immigration Services (USCIS). Defensive asylum seekers, on the other hand, are

those who have already encountered immigration enforcement and are in removal proceedings, and therefore must apply for asylum before an immigration judge. As a result of U.S. deterrence policy, many defensive asylum seekers are detained while their cases are determined. Those who are caught crossing the border without inspection are subject to mandatory detention pending their credible fear interview. Credible fear is a screening process for those in expedited removal according to the Illegal Immigration Reform & Responsibility Act of 1996 which was created to authorize Department Homeland Security (DHS) and to perform rapid deportations of individuals who entered the U.S. without inspection (Binkin). There is no limit to the amount of time an individual can be in detention. Some asylum applicants are in detention for several months, and sometimes years (Wasem).

In both affirmative and defensive cases, asylum seekers must apply within a year of their arrival to the U.S. (Fragomen). On average, it can take over a year, and in many cases much longer, to receive a decision on an asylum case (Fragomen). *Figure 1* shows the annual flow of affirmative and defensive asylees between 1990 and 2013. In 2013 alone, there were 25,199 individuals granted asylum (DOJ). The Department of Justice provides a snapshot of affirmative asylees granted stratified by state. In 2013, 185 affirmative asylum application were granted in Washington State (DOJ). In 2014, 201 asylees were granted defensive asylum (DOJ).

Health of Asylees

A large percentage of asylum seekers flee their home country after having experienced a number of human rights abuses. Including, but not limited to torture, imprisonment, and threats against their life and safety (Silove). Because of this, asylum seekers are leaving their countries with high rates of trauma-related mental health conditions such as depression, anxiety, and post-

traumatic stress disorder (PTSD) (Silove). Additionally, many asylees are coming from countries with already high rates of morbidity (Silove). Stressors that occur in the process of leaving and migrating to seek refuge exacerbate these conditions (Silove). Often, people risk their safety to escape their homes, some crossing dangerous borders, and others traveling by sea (Silove). In most cases, people are deprived of their basic needs and are not even sure if they will make it to safety (Silove). Also, untreated medical and mental illnesses have resulted in the exacerbation of already existing traumas (Silove).

In addition to the stress of migrating, and for some, being detained, asylum seekers have the burden of solely being responsible for proving and claiming legal status (Silove). An asylum seeker has the sole burden of showing persecution, or a "well-founded fear" of persecution. The persecution would need to be on account of race, religion, nationality, membership in a particular social group, or their political opinion (Wasem). Proving a well-founded fear is an overwhelming task. Especially when language is taken into account; as well as the fact that the majority of asylum seekers do not have the knowledge or understanding of the law specifically related to the immigration procedures in this country (Silove). Also, most lack adequate documentation that proves their persecution. This becomes daunting, and many do not have the support to navigate those systems, especially because they do not have the right to an attorney. This process, and the uncertainties that come with it, only elevate the stress and anxiety that asylum seekers experience, resulting in "re-traumatization" (Silove). This is compounded by fears of forced repatriation (Silove). Due to the overwhelming burden asylum seekers face, mental health and overall wellness are overlooked (Correa-Velez). Not only do people not have access to care because the law prevents it, but they also are not aware of what services they are eligible for once granted asylum.

The overall health of asylum seekers and asylees is unknown because unlike refugees, in most cases, asylees do not receive a health screening in their home countries, nor do they receive one upon entry. Asylees are left vulnerable without access to health care or public benefits. They are ineligible for all state and federal benefits until granted asylum (CLIN). Additionally, they are not granted employment authorization until six months after they have applied, meaning that even if they wanted to access any care, they might not be able to afford it (CLIN).

However, once asylum seekers are granted legal status in the U.S., they are afforded almost all the same rights and benefits as refugees for up to 8 months beginning on the date that asylum is granted (CLIN). In Washington State in particular, they are now eligible to receive the free Refugee Health Screening provided by the Washington State Department of Health (CLIN). In King County, screenings are conducted by Public Health Seattle & King County. The refugee health screening, offered through the Office of Refugee Resettlement, is a service granted to newly arriving refugees that is used to identify both communicable and non-communicable medical issues that may have public health or resettlement implications (CLIN). Also, health screenings are used to refer refugees to primary care providers. Refugees receive this service within 90 days of their arrival to the U.S. (CLIN).

Asylees, on the other hand, are not eligible for this service until after granted status. This means that asylees have to wait anywhere from two to four years before they receive any medical attention (Kalt). Even while they are eligible for a health screening after being granted asylum, many are not accessing these services. According to the Washington State Department of Health, only a small percentage of asylees have received the refugee health screening to date. Through interviews with key stakeholders in King County, this study hopes to assess why asylees do not access this service. Additionally, it will assess why seeking a health screening may have

important implications for both public health and resettlement. Moreover, it will look at why this service may be beneficial to asylum seekers while they wait for the decision on their case.

Overview of Health Screening Requirements

There are two health screening requirements for immigrants: 1) an overseas screening and 2) a domestic screening (CDC). Health screening requirements vary depending on how an individual entered the U.S. Asylees come to the U.S. through two ways: they either arrive on a visa, or they enter without inspection (Schoenholtz). If an asylee first entered on a visa, they are required to have overseas medical screenings, conducted by a panel physician, a physician trained, and appointed by local U.S. embassies or consulates (Kennedy). This screening is a requirement for admission to the U.S. by immigrant visa applicants and refugees (CDC). The Division of Global Migration and Quarantine (DGMR), which is part of the CDC, developed these medical screening guidelines (CDC). The purpose of the screening is to identify visa applicants with medical conditions that pose a significant danger to public health. Figure 3 shows CDC screening guidelines (CDC). In general, the overseas screening is used to exclude individuals who have communicable diseases of public health significance (Helton). These conditions are classified into two categories: Class A conditions and Class B conditions (see Table 1) (CDC). The completeness of these screenings varies from country to country, and even within countries depending on the availability, and quality of health care (CDC).

The second type of screening is a domestic screening (Helsinki Watch Organization). The Federal Refugee Act of 1980 entitles all newly arriving refugees and newly granted asylees to a health screening to be initiated as soon as possible following arrival (or in the case of asylees, soon after they are granted asylum) (Helton). The screening, established by the CDC, is used to

identify medical conditions that might affect public health or an individual's ability to resettle successfully (CDC). This screening includes both a medical history and a physical examination (CDC). Unlike the overseas screening, the domestic health screening includes the screening of infectious diseases, as well as non-communicable chronic conditions, and at a surface level, mental health. The goal of the domestic screening is to:

1. Ensure follow up with any conditions identified during the overseas screening.
2. Evaluate the current health status of an individual and identify any health problems that were not identified during the overseas screening, or that may have developed afterward.
3. Ensure refugees are referred for follow up with primary care.
4. Provide an introduction to the U.S. health-care system.

The screening, for refugees, is conducted within 90 days of their arrival (CDC). Asylees are only able to access the screening within 90 days after being granted asylum (CDC). Civil surgeons, physicians designated by USCIS and authorized to perform medical exams, conduct screenings. These screening are designed to occur as soon as possible after arrival to the U.S. (Kellermann).

It is also important to note that there is a third group who is eligible for a domestic screening: detainees, those held in detention centers by Immigration and Customs Enforcement (ICE). Although not identical to the refugee health screening, those detained by ICE are required by law to receive a health screening by a medical professional within 12 hours of being detained (Arenilla). The screening includes a medical history and a physical exam in accordance with the Detainee Basics Medical Care Act of 2008 (Arenilla). Although regulations and guidelines

require screening, the quality of the screening is unknown because there aren't studies that have looked at this population in Washington State.

Health Screening Utilization

The 2014 Refugee Health Screening Report created by the Washington State Refugee Health Program reported that in 2014, out of 2,899 individuals screened, only 1% of those that accessed the Refugee Health Screening were asylees (DOH). Only twenty-nine asylees accessed the refugee health screening. Twenty-nine is an underwhelming number compared to the number of asylees in the state (DOH). Next, I aim to assess why asylees are not accessing this service through interviews with key stakeholders in King County. I will assess why seeking a health screening may have important implications for both public health and resettlement. Additionally, I examine at why this service may be beneficial to asylum seekers while they wait for the final determination on their case.

General Objectives

This study assesses the importance of refugee health screenings for newly granted asylees in Washington State. There is limited research about the impact or importance of refugee health screening and even less research on its importance for asylees. This information may be important for health care providers, legal advocates, and others working with asylee populations. Finally, this study will provide preliminary recommendations for policy makers.

Specific Aims

1. To assess the barriers asylees face in accessing the refugee health screening.
2. To assess the importance of the refugee health screening from both a health and legal perspective.
3. To provide an overview of policy issues that need to be addressed regarding asylee eligibility to the refugee health screening.

Methodology

This study examines the overall importance of the Refugee Health Screening for asylees and makes recommendations to policy makers. A literature review assesses the body of knowledge about the refugee health screening, as well as asylee eligibility for resettlement assistance. Qualitative interviews with key informants that provide the perceptions professionals have about the refugee health screening.

Literature Review

This paper provides a summary of themes found in peer-reviewed journals from the University of Washington's online library system, data from the Department of Justice Yearly Statistics Report, and policies from the Department of Human and Social Services. The purpose of the initial literature review is to gather information on current policies surrounding asylees, their health, and their eligibility for benefits. The following subject headings were entered in EBSCO Host, SCOPOS, and the Web during my search: "U.S. immigration policy," "refugee health screening," "U.S. medical screening," and "asylee health in the U.S."

Key Informant Interviews

Initially, sixteen individuals were recruited for this study who are stakeholders in the State of Washington concerning the refugee health screening as well as the health, well-being, and rights of asylees. Ultimately, six individuals were interviewed. Those who did not participate did not feel equipped or knowledgeable about the specifics of the health screening to participate. The interviews occurred over an eight-week period from January 2016 to February 2016. Through my interviews, I hoped to discover how stakeholders viewed the refugee health screening and its importance for asylees. Table 2 provides the list of interview questions asked.

Recruitment

This study used non-probability, purposeful sampling (specifically, expert sampling) in the recruiting process to identify key informants. The information needed for this study is specific and thus, does not require a random sample, nor does it require a representative sample (Bernard). In addition, snowball sampling was also used if the selected informants provided information about other individuals who provided valuable information for the study. Each informant was notified about the purpose of the study, what would be asked of them, as well as what the use of the study would be. The study is approved by the International Review Board and is considered to be exempt. All informants were ensured confidentially, and consent was received before conducting all interviews. Interviews were conducted in person, and all responses were hand-written on questionnaires that were not labeled with any identifiable information. All data was analyzed after each interview, and direct quotes were selected from each informant's interview to be included in this paper.

Results

From January 2016 to February 2016, I interviewed six key informants residing, and working in Washington State on the topic of the refugee health screening, its importance, who receives it, and barriers to access that asylees face. The professions of those interviewed ranged from lawyers, doctors, public health professionals, and social workers. All informants work directly with asylum seekers. The names of the informants will stay confidential, even though the information gathered is not sensitive information. Responses from the six informants reveal general agreement on the four questions asked. All of the informants agreed that the screening had two main purposes: surveillance and referral. Although some differed on their perception of which was more important, the majority agreed that the screening was something that every asylee should receive. Below are direct quotes from the key informant interviews.

Question #1: Why is the refugee health screening important for asylees?

The informants agreed that the screening was important primarily for two reasons: detection/surveillance and as a tool for referral.

> One participant stated, "The importance of the refugee health screening is to connect them to the health system and refer them to services. In addition, it helps them start thinking about primary care and preventative medicine. The Refugee Health Screening is an opportunity for asylees to receive a health screening exam that is focused on a range of health conditions. This includes screening for infectious conditions but also nutrition, emotional wellness, and immunization assessments. This appointment is with a clinic that is familiar with refugee populations and some of the conditions, which may be less commonly considered

> in a general primary care environment. The screening appointment is also another opportunity for connection to health insurance and primary care if the client does not already have these established. Immunization assessment is another very important component of the exam for individual health and public health because the U.S. schedule for immunizations is specific to the U.S. and some vaccines are not available overseas. Often immunizations are needed at this visit."

Question #2: Do asylees receive any type of health screening upon arriving to the U.S.?

The majority of informants had a general understanding that those who entered on a visa may have had some sort of screening abroad and that those detained may also receive some sort of screening. However, there wasn't a consensus on the quality of the screenings.

> "There isn't a uniform screening where you could say that every single asylee has had this screening. It depends on the way the person entered the country and claimed asylum. If ICE detained a person, they would have received a medical exam per this standard. If they entered on a different visa, and then claimed asylum they may have had some health screening, depending on the visa type. If medical evaluation were part of their asylum application (e.g., survivors of torture) this wouldn't be a screening exam, but rather legal documentation to support their application."

Question #3: What are the issues limiting asylees from accessing the refugee health screening? What are the biggest barriers to informing asylees about the refugee health screening?

The majority agreed that there were many reasons why asylees may not be accessing the screening. Informants addressed the following barriers: knowledge of the screening, perception of its importance, and lack of support.

> "I do wonder if clients have a perception that maybe they don't need another exam or understand how the health screening might be helpful. An asylee has been in the U.S. at the time asylum is granted and likely has existing obligations. They also don't have access to the same types of support systems to help ensure health screening happens, such as a case manager to make appointments and who is working through a checklist of areas that should be addressed within set timelines."

> "From my perspective, the biggest barrier we have at the state level is not having a systematic way to know that a person has been granted asylum and is a Washington State resident. Health screening is supposed to happen within 90 days of when someone arrives/is granted asylum. If the state received prompt notification that someone was granted asylum and their contact information, we could help facilitate getting people into screening via a call or letter and information. With the current system, we have to rely on the clients hearing about the health screening, and contacting the clinic for an appointment themselves. Having a case manager who knows all the systems is a huge asset. I could see from a busy client perspective that going to the health department may seem duplicative if you have a primary care doctor and know you'll have to see a civil surgeon regardless."

Question #4: Do you think the refugee health screening would make more of an impact and reach more people if the screening was granted to asylees as soon as they file for asylum?

After completing each interview, I concluded that the majority of informants believed that asylees may have the perception that a screening after being in the U.S. for years isn't a priority, especially because asylees are required to get a medical exam before they adjust their status to that of a Legal Permanent Resident. So I went further and asked the informants one final question. . The majority agreed that theoretically, yes, it may be beneficial, and may make more of an impact if the refugee health screening was provided to asylees as soon as they apply for asylum. They agreed that screenings are an important first step for every asylee, but the majority did not know how it would be implemented and were worried that it may not have a significant impact since asylum seekers are not eligible for services.

> "With the system structured as it currently is, I don't know how practical this would be since it would have to be paid for by the client and I would hate to add any barriers to a process that already sounds very extensive. It would take legislative change to enable funding to include individuals who had not had their claim of asylum verified. The other factor is that while they are applying for asylum, clients aren't Medicaid eligible. Treatment of any conditions identified and referral to primary care for follow-ups for someone without insurance would be challenging even if screening was able to be funded."

Policy Problems and Possible Next Steps

After a brief literature review and key informant interviews, I identified two major policy issues, which I will discuss in the following section.

Policy Issue #1: A large percentage of asylees do not receive health screenings upon arrival to the U.S., ultimately placing their own health, and the health of their communities at risk.

According to a study conducted by Schoenholtz et al., before 1998, the majority of asylum seekers were those who had entered without inspection (Schenholtz). The data analyzed was drawn from the Department of Homeland Security's Refugees, Asylum, and Parole System (RAPS) system, which provided information about 552,760 asylum applications filed between 1996 and 2009 (Schoenholtz).

According to the study, after 1998, two-thirds of asylum seekers had entered on a visa but had then overstayed either before declaring asylum or while awaiting their decision *(see figure 4)* (Schoenholtz). By 2008, 70% of asylum applicants had entered with inspection *(see figure 4)* (Schoenholtz). Although the number of asylees entering with inspection is increasing, 30% is a significant number from a public health perspective because it means that 30% of applicants entered without a health screening (Schoenholtz).

As stated earlier in the introduction, there is a gap in knowledge concerning asylees and asylum seekers. There is an even greater gap for the asylees and asylum seekers who entered the country without inspection (Schoenholtz). Asylum seekers usually come to the United States from countries with few or poor health care services. Without realizing it, individuals entering the country could potentially enter with illnesses that may have public health implications. Moreover, these illnesses, if left untreated, could turn into severe medical conditions (Kalt). Because of their status, asylum seekers, specifically those not inspected, will have waited several years before receiving any health screening unless they suddenly fall ill and have to resort to emergency care. Furthermore, asylum seekers who experienced severe trauma, and in many

cases torture, in their home countries may have developed serious medical problems while in detention, and during the asylum process (Kalt).

Although by definition refugees and asylees differ, they are ultimately coming from very similar country conditions. The refugee health screening is intended to screen for infectious diseases, as well as chronic conditions and overall well-being. If asylees are coming from the same conditions, it could make sense to also screen asylees, both as a way to protect individuals, as well as maintain public health. The CDC recommends that medical screening is conducted as soon as possible (CDC).

Federal and state policy for immigrant access, including The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), restricted access to Temporary Assistance for Needy Families (TANF), Medicaid, and Supplemental Nutrition Assistance Program (SNAP) for many documented and undocumented immigrants (CLIN)). PRWORA restricted eligibility based on two categories: qualified and non-qualified. Asylum seekers are non-qualified (CLIN).

> *Qualified aliens eligible to receive assistance: lawfully present immigrants defined in federal law as individuals who have been granted asylum under INA $208 (CLIN).*
>
> *Non-qualified aliens eligible to receive assistance: Persons Residing under Color of Law (PRUCOL) are immigrants legally residing in the U.S., but do not yet have official status as a qualified alien (CLIN).*

Those with pending asylum applications are considered unqualified (CLIN). The only form of medical relief offered is Emergency Medical care (CLIN). As a result of these restrictions, asylees, in most cases, will not seek care until they fall extremely ill. This is due to a

lack of understanding of the U.S. healthcare system, and fear of being denied care due to their status. Created in 1986, under the Emergency Medical Treatment & Acute Labor Act (EMTALA), patients cannot be denied emergency medical treatment on account of their immigration status or their ability to pay (Yew). The EMTALA is a safety net for those who are uninsured. Although EMTALA is significant, it limits asylees to only receiving treatment when they are in dire need (Zahradnik). The only non-qualified immigrants eligible for federally funded care are pregnant women, and children, both who qualify for federally funded Medicare (WAC). For everyone else who falls ill, they are forced to pay out of pocket. This is an impossible task for someone who has just fled persecution, and in most cases, has no source of income. This is especially true because asylees are not eligible to work until 180 days after they have filed their application for asylum (CLIN).

Possible first steps towards addressing issues around surveillance and its importance for public health: Recognition within the asylum process that refugee Health screenings are a form of surveillance and a way to protect public health.

Policy Issue #2: As a result of being ineligible for federal or state funded medical care, many asylees wait until they are extremely ill before seeking care. Many asylees are not aware that they have other medical care options.

One of the hesitations many of those interviewed held was that health screenings may not be useful for asylum seekers since one of its main purposes of the screening is using it as a tool for referral. Some even said that because asylum seekers aren't eligible for Medicaid, there would be an ethical challenge of screening without treating and referring. What I believe is being overlooked is the availability of alternative forms of care, namely, community health clinics.

Through the work of community health clinics, undocumented immigrants, including asylum-seekers, receive treatment for common illness, and routine physical exams (Kalt).

Community Health Centers

The role that community health clinics play is underappreciated and overlooked. Community health clinics were launched in 1965 by the Office of Economic Opportunity as part of President Lyndon Johnson's "War on Poverty" (Adashi). Community health clinics were designed to reduce health disparities that affected underserved populations, namely minorities, the poor, immigrants, and those who are uninsured (Adashi).

Community health clinics operate in more than 8000 sites, both urban and rural, in every state in the country *(see figure 5)* (Adashi). These centers serve over 20 million Americans. Community health clinics are federally funded under the authority of the Public Health Service Act and administered by the U.S. Health Resources and Services Administration (Adashi). Community health clinics deliver medical, dental, behavioral, and social services to underserved communities (Adashi).

In Washington State, the Washington Association of Community & Migrant Health Centers (WACMHC) is made up of 26 community health centers that provide services to those in urban and rural parts of Washington (Portes). Formed in 1985, WACMHC advocates on behalf of low-income, uninsured, and underserved communities (Portes).

In 2010, the Affordable Care Act allocated $11 billion for the expansion of the CHCs for five years; beginning in 2011 (Adashi). Community health clinics can deliver affordable, comprehensive care in facilities accessible to the patients who need it (Adashi).

The availability of the CHC's for asylum seekers could be crucial, and the presence of a free primary care clinic could reduce hospital costs associated with non-urgent ED use (Portes). The Center for Immigration Studies estimated the cost of treating uninsured, undocumented immigrants in emergency rooms to be $4.3 billion a year. The utilization of community health clinics is beneficial at an individual, public health, and socio-economic level (Rust). Although there are few studies that have assessed the overall impact of the provision of free primary care within a community, access to the services will only be beneficial to asylees who do not have any other option outside of emergency care (Davidson) (Kalt) (Kennedy) (Portes) (WAC).

Possible first steps towards addressing issues around the need for health screenings as a tool for prevention and referral: Strengthen access to screening as a way to refer and connect asylees to Community Health Clinics so that emergency medical care is not their only option.

Current and Past Interventions

There are two examples of organizations seeking to meet the needs of asylees. The Pennsylvania Asylee Outreach Project (AOP) created a successful program and served as case management and reached many asylees. AOP created an intensive case management program that intended to provide outreach to newly granted asylees and connect them to social services, legal services, referrals to primary care, employment assistance, and access to other essential needs.

In Washington State, International Counseling & Community Services (ICCS) has created a new asylee assistance program that hopes to do similar work. Started in November 2015, ICCS hopes to reach many asylees and get them connected to services, including getting

them signed up for the refugee health screening. Although these interventions are and have been doing very necessary work, they still do not address the issues presented in this paper. These interventions address the concerns presented by the key informants. However, the interventions necessary to address the issues presented in this paper require more than just case management and referral. The refugee health screening would first have to be granted to asylum seekers as soon as they make a claim for asylum so that they aren't waiting years before receiving any type of care.

Discussion

The overall well-being of asylum seekers could be addressed if they had access to the refugee health screening. However, the expansion of the refugee health screening will have some short-term costs. Most importantly, Washington State would have to be willing to increase funding to the Washington State Department of Health and The Department of Social and Health Services (DSHS), for these services. Additionally, the current political atmosphere and xenophobic rhetoric may have an impact on legislative changes that would need to be made for the screening to be granted to asylum seekers (Curran).

Potential Biases, Limitations, and Strengths of This Study

This study is limited primarily because it is a qualitative study that focuses mainly on a single policy issue. This study will provide important information on the relative importance of health screenings for newly granted asylees. While the health issues are similar among asylees across the United States, Washington State's asylee policy may differ from that of other states.

Moreover, the context of this study only tells a single story, meaning that the information collected will not be transferable to other settings. In addition, this study will be limited by both the short amount of time spent conducting research, and by the potential bias among those interviewed. The key informants that were interviewed were stakeholders who all bring in their biases. Additionally, there may be researcher bias as a result of the data selected for analysis during the study. My biases and ideology about asylees and the importance of health screenings may have an impact on the range and type of information gathered, as well as the kind of questions asked of informants. By collecting a broad selection of data and from multiple primary and secondary sources, I hope to avoid some of these biases.

The literature review presented in this paper has several limitations. The main limitation being that the literature review is not comprehensive due to the lack of data and research on the asylee population made it difficult to make generalizations. Moreover, the majority of the literature was qualitative in nature & therefore lacked substantial statistical power. Additionally, there wasn't any data specific to asylees in Washington State, nor were there studies which focused on health screening for asylees.

Regardless, this study does provide relevant information, and recommendations, regarding asylee eligibility for health screenings, and the impact it may have on the health and well-being of asylees, and asylum seekers. There is a gap in this area of research, and this paper does begin to address these issues by providing the perspective of key informants who have first-hand experience working with the asylee population.

Conclusion

Asylum seekers access to the refugee health screening may be an important first step to ensuring individuals have access to medical care soon after they file for asylum. Although this may have short-term costs for the state, the long-term benefits would have an impact on many lives. Health screenings could prove to have a significant impact on both individual health, and public health, if used as a form of surveillance and a tool for referring asylum seekers to community health clinics.

Moreover, it is evident from the research conducted in this paper that the overall health of asylum seekers is not well known and that more research is needed. Those in the field of public health must find an ethical way of doing research without compromising the safety and the status of asylum seekers.

Figures

Figure 1. Annual Flow of Affirmative and Defensive Asylees: 1990 to 2013

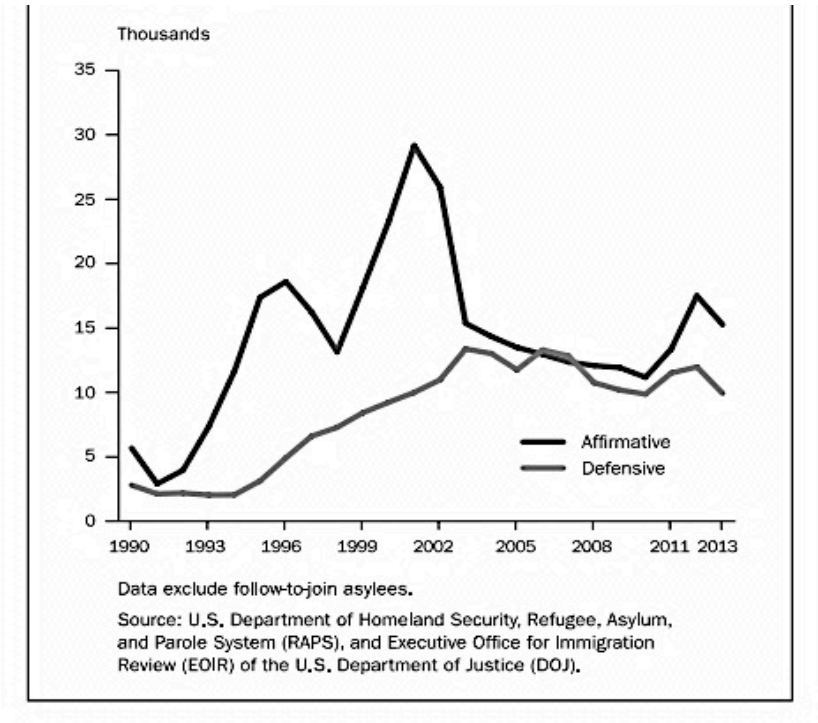


Figure 2. All Asylees by Country of Nationality: Fiscal Years 2011 to 2013.

Country of nationality	2013		2012		2011	
	Number	Percent	Number	Percent	Number	Percent
Total	25,199	100.0	29,367	100.0	24,904	100.0
China, People's Republic	8,604	34.1	10,121	34.5	8,592	34.5
Egypt	3,407	13.5	2,876	9.8	1,027	4.1
Ethiopia	893	3.5	1,121	3.8	1,071	4.3
Nepal	854	3.4	975	3.3	740	3.0
Syria	811	3.2	364	1.2	60	0.2
Venezuela	687	2.7	1,090	3.7	1,104	4.4
Iran	675	2.7	716	2.4	474	1.9
Russia	534	2.1	718	2.4	661	2.7
Haiti	496	2.0	681	2.3	872	3.5
Iraq	462	1.8	425	1.4	379	1.5
All other countries, including unknown	7,776	30.9	10,280	35.0	9,924	39.8

Note: Data exclude follow-to-join asylees.

Source: U.S. Department of Homeland Security, Refugee, Asylum, and Parole System (RAPS) and Executive Office for Immigration Review (EOIR) of the U.S. Department of Justice (DOJ).

Figure 3. 2014 Refugee Health Screening Report

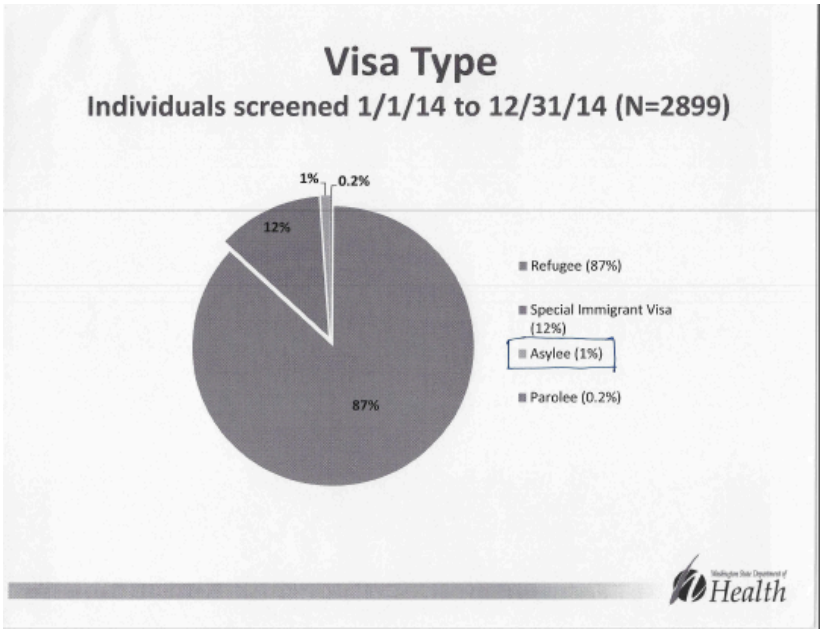


Figure 4. Percentage of Applicants Who Were Inspected (that is, entered the U.S. lawfully)

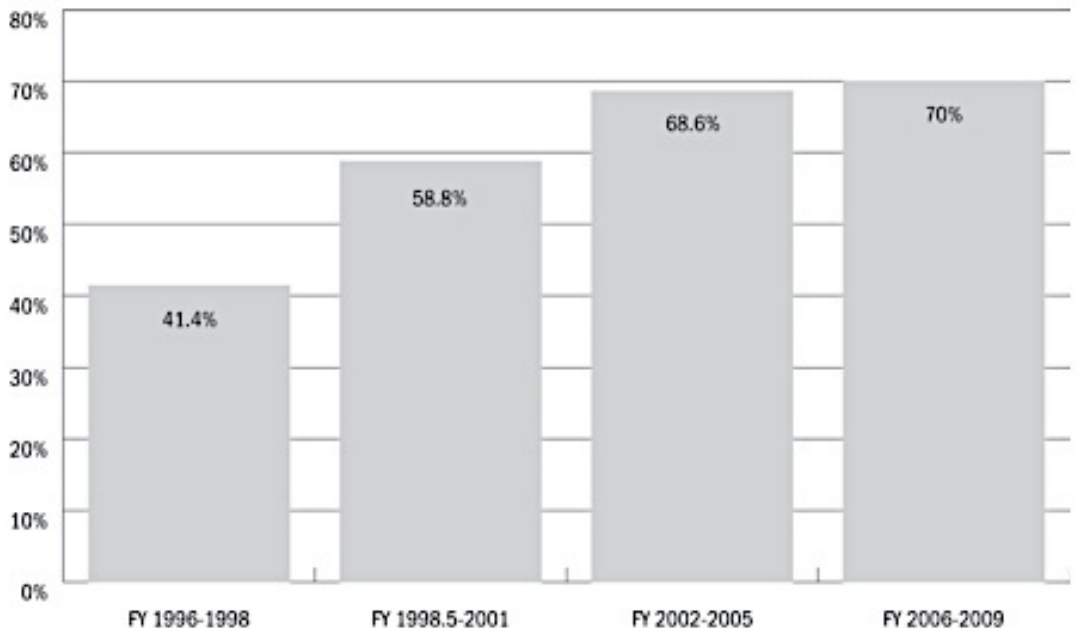


Figure 5. Nationwide Distribution of Community Health Center Sites, 2008.

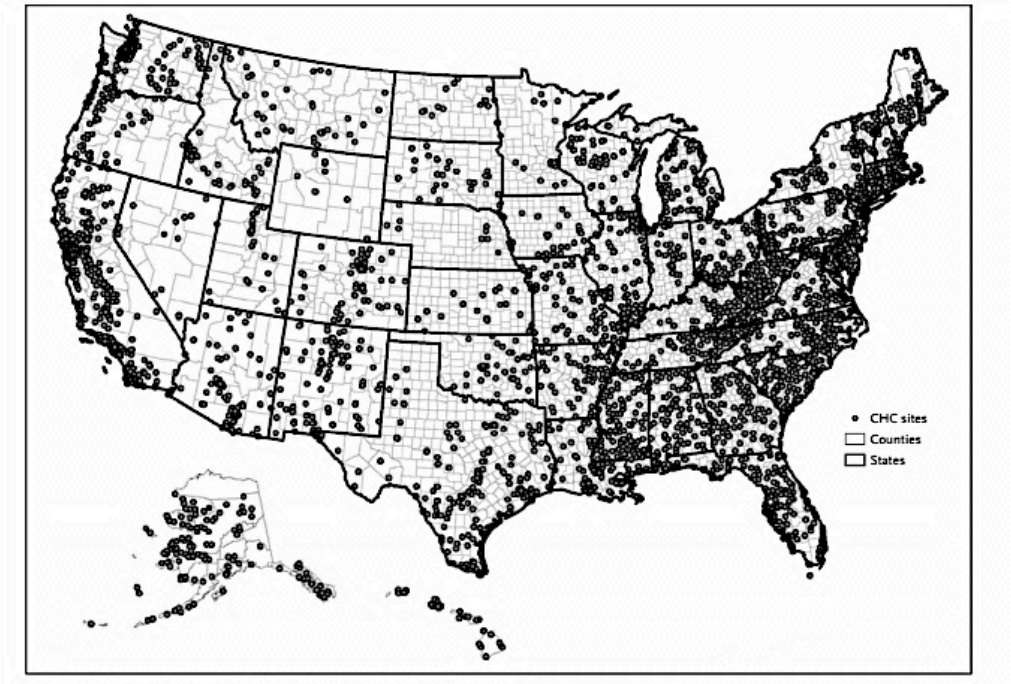
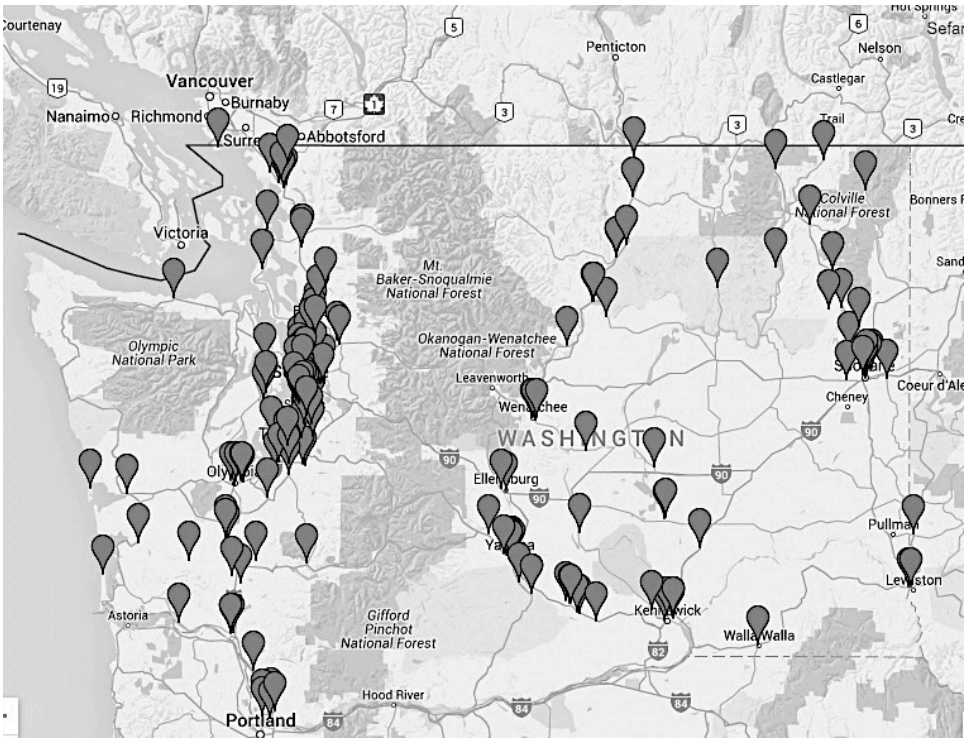


Figure 6. The Washington Association of Community & Migrant Health Centers.



Tables

Table 1. Communicable Diseases of Public Health Significance.

Class A	Class B
Chancroid Gonorrhea Granuloma Inguinate Lymphogranuloma Venerum Syphilis TB HIV Drug Addiction Hansen's Disease Mental Illness	TB (non-infectious) Hansen's Disease (not infectious)

Table 2. Informant Interview Questions.

Informant Interview Questions

1. Why is the refugee health screening important for asylees?
2. Do asylees receive any type of health screening upon arriving to the U.S.?
3. What are the issues limiting asylees from accessing the refugee health screening? What are the biggest barriers to informing asylees about the refugee health screening?
4. Do you think the refugee health screening would make more of an impact if the screening was provided to asylees as soon as they file for asylum?

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