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Changing The Playbook For Immigrant Health

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Changing The Playbook For Immigrant Health

Philadelphia's response to welcoming Afghan evacuees during the COVID-19 pandemic suggests the need for a new approach to immigrant health care.

BY CHERYL BETTIGOLE, PATRICIA C. HENWOOD, SAGE MYERS, AND MAURA SAMMON

In the chaotic days of the US withdrawal from Afghanistan in 2021, the news reports from the Kabul airport were dire: men, women, and children desperate to get onto planes, with too few seats available for the thousands at risk as the Taliban took over. A bomb going off in a crowd, with hundreds killed. The horror of hearing of young Afghan men killed after attempting to cling to airplane wheels or stow away in wheel wells and then falling from the sky. And the collective shame we felt for these deaths and for our inability to protect our allies and their families during that withdrawal.

But despite our horror, here in Philadelphia this was still all a world away. And then one August day, the city's Office of Emergency Management was informed that Philadelphia International Airport would become the second airport to receive evacuees from Afghanistan, after Dulles International Airport, outside Washington, D.C., as part of Operation Allies Welcome. We were to expect 1,000 or more evacuees to begin arriving each day, starting in just forty-eight hours.

At that moment, the world was in the midst of the Delta wave of the COVID-19 pandemic, and the federal government was concerned about creating a new wave of infections in the US. So Philadelphia's Department of Public Health was tasked by our federal partners with setting up a system to test all new arrivals for COVID-19 and then ensuring that each of them had received a first dose of the vaccine before they left the airport—the same model used initially at Dulles.

The response developed in Philadelphia, however, ultimately looked quite different. That response did include COVID-19 testing for all the evacuees, as well as offering COVID-19 vaccines to all eligible new arrivals. However, we opted not to make those on-arrival vaccines mandatory, sharing our concerns with our federal partners that mandatory vaccination on arrival would add to the trauma experienced by the exhausted, deeply traumatized evacuees coming off long flights out of a war zone. Our federal partners agreed, and they also made space for a medical triage clinic to address the potential for urgent medical needs among this population, who had fled their homes so quickly.

We—the authors of this narrative—adapted our approach according to our collective understanding of immigrant health needs, global medical response, and the needs and state of our local health care system. (Throughout this narrative, we use the term "immigrant" to mean anyone who has entered the US with the intent of staying permanently, whether legally present or not, and the term "refugee" to indicate those who have been approved for official refugee status.) Our response to the Afghan evacuees reflects what we propose as a new way of thinking about public health and the global movement of populations more broadly: a new playbook based on public health data that informs our assessment of the risk for infections and other health problems from and to im-

Illustration by Brett Ryder

migrants and refugees and our collective understanding of the importance of a compassionate, culturally sensitive approach to the provision of care to displaced people.

Preparing For The Arrival

First, we needed to assemble our team. Because of the pandemic, one of us—Cheryl Bettigole, Philadelphia's health commissioner—was in regular communication with the chief medical officers of the city's hospital systems. On reaching out to them, she was quickly connected with another of us—Maura Sammon, an emergency medicine physician and an expert in global health. Sammon was scheduled to depart in forty-eight hours for Bahrain to help treat Afghan evacuees expected to arrive there in the coming days. Instead, she agreed to change her plans and lead the planning of the medical triage unit at Philadelphia International Airport. She quickly looped in two more of us—Sage Myers, a pediatric emergency medicine physician at Children's Hospital of Philadelphia, and Patricia Henwood, an emergency medicine physician at Thomas Jefferson University Hospital—as well as other fellow emergency physicians with global health expertise and recent experience with off-site medical clinic creation as a result of community COVID-19 testing and vaccination work.

During the next two days, our team drew up protocols, created an online signup system for medical staff, recruited physicians and nurses willing to volunteer 24/7 to staff our nascent clinic, and developed a list of essential medications we would need to have available on site. Physicians, nurses, and other medical professionals volunteered in massive numbers. By our forty-eight-hour deadline, we had a fully staffed, well-supplied triage clinic up and running in the baggage claim area of the airport's international terminal that was able to screen all evacuees for unmet medical needs, diagnose and treat urgent medical conditions, and partner with a volunteer pharmacist set up in a nearby office to dispense medications prescribed by the team both for urgent conditions and to replace missing medications for chronic conditions that had the potential for acute deterioration.

Next to the clinic, staff from Philadelphia's Department of Public Health set up COVID-19 testing for all new arrivals until a contract agency could be engaged to cover this aspect of the work, and they provided 24/7 logistical support, ensuring that supplies and medications were available and that all medical personnel were rapidly enrolled in the Medical Reserve Corps. Because of severe overcrowding in the city's emergency departments (EDs) and overall high patient volumes faced by our local health care organizations at that time, we created procedures to ensure that as many medical issues as possible could be handled on site. For those who needed to be transferred to the ED, we used rotating schedules to ensure that no single hospital was overwhelmed and that they had close communication with emergency medical services and the accepting hospital providers to smooth the process for patients, families, and the hospital teams alike.

We were by no means alone in our preparations. Multiple federal, state, and city agencies had been hard at work preparing, including making welcome signs in multiple languages. The Red Cross table offered snacks, toys, and a huge pile of St. Bernard stuffed animals. Other tables were staffed by young soldiers and other representatives from federal agencies to help the evacuees with each of their next steps in processing and relocation.

And then all was ready, and the first plane's arrival was announced. We all stood near the ramp where the evacuees would come down from Customs and Border Protection. As the first families trailed down the cordoned-off space, young children in tow, babies in arms, all looking tired, scared, and at sea, spontaneous applause broke out among those assembled to welcome the evacuees. We watched as the children took their toys, looked at their parents for approval, and then began to play, enormous smiles lighting up their small faces. The adults began to visibly relax, and a hubbub of conversation filled the baggage hall where we were stationed. And we were on.

Long Days And Nights

We soon fell into a rhythm. Staff members from Philadelphia's Department of Public Health wearing bright teal shirts staffed a table near the entrance to the clinic operation, next to the baggage carousel, to sign in new medical staff and point them in the right direction and to troubleshoot supply shortages and other needs as they came up. The medical team lead for each shift would form a quick circle with staff to go through procedures and make sure that they understood their roles. And each day, medical staff would show up with additional equipment and supplies that they had noticed were missing the day before. Otoscopes, a baby scale, and more became part of our medical equipment and smoothed operations.

One of our initial worries was that we knew that many people would speak only Dari or Pashto, and we would need many interpreters to avoid bottlenecks that would stop the progression of the evacuees and potentially dissuade them from getting needed treatment. What we did not anticipate was the overwhelming commitment of the local Afghan community. Despite the fact that this community was only about 600 strong before Operation Allies Welcome, that first night twenty-four young adults, primarily women, showed up to volunteer to interpret. The city's Office of Immigrant Affairs, normally a policy office rather than one that provides direct service, mobilized quickly to create a system for checking in and identifying these interpreters, with vests color-coded by language spoken.

We had set up our medical intake tables with American-size nuclear families in mind, not counting on the very large

Policy Checklist

The issue: Current US health policies treat incoming immigrants and refugees as potential health threats and vectors for disease and subject them to mandatory screenings but do not provide ongoing access to care. These policies should be replaced with a new evidence-based, trauma-informed, and culturally sensitive approach to immigrant health care.

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size of Afghan family units, which often included twenty or more people. Our team quickly moved tables and chairs around to create fewer medical stations with many more chairs, allowing us to keep families together. The interpreters asked to stay with the initial family they were assigned to, following them from area to area, instead of having separate interpreters for the medical team. In addition to providing comfort for the family as they became acquainted with the interpreter, it also added efficiency and safeguards to the system as the interpreters came to know details about the family and helped advocate for their needs. We recognized that staying together was a top priority for these families after all they had been through—they were terrified of losing each other. We quickly learned that if we needed to send someone to a local hospital, an eventuality that was rare, we needed to arrange with the hospital, emergency medical services providers, and others for their family to accompany them there. The local hospitals showed remarkable cultural sensitivity in agreeing to these requests, but these asks were also made easier by our ability to manage most conditions on site, avoiding overloading our local EDs.

During the ensuing weeks and months, of the more than 29,000 Afghan evacuees who came through Philadelphia International Airport, our team cared for more than 1,000 evacuees with acute medical needs, sending only about eighty patients to hospitals. Our ability to avoid overloading our local health systems was critical during the Delta wave of the pandemic, when our local EDs were already filled to capacity. But perhaps equally critical was the pride and engagement felt by the hundreds of Philadelphia doctors, nurses, public health professionals, and others who took part in the operation at a time when we were exhausted and overwhelmed after more than a year of the pandemic. Here in Philadelphia, we call ourselves the city of brotherly love and sisterly affection. We have never seen that be truer than during the long days and nights of Operation Allies Welcome.

Questioning Assumptions

But this operation did not only show what our city is capable of when we come together. It also brought into question some of the fundamental and long-standing assumptions built into the way that this country approaches health care for immigrants and refugees. For example, when we looked back at the data from this operation, we found that the incidence of COVID-19 was less than 1 percent. However, approximately 5 percent of evacuees had a medical condition for which they needed prompt medical care, many of which related to chronic medical conditions for which they did not have urgently needed medication and were at risk for acute complications. This included a young child with decompensating insulin-dependent diabetes, other young children with complex medical needs, many pregnant women close to delivery, and people of all ages with seizure disorders but no medications. In addition, we saw people with injuries, including gunshot and other war-related wounds and joint injuries from evacuation trauma. We also saw people with the sequelae of prolonged travel: infants with severe diaper rash resulting from days of travel without access to proper hygiene, and evacuees of all ages with abdominal pain and nausea because of constipation. And we uncovered these conditions with two simple questions: Do you have a medical problem for which you would like to see a doctor? and, Do you need medication? But we also identified these conditions by providing compassionate, trauma-informed, culturally sensitive care that recognized the rights of these new arrivals to consent to or decline care and to receive the care that they felt they needed.

The roots of the treatment of immigrants as potential vectors of disease go back centuries, to medieval efforts to prevent travelers from spreading plague across Europe, according to scholar Eugenia Tognotti. In the US, a regulatory approach requiring screening of immigrants for infectious disease goes back to the late nineteenth century. Specific regulations laying out which conditions make immigrants ineligible to enter the US or, for those already present, to obtain legal permanent residency status are promulgated by the Department of Health and Human Services and administered by the Centers for Disease Control and Prevention (CDC). These

regulations lay out the specifics of how we should assess whether a given prospective immigrant poses a public health threat to Americans. Implicit in this approach is both an assumption that foreign-born people as a group pose such a threat and a parallel assumption that a screening program for prospective immigrants protects us against that risk.

Our experience during Operation Allies Welcome makes us question those assumptions and points out that another, more humane approach may offer important advantages. By providing medical triage services for those who needed them, we identified medical conditions that could have become serious had they gone untreated for longer. Further, through the relationship-building possible by offering rather than requiring medical care to this highly traumatized population, we were able to build trust and to connect those who needed ongoing care with providers at their next destination.

The first assumption we call into question is that screening immigrants for infectious diseases prevents infections from spreading to Americans.

The CDC requires that immigrants and refugees be screened for active tuberculosis, infectious syphilis, gonorrhea, and infectious leprosy. Rates of these conditions are higher in some parts of the world than in the US, although rates of syphilis have been rising recently in the US. However, immigrants and refugees make up only a very small percentage of people entering the US from abroad. Just under a half-million noncitizens were granted immigrant visas to enter the US in fiscal year 2022, according to the Department of State Bureau of Consular Affairs. This number is dwarfed by the forty-three million nonimmigrant admissions during that same year for other international travelers visiting the US (such as for tourism and business), according to the Department of Homeland Security. And the Department of State estimated that there were roughly nine million US citizens who lived abroad in 2019; such people may return home at various times without any federal requirement for medical evaluation.

Immigrants seeking permanent residency are now screened before arrival to get permission to immigrate. But international travelers have no such requirements. Tourists from areas with high rates of multidrug-resistant TB, for example, have no medical requirements before receiving a visa, nor are there any requirements for Americans who reside abroad in countries with high burdens of infectious disease to have any type of medical evaluation before or after their return to the US. Although the majority of cases (71 percent) of active TB in the US in 2021 occurred among foreign-born patients, fewer than 10 percent of those cases occurred during the first year after arrival, the CDC notes. In other words, our ability to provide affordable access to a trusted source of health care likely matters far more in the control and prevention of active TB than initial screening at entry, even for the small subset of foreign-born people entering through the immigration system. And this is not just true for TB. As we look to prevent future pandemics, a system in which we severely limit access to health care for the vast majority of immigrants to our country puts us all at greater risk from a wide range of pathogens that may be acquired abroad or spread within the US.

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The second assumption we question is that pandemic-related immigration bans and restrictions were based on public health concerns.

Title 42 of the Public Health Service Act, passed in 1944, requires medical screening for immigrants and authorizes the CDC to disallow entry of individuals into the US to protect the public health. In 2020 the Trump administration used Title 42 to prevent immigration from Mexico and (in theory) Canada, based on the risk for COVID-19 spread in congregate facilities at the border. This use of Title 42 was questionable in 2020, given the high rates of COVID-19 spread within the US. Its continued use through mid-May of 2023, despite calls for its revocation by multiple public health experts, including testimony to Congress by former CDC official Anne Schuchat, defied logic and hijacked public health terminology in the service of xenophobia and racism.

The third assumption we question is that the current requirement for medical screening for immigrants is doing more good than harm.

We made a decision in Philadelphia to offer, rather than require, COVID-19 vaccination immediately upon the Afghan evacuees' arrival, given the traumatized state and exhaustion of the evacuees that we anticipated. We also made the decision to offer medical care to those who wanted it and to make that care as culturally appropriate and trauma-informed as possible.

As physicians who together have a combined half-century of experience caring for immigrants, we have seen that foreign-born populations in the US too often avoid medical care for fear of the way they may be treated, concerns about language barriers, and costs that can bankrupt their families. Over the years, we have all seen the impact of this avoidance in needless complications, pain, disability, and death among our patients who waited too long to seek care because of exactly these concerns. The current system of required medical screenings feeds into these fears instead of assuaging them. If the first experience immigrants have of US health care involves treating them as threats and vectors, they may avoid future care until and unless their circumstances are dire. This means that we will miss out on the opportunity to treat a patient with latent TB before reactivation or a patient who acquires a sexually transmitted infection in the US, just as examples. And it also means that we miss the opportunity to help prevent future health problems by treating chronic conditions promptly.

A New Playbook

The choices we make in how we offer or require medical care before and after

immigrants arrive in our country determine a great deal about how they use that care going forward. It is time for us as a nation to step away from the framework of past centuries and to see immigrants clearly for what they are: potential new Americans whose health we should protect, not threats or vectors. To that end, we need a new playbook. In place of a screening protocol that aims to shut out those deemed to be potential vectors of disease and ignores the vast majority of people who have traveled from or to those same nations, we should ensure that immigrants—however and whenever they came to the US—have access to high-quality, affordable health care, including culturally and linguistically appropriate care. To do that, we need to end the five-year bar to Medicaid access for legally present immigrants and to pass comprehensive immigration reform that addresses our country's reliance on a workforce of millions of undocumented workers who are effectively priced out of access to health care.

Any screening for infectious disease that is appropriate based on individual exposure history should be offered within primary care and should be made available to all those who have traveled to areas where such infections are common, instead of being restricted to a subset based on immigration status. It is time to discard not only the discriminatory use of Title 42 at the southern US border, which is no longer in place with the end of the COVID-19 public health emergency, but the entire paradigm from which it originated.

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Philadelphia's international terminal baggage claim area is once again just a baggage claim area. The welcome signs in Dari and Pashto with their decorations of flowers are gone, as are the children's drawings and the tents set up for vaccination and for breast-feeding. Whenever we walk through it, though, we will always picture the young families, the piles of luggage, donated clothes and toys, and the army of health care providers who came together to make a miracle happen in the midst of tragedy piled on tragedy. We have seen that compassion can provide a way forward to create the new playbook that we need—a set of protocols that meets people where they are, recognizes all that they have been through, and builds a path toward a new way of providing care for immigrants and refugees that is humane and evidence-based and that builds trust in our health care system. ■

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