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ORIGINAL PAPER

Socio-Medical Challenges of Asylum Seekers Prior and After Coming to the US

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Abstract Refugee asylum seekers face complex social and medical challenges. We evaluated 30 consecutive asylees in New York for socio-demographic and health backgrounds, characteristics of torture, presentations and medico legal path. Results: Majority was male, young, educated from sub-Saharan Africa. In home countries, all had employment; 58 % had fair or good access to healthcare; 36 % used traditional medicine; and 14 % had insurance. In the US, social support and accommodations were provided by countrymen; overwhelmingly they were unemployed; none had insurance; and 57 % never had any contact with healthcare system. Sixty nine percent had PTSD and 69 % depression. Almost all had scars with significant sequelae. Eighty eight percent were granted asylum. Ironically, asylees had better access to social and health services in home countries than the US. We recommend better recognition of, and addressing asylees' social and health needs through a multidisciplinary approach drawing on other countries' experience, and expanding existent programs for refugees to cover asylees.

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Introduction

Asylum seekers are individuals who apply for protection in another country before their asylum application has been granted by the host country. In the US, asylum status is available to those who: (1) meet the definition of refugee (2) are already in the US and (3) are seeking admission at a port of entry [1]. Asylum seekers face complex social and medical challenges [2–7] and a majority leave their home countries due to fear of persecution or their experience of torture. United Nation High Commissioner of Refugee (UNHCR) reports that around 837,000 asylum seekers were still waiting a decision on their asylum claim at the end of year 2010 [8]. Whether physical or mental, the consequences of torture and abuse are profound and have been well-documented [9]. Clinical sequelae are both short-term and long-term and include PTSD, major depressive disorder, chronic pain syndromes and functional limitations from blunt trauma and other forms of physical torture [10–15]. Though exact numbers of torture survivors residing in the US are difficult to estimate, a recent survey of foreign-born patients presenting to an urban primary care clinic estimates that the prevalence of torture is as high as 11 % among all comers [16]. Others report much higher rates among select ethnic groups such as Cambodian survivors of the Khmer Rouge [17], Bosnians fleeing the Balkan wars [18], and Somalian refugees [19]. Studies have shown that many obstacles within the medical system lead to suboptimal care for asylees [2–7, 20, 21].

Primary care providers are often the gatekeepers for entry of asylees into the healthcare and the legal system

[22]. Beyond addressing the unique medical and psychiatric needs of these patients, they also have the pivotal role of documenting the physical and mental scars of torture for the purpose of gaining asylum [22, 23]. However, there is a low level of awareness among health care professionals of the significant prevalence of torture among their foreign born patients and the process and skills by which they can assist asylum seekers [24, 25]. Although multiple UN declarations and conventions against torture [26] explicitly call for the training of all health professionals in the evaluation and treatment of torture survivors, only a limited number of the US medical schools, post-graduate programs, and allied health training programs provide such educational opportunities [24, 27, 28].

In general, there is limited data on medical, social, and legal characteristics and needs of asylum seekers in the US [7]. Proper data is needed to design, implement, and evaluate appropriate social and health programs for asylum seekers. Therefore, we conducted a comprehensive assessment of the demographics and sociopolitical background, types of torture, and physical and psychological sequelae of abuse among asylum seekers before entering to the US. We described the path many have taken to reach the US, their socio-demographics status and medico legal path in the US, and the outcome of their asylum application after proper legal representation and medical evaluation. It is our hope that this paper sheds light onto the lives of this marginalized and underserved population and raises awareness among social and medical service providers so to improve future healthcare and social services.

Methods

Study Setting

The Human Rights Clinic (HRC) was established in 2008 and was staffed by an expert faculty preceptor. It applied a multidisciplinary approach working collaboratively with advocacy and legal organizations as well as social service providers. The clinic also provided training opportunities to medical students and residents in how to evaluate and provide care for asylum seekers and torture survivors. Asylees were referred to the HRC via a network of international and national advocacy organizations, grassroots community organizations, as well as independent attorneys and informally by word of mouth. Asylees were provided with full physical and psychological evaluations. Clinician-student pairs wrote medical affidavits for meritorious cases, testified as expert witnesses in immigration court when necessary, and subsequently provided and directed asylees to further social and medical services.

As part of a standard protocol and evaluation, all asylees completed an intake questionnaire and subsequently received a physical and psychological evaluation for their forensic evaluation of asylum application. The evaluation followed a standard protocol defined in the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, also known as the Istanbul Protocol (IP) [29]. The manual applies a standardized approach to the evaluation of asylum seekers for evidence of torture. It summarizes the recommended steps for the interview, exam and affidavit preparation, which includes the allegations of torture, physical symptoms and disability, psychological history, interpretation of evidence, and recommendations ("Appendix"). After consent and before the exam and interview, socio-demographic data was collected. This included data on occupation, living situation, support services, and details of the client's journey from his/her home country to the US, medical insurance in country, and home country health and sociopolitical conditions (see Table 1).

Each asylee was then interviewed and examined in the clinic by an attending physician, who documented the relevant portions of the history and physical exam in the medical record. On average, the interview and exam took

Table 1 Human Rights Clinic intake form

HRC intake form (*all answers are optional*)	
Client #	
Age	Sex:
Country of origin:	Region:
Children:	Occupation:
Primary language:	English:
Education:	Martial status:
Country condition:	
Current status:	
Religion:	
In native country	
Availability of health services:	
Type of services most used:	
Living area:	
Insurance:	
If no regular care:	
Before entering the USA and in USA	
Refugee camp:	# Countries en route:
Financial support en route:	
Transported to the US by:	
Helped and supported in US:	
Living conditions in US:	
Financial support in US:	
Medical care in US:	

3 h and a half. All physical scars were photographed digitally.

Study Design and Outcomes

Data from 30 consecutive asylees who presented to our clinic between September 2008 and October 2011 was included in this study. Information was retrospectively extracted from the de-identified intake questionnaires and subsequent de-identified medical affidavits, which was then coded into an Excel spreadsheet (Microsoft, Redmond WA). We evaluated the socio-demographics and health background of the asylees before and after entering the US, characteristics of torture and abuse, clinical presentations and sequelae of torture, and the medico-legal outcome of asylum applications. When the method of torture was not explicitly included in the IP, effort was made to corroborate the asyless's story with his or her physical exam findings. Additional data was obtained from legal affidavit or client's legal synopsis. Denominators for prevalence estimates varied due to missing data. All statistical analyses were done using SPSS (Version 19, IBM).

Results

Seventy percent of the asylees were male, and 63 % were from sub-Saharan Africa. They came from 18 different countries including Guinea (5), Cameroon (4), Russia (3), El Salvador (2), Republic of Congo (2), Chad (2), and one each from Mauritania, Ghana, Central African Republic, Gambia, Ethiopia, Belarus, Albania, India, Nepal, Guatemala, Colombia and Mexico. Five clients had to travel through and/or live temporarily in other countries (ranging from 1 to 4 countries) before entering the US. Ninety-two percent were below the age of 40 and 40 % had at least a college education. Religions represented were Christianity, Islam, Hinduism, Buddhism, and "no religion". In their home country, 71 % lived in urban areas. Fifty-eight percent reported "fair" or "good to very good" access to healthcare and 36 % used traditional medicine as primary sources of healthcare. High cost of health services and lack of health professionals were cited as main reasons for lack of access to healthcare in home countries. In the US, social supports were provided by relatives, community members, friends and charities, and 43 % lived with a known acquaintance. Fifty-seven percent were unemployed and 29 % had intermittent employment. Fifty-seven percent never had contact with the US healthcare system. Table 2 describes the socio-demographics, healthcare in home country, and support service in the US in more detail.

Except for two asylees who underwent additional abuses and maltreatment in a second country on their way to the US, all other aslyees were primarily abused and tortured in their home countries. Sixty-three percent stated political factors and 43 % cited being a member of a particular social group as the reasons for persecution and torture. Ninety-three percent received blunt trauma as a form of torture and abuse. Significant scars and deformities included scars on head and/or face (69 %), genitalia (10 %), broken bones (6 %), and burn marks (6 %). Two females and two males survived rape. We diagnosed PTSD in 69 % and Depression in 69 % at the time of interview and examination. All diagnoses were made using the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision (DSM IV-TR) diagnostic criteria for Depression and PTSD. Table 3 presents this data.

Our most recent data indicates that 50 % of our total client population and 88 % of all clients with concluded asylum cases were granted asylum, while another 37 % are still awaiting their legal hearing. Table 4 presents outcomes of asylum application process.

Discussion

Although our asylees came from different areas of the world, the majority were young, educated men from urban areas in sub-Saharan Africa, which remains consistent with previous research [30]. Many were successful in their respective businesses and were actively engaged members and leaders in their communities. However, their options for private or public health insurance were limited and seeking care was often cost prohibitive. Ironically, when arriving to the US, they continued to face similar or worse conditions and often the only supports they received were from relatives and home country community members, including both financial support and housing accommodation. In the US our clients had no health insurance and little to no exposure to the health system despite their many physical and psychological sequelae. Furthermore, while many had access to traditional medicine in their home country, which was culturally appropriate, this was not an available option in the US.

Sixty nine percent of our asylum seekers were found to have depression, PTSD, and an overwhelming number of psychological symptoms including avoidance, isolation, difficulty concentrating and feeling sad [12, 30, 31] which would likely interfere with their social functioning and ability to take care of themselves. The high rate of psychiatric morbidity and continuous suffering will have a significant impact on their life and certainly underlines the need to address barriers to proper mental health care [7]. It also highlights the importance of a thorough psychological assessment during the initial evaluation of torture survivors.

Table 2 Socio-demographics and healthcare at home and the US

Demographics			
Gender (% male)	N = 30		70 %
Age (mean years, range)	N = 26		31.2 (19–51)
Under 40 years old	N = 26		92 %
Occupation in home country	N = 21		
Business	48 %	Public relations	5 %
Activist	14 %	Technical skills	5 %
Teacher	10 %	Technology	10 %
Law enforcement	5 %	Interpreter	5 %
Housewife	5 %	Nurse	5 %
Region of origin	N = 30		
Sub-Saharan Africa	63 %	East Europe and Russia	13 %
Central, South America, and Mexico	17 %	Asia	7 %
Marital status (% married)	N = 28		68 %
Has at least one child	N = 28		75 %
Level of education	N = 20		
Undergraduate and >	40 %	High school	30 %
Mean # of languages spoken	2 (1–6)		
Healthcare in home country			
Living area	N = 14		
Urban	71 %	Rural	29 %
Availability of health services	N = 14		
Poor	43 %	Good or very good	29 %
Fair	29 %		
Types of services uses	N = 14		
Clinic/hospital	57 %	Traditional care w/other type	15 %
Physician/nurse	14 %	Traditional care only	21 %
Health promoter	7 %	No services used	7 %
Insurance system	N = 14		
Self-pay	86 %		
Government insurance	14 %		
Reasons for no regular care	N = 9		
Too expensive	78 %	Distance too far	11 %
Lack of medical professionals/facilities	33 %	Not needed	11 %
Corruption/bribing	11 %		
Support services in the US			
(a) Living status	N = 14		
Shared room/apartment	50 %	Shelter	7 %
Lives with known acquaintance	43 %		
(b) Social support system	N = 14		
Relatives	50 %	Personal friends	14 %
Community	43 %	None/charity	21 %
(c) Financial support system	N = 14		
Unemployed	57 %	Welfare	14 %
Intermittent employment	29 %	Direct personal support	14 %
Full time employment	7 %		
Time spent in the US detention centers	4		
Medical care in the US	N = 14		
None	57 %	Inconsistent primary care	14 %
Registered with services/clinics	21 %	Hospital—based care[a]	7 %
Regular primary care	14 %		

[a] Comprised primarily of ER visits

Table 3 Characteristics of torture and psychological and physical findings

Characteristics of torture			
Reasons for torture	N = 30		
Political opinion	63 %	History of activism	7 %
Role in a social group	43 %	Sexual orientation	7 %
Gender	10 %	Family of activist	7 %
Ethnicity	10 %	War/social instability	3 %
Religion	10 %	Multiple reasons	47 %
Political activity	10 %		
Type of abuser	N = 30		
Police/prison guard	56 %	Spouse/family	11 %
Social/ethnic group	41 %	Government authorities	33 %
Political party members	30 %	Multiple abusers	63 %
Military	41 %		
Physical torture techniques	N = 30		
Blunt trauma	93 %	Asphyxiation/water submersion	17 %
Positional torture	40 %	Loss of consciousness	13 %
Denied food/water	30 %	Soles or palms beaten	7 %
Sexual assault	37 %	Chemical/pharmacological torture	7 %
Terrible prison conditions	27 %	Burns	3 %
Denied medical care	20 %	Female genital circumcision/mutilation	7 %
Broken teeth	13 %	Crush injuries	10 %
Penetrating injuries	17 %	Electrical shock	3 %
Psychological torture techniques	N = 25		
Verbal abuse	64 %	Threats against family	12 %
Stripped naked	12 %	Psychologically abusive photographs	4 %
Death threats	48 %	Witnessed beating/rape of family member	24 %
Acts against religion	4 %	Prison cell with dead body	4 %
Psychological sequelae			
Diagnosis of mental illness[a]	N = 30	Post-traumatic stress disorder	69 %
		Depression	69 %
Psychological symptoms	N = 30		
Difficulty sleeping	93 %	Feelings of guilt	52 %
Feelings of sadness/depressed mood	93 %	Poor memory	24 %
Isolation/poor social interactions	83 %	Headaches	24 %
Recollections	76 %	Detachment	24 %
Nightmares	76 %	Startling	17 %
Difficulty concentrating	66 %	Flashbacks	17 %
Avoidance	66 %	Suicide attempt	7 %
Poor appetite	52 %		
Clinical findings	N = 30		
Scars on head/face	69 %	Loose/missing teeth	14 %
Scars on genital	10 %	Broken bones	7 %
Scars unrelated to torture	83 %	Poor vision	10 %
Physical deformities	27 %	Burn marks	6 %
Limited joint motion	14 %		

[a] Diagnoses of PTSD and depression are not necessarily inclusive

In addition to unemployment, fragile legal status, lack of access to medical insurance, poor housing, and low food security [6] in asylum seeker population, other external barriers such as lack of providers' cultural competencies and vigilance about mental illness are compounding structural factors that negatively affect their health [7].

Table 4 Asylum application outcomes

Asylum outcome	N = 30 (%)
Granted asylum	50
Awaiting hearing	37
Withholding of removal	3
Denied, awaiting appeal	3
Loss to follow up	7

These factors also contribute to asylees' limited access to primary care services and the tendency to use episodic medical care for acute illnesses at best [7]. Medical providers increasingly face challenges related to international migrations and different health perceptions, presentations, and health literacy by patients of diverse origins. For countries hosting asylum seekers, it is not only a socio-political and economic issue but also a medical and ethical one [32] that warrants a complementary approach to address all of these facets [32].

Moreover, the importance of a medico-legal evaluation of torture and gaining asylum status cannot be overemphasized [7, 23]. We documented an 88 % success rate in obtaining asylum, which we contribute to the multidisciplinary and collaborative nature of our work. Practitioners caring for asylum seekers often come in contact with the immigration system and provide a medical affidavit of expert opinion on sequelae of injury, potential treatment choices in home country, and consequences of returning asylees to their native countries [33]. Other studies have suggested that a psycho-legal approach may result in survivors' feelings of empowerment, increasing self-esteem and knowledge about the legal system [34, 35]. Some have documented the therapeutic effect of law in the treatment of survivors of torture and the positive effect that various forms of legal intervention can have on their lives [35, 36]. A multidisciplinary approach including legal services has been shown to be more effective in decreasing symptoms and disability, while increasing subjective well-being and functioning compared to psycho-education sessions alone [35, 37]. Temporary work permits and the granting of asylum, as a more permanent solution, have a dramatic effect on the mental health and well-being of asylees [35, 36]. At a broader level, the pursuit of justice through legal process produces a healing result for survivors, even in cases where the legal decision was not the desired outcome [35, 38].

From a medical and public health ethics standpoint and a human rights perspective, the way that asylum seekers and refugees are accepted and treated in a society depends on factors including characteristics of the health system and its accessibility, views towards the right to health and rights of minorities and immigrants, as well as the commitment to a multicultural society [39, 40]. Beyond their responsibility to provide the best care for their patients and to facilitate the proper access to healthcare, practitioners should also raise awareness about the public health implications of inadequate or inhumane treatment and the fundamental conditions that deteriorate their health [41, 42]. Experts have argued that, "in serious cases of humanitarian and human rights abuses affecting health and well-being, there is a case for political action by health professionals, academic and professional institutions, and associations of medical, public health, and ethics" [43].

We recommend, at a minimum, that state agencies and advocacy and non-governmental organizations consider providing the same range of social and medical services that are provided to refugees coming to the US through UNHCR, which is consistent with other western countries' policies [44–48]. The resettlement agencies should help asylees with social services such as housing, employment, food security, language and cultural immersion programs, insurance, and facilitate medical and psychological evaluation and services. In the state of New York, asylees are eligible to apply for medical insurance for the first year of their stay in the US. However, due to the exhaustive and prolonged process and/or the lack of awareness among asylees, this is not accessed by the majority of asylees [7]. These dedicated state and federal agencies, which provide services to refugees, certainly have expertise, and likely the capacity, to provide assistance during the asylum application process. Many other host countries have provided these services and have maintained the minimum standards for access to care and social services [44–48].

There are multiple limitations to the generalizibility of our data which includes a selection bias towards our asylees who represent the experiences of those reporting to a large medical institution in the metropolitan area of New York, a lack of information about asylees who were in the US but never applied for asylum and/or medical evaluation, and asylees who have been deported at the border. Our data, however, is fairly similar to other limited studies from around the world and the US with regards to characteristics of torture [22, 49–51]. Women were significantly underrepresented in our study likely due to a lack of social capital and resources to flee their home country and/or to get connected to advocacy and service providers in the US. This highlights the need for better outreach to the immigrant community in the US as well as international efforts to help potential asylees in their home countries.

From a global perspective, all international strategies and policies currently in place that address human rights

abuses should be reinforced with the recognition of the patterns and characteristics of torture and abuse. The emphasis should be placed on prevention strategies and the need to proactively implement dissuading and deterrent policies for abusers. These policies should maintain support for civil society initiatives that incorporate local and regional socio-cultural norms.

Conclusion

The asylees seen at our clinic were mostly young, educated men who endured multiple types of torture including associated abuse of a family member. Sixty-nine percent of our clients were diagnosed with PTSD at the time of the interview. Eighty-eight percent of our asylees whose hearings had concluded were granted asylum, compared to national rate of 25–37 % [23]. We attribute this to the nature of our collaborative work with advocacy and grass-root organizations, legal representation, and the strict and diligent application of a standard protocol in medical evaluation [29].

From a humanitarian and human rights perspective, we have a moral responsibility to show solidarity and to provide asylees with the same standard of care and treatment as the rest of the population. There has increasingly been a greater recognition of the ethical foundations in the disciplines of medicine and public health that should expand the response to the inadequate and substandard treatment of refugees and asylees. Thus, the role of health professionals as informed and resourceful advocates and agents of social change cannot be overemphasized. A fundamental, multi-disciplinary and comprehensive approach is warranted and long overdue, one that draws on examples set by other nations and expands the state and federal services already available to refugees in the US to cover asylum seekers' social and health needs up until their asylum claim is decided, at a minimum.

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Conflict of interest Authors declare no financial and conflict of interest for this study.

Appendix

See Table 5.

Table 5 Components of the evaluation and affidavit writing

Case information
Clinician's qualifications
Statement regarding veracity of testimony
Background information
Allegations of torture and Ill treatment
Physical symptoms and disability
Physical examination
Psychological history/examination
Photographs
Diagnostic test results
Consultation
Interpretation of findings (physical and psychological evidence)
Conclusions and recommendations
Statement of truthfulness
Statement of restrictions on the medical evaluation/investigation
Clinician signature, date, place
Relevant appendices (anatomic drawing, physician CV, photographs, etc.)

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