

Health Needs of Refugees: Port of Arrival versus Permanent Camp Settings

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Executive Summary

The world's refugee population currently stands at over 19 million, the large majority of whom reside in developing countries.¹ The quality and availability of healthcare for refugee populations varies according to the geographic setting, availability of adequate resources, and proper training of healthcare providers. This report investigates the top health issues faced by refugees in short- and long-term settings. The report compares and contrasts two important settings for healthcare provision for refugees: permanent camp settings, such as in Za'atari, Jordan, and transitory arrival centers, such as in Lampedusa, Italy, which is a major port of arrival for refugees.² First, the most pressing health concerns of refugees and major barriers to healthcare provisions are identified in Lampedusa versus in Za'atari. Second, coordination among health-related agencies is addressed, including successful

Introduction: Overview of the Refugee Crisis

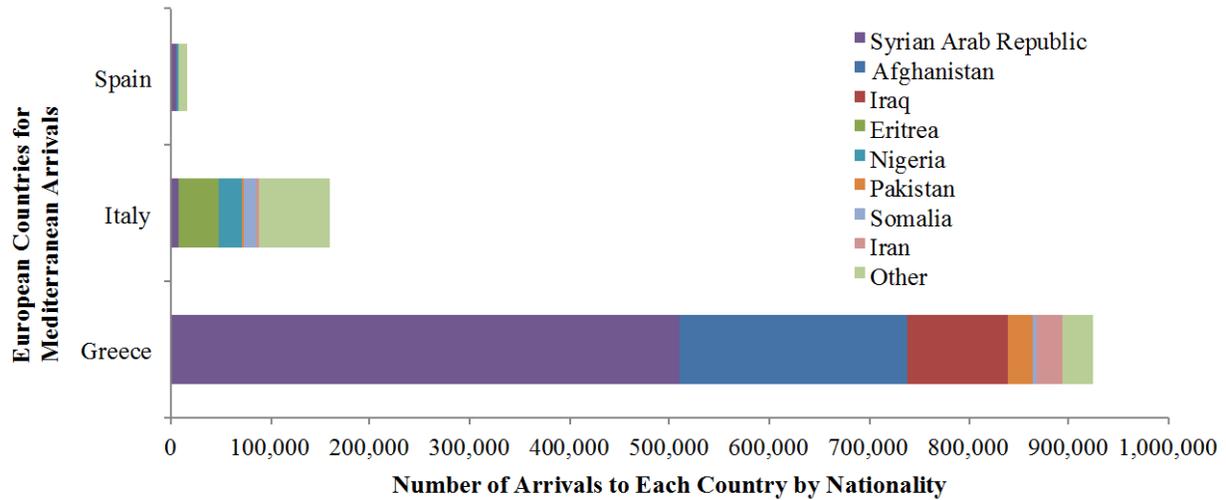
The media have been flooded with images and stories of refugees trying to make their way to new communities.³ Many are fleeing the violence and persecution in the Middle East and Central Africa, as well as the intensifying consequences of climate change, which are leading to droughts and flooding in numerous countries. The number of refugees worldwide continues to grow, which has precipitated a number of diverse reactions and intense debates in the international community. Many host communities are experiencing social and political

and unsuccessful models. Third, gaps in training for healthcare providers is explored, especially opportunities to improve culturally competent care. Through literature and Internet searches, this report has gathered background information on these subjects, developed areas of priority, and identified leaders and experts in the fields of international policymaking and refugee health in either Jordan or Italy. This background research was utilized to develop a set of questions to interview these leaders and experts. The report concludes with a set of recommendations to improve healthcare services for refugees in both temporary and long-term settings, including unaddressed health needs, models for coordination among providers, and types of training for healthcare providers. Comparison of these two settings helps to not only elucidate important differences but also to identify overlapping needs for health services for refugees.

backlash, but at the same time, governments and organizations are continuing to donate much-needed funds and resources to refugee services and programs. The current refugee crisis largely stems from the unrest that spread throughout the Middle East and North Africa starting in 2011. Many of these conflicts have evolved into chronic situations of conflict and instability, and the scale of the humanitarian crisis continues to grow. Refugees are using both land and sea routes. Nearly 35,000 traveled to Europe by land, with the highest number from Syria (50 percent), followed by Afghanistan (20 percent), Iraq (7 percent), and Eritrea (4 percent), with the remaining 19 percent largely from Pakistan, Nigeria, Iran, and Somalia.⁴

Figure 1

Total Refugee Arrivals to Europe via Greece, Italy, and Spain by Nationality, January 2015–January 2016



Data from United Nations High Commissioner for Refugees, *Europe Refugees and Migrants Emergency Response: Nationality of Arrivals to Greece, Italy, and Spain*, March 2016.

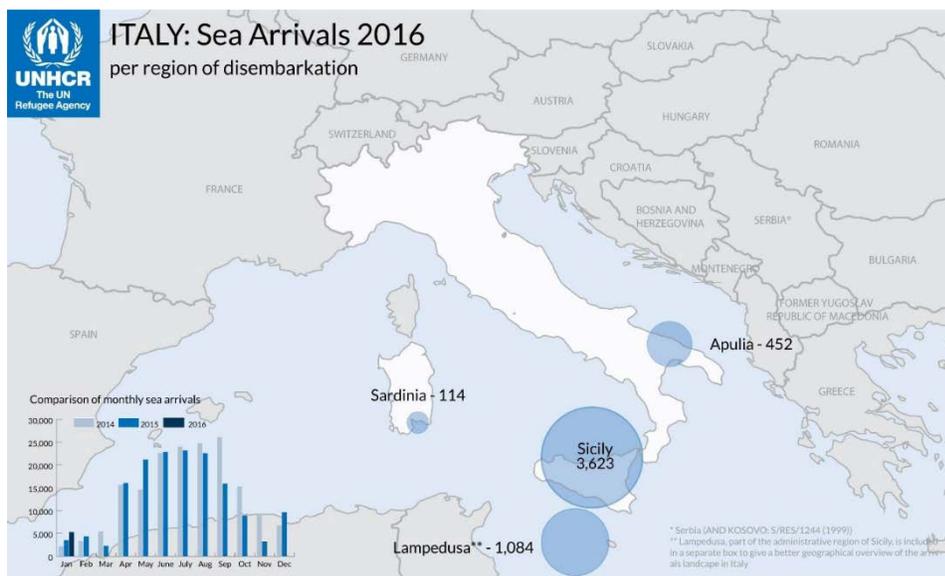
In 2015, over 1 million arrived in Europe by sea via Spain, Italy, or Greece, with the top countries of origin being Syria, Afghanistan, Iraq, Iran, Eritrea, Pakistan, Nigeria, and Somalia (see figure 1). In addition, over 3,700 were reported dead or missing, which is the highest figure since the beginning of the current crisis.⁵

Lampedusa, Italy, a small island off the coast of Libya, has experienced a marked influx of refugees headed to mainland Europe (see figure 2).⁶ In 2015, over

153,000 refugees arrived in Italy—all having made the dangerous trip by sea—from 60 countries, with the largest numbers coming from Eritrea (25 percent), Nigeria (14 percent), Somalia (8 percent), Sudan (6 percent), Gambia (5 percent), and Syria (5 percent).⁷ This influx has put a strain on the resources of the local communities and has necessitated a coordinated response from local organizations, the Italian government, and international nongovernmental organizations (NGOs).

Figure 2

Number and Location of Refugees Arriving at Italy, January 2016



In January 2016, over 5,200 refugees arrived in Italy, a 50 percent increase over January 2015. Twenty-one percent of those refugees landed in Lampedusa; it is estimated that 360 died at sea or were reported missing.

Source: United Nations High Commissioner for Refugees, “Refugees/Migrants Emergency Response—Mediterranean—Regional Overview,” 2016.

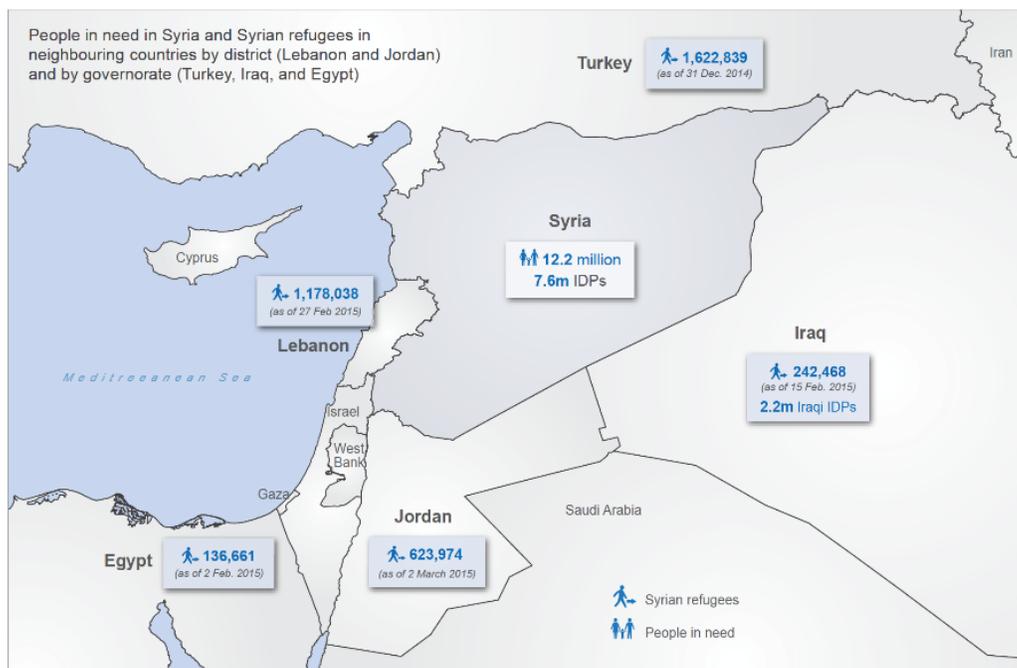
Over the past two years, the fastest-growing group of refugees has been Syrians, who are fleeing the violence that developed out of the Syrian government’s crackdown on prodemocracy protests that began in March 2011. The conflict is now a complex civil war with government, rebel, and Islamist groups, including Islamic State, fighting for different parts of the country and supported by local, regional, and international actors. The number of Syrian refugees is expected to grow as the civil war continues and as the need for humanitarian aid rises (see figure 3). Some Syrians have sought refuge in Europe, arriving mainly via Italy and Greece, but the vast majority, nearly 4.3 million, live in the neighboring countries of Jordan, Turkey, Lebanon, Iraq, and Egypt.⁸ The Jordanian government has estimated that 1.4 million Syrian refugees are living in Jordan. However, only about 642,000 are registered by the United Nations High Commissioner for Refugees (UNHCR), which is helping to lead the regional Syria response strategy. About 125,000 (20 percent) of the registered refugees live in one of three refugee camps in Jordan. Therefore, the vast majority of Syrian refugees in Jordan—and in the region as a whole—live outside of camps. Za’atari, which opened in 2012, is the second-largest camp in the world and houses nearly 80,000 refugees.⁹ The

other UNHCR camps in Jordan are Azraq and the Emirates Jordanian Camp.

Refugees are a particularly vulnerable population with specific health needs. The journey out of violent and unstable areas can be dangerous and taxing with deleterious consequences for health during travel through unsafe, unsanitary, and poorly resourced settings. Even after they reach a border, refugees face many challenges integrating into new communities, adapting to altered lifestyles, and dealing with the effects of traumatic experiences. Various international NGOs, governments, and local organizations are working together to provide basic health services in order to manage the overload of patients amid inadequate resources, as well as to stem the spread of infectious diseases and potential outbreaks. As the number of refugees grows and outpaces available international funding, it becomes increasingly important to identify the major gaps in healthcare and areas for improving quality, access, and coordination. Likewise, interagency coordination and training in cultural competency become even more critical. In entering the sixth year since the onset of the current refugee crisis, there are numerous opportunities to learn from past successes and failures in order to identify areas of priority

Figure 3

Estimate of Number of People in Need in Syria and Number of Syrian Refugees Registered by the UNHCR in Neighboring Countries, Early 2015



The number of Syrians in need of humanitarian assistance has steadily risen since 2012.

Source: Regional Refugee and Resilience Plan, Updated Overview: 2015 Syria Response Plan and 2015–2016 Regional Refugee and Resilience Plan, March 31, 2015.

for developing new programs with the greatest amount of beneficence, justice, and efficacy.

Refugee Health and Health Services

The health of refugees is of utmost importance not only for their personal well-being and safety but also for maintaining the health of host communities. Significant resources from local, national, and international sources are currently funding a variety of health services for refugees. For example, the UNHCR oversees and funds dozens of NGOs working in and outside of Za'atari camp in Jordan, and Italy's national healthcare system, Servizio Sanitario Nazionale, which is the main provider of health services for Italians and non-Italians, coordinates with many NGOs. Based on background research and interviews, this report has identified different health conditions and services available for refugees living in Za'atari versus those arriving in Lampedusa. By defining the top health issues, needs, and areas for improvement, this report hopes to increase public awareness and proactively develop a more effective long-term plan for meeting the health needs of refugees.

The most recurrent healthcare need of refugees in Za'atari is chronic-disease management, including emergent needs and long-term complications. Noncommunicable disease incidence was on the rise in Syria before the war broke out, and a high level of medical services was available. However, over the past five years, the health system in Syria has vastly deteriorated—and has even been purposefully targeted in attacks¹⁰—so that many Syrian refugees arrive in Jordan with health complications. The UNHCR and its implementing partners provide free primary and secondary healthcare to refugees residing in camps. Primary healthcare services in Za'atari are effective and well coordinated, as are the systems for outbreak response, for which surveillance measures and standard operating procedures have been developed and implemented. Importantly, more health services are being integrated into primary healthcare, including psychosocial support. Unfortunately, limited assistance is available to refugees in noncamp settings, especially after the Jordanian government switched its policy in late 2014 to no longer cover the health expenses of refugees seeking care in Ministry of Health facilities.¹¹ This change puts an even greater burden on the UNHCR and NGOs to provide cash-based assistance and other financial resources so refugees can obtain care.

Refugees with preexisting health conditions, such as diabetes, may arrive with symptoms related to their underlying disease upon arriving in Jordan because the

conditions of travel often lead to inadequate sanitation and access to medications. In addition, Za'atari's setting in the open desert, with its hot summers, dust storms, and cold winters, coupled with a dearth of options for exercise and healthy food, can exacerbate many chronic conditions. A UNHCR public health officer for Za'atari noted the prevalence of hypertension and diabetes among the 5,000 refugees in the camp who are living with chronic health conditions.¹² Other conditions include asthma, thyroid problems, and ischemic heart disease.¹³ The prevalence of these conditions results in high costs for secondary and tertiary healthcare, especially because some of the complications must be referred to hospitals outside of the camp, assuming that in-country services are even available. Chronic, noncommunicable diseases will continue to be a major health problem, even as refugees leave the camp to resettle in permanent host communities or return home, when possible. Acute health conditions, including upper respiratory tract infections, dental conditions, and skin infections, represent a smaller burden of disease, and no disease outbreaks were reported in 2015. However, surveillance of diseases must continue in order to prevent any large-scale crises and to focus resources where they are most needed.

In contrast, one of the biggest health issues for refugees arriving in Lampedusa is infectious diseases, especially scabies, other skin conditions, and hypothermia.¹⁴ Bacterial infections and skin burns that develop as a result of the overseas traveling conditions—including salty water, urine that accumulates in the small and crowded boats, sun exposure, and proximity to the boat motor—are all contributing factors. Even if the refugees are otherwise healthy, the unsanitary and low-resource conditions in which they are traveling increase their vulnerability to contracting communicable diseases. Therefore, it is especially critical that antibiotics, topical ointments, and screenings, such as for tuberculosis, are provided upon arrival to prevent the worsening of these conditions or their spread to others.

Women's and children's health continue to be priorities for refugees, whether arriving in Lampedusa or living in Za'atari. Refugees arriving in Lampedusa who are pregnant require immediate gynecologic care. However, long-term antenatal and postpartum care may be difficult to provide because of the transience of the population. One in five households in Za'atari is led by a woman, and the average birth rate in the camp is 79 per week.¹⁵ Since refugees often spend three or more years there, pediatric and maternal healthcare services, including routine antenatal screenings, are critical. Currently, 100 percent of births are attended by skilled medical personnel, and no maternal

deaths were reported in 2015. Sexual or gender-based violence has been documented and identified as an important area of concern by the UNHCR, requiring specialized services in both Lampedusa and Za'atari. Appropriate responses and protection programs, including safe reporting, referral mechanisms, and follow-ups, must be provided for survivors, who are an especially vulnerable population.¹⁶

Finally, screening and treatment for psychiatric disorders is a critical health need in Za'atari and Lampedusa, especially in light of the physical and psychological trauma many of these refugees have endured. In Za'atari, the International Medical Corps, which is a UNHCR-funded NGO, has recently been put in charge of mental health service coordination with the goal of integrating mental health into primary care services.¹⁷ Currently, refugees entering Jordan (now limited to 15 to 100 per day) are screened for general health conditions at the registration center and are then sent to one of the three UNHCR camps, of which Za'atari is the oldest and largest. Referrals to healthcare providers within the camp can be coordinated on an ad hoc basis. However, the quality of these screenings and services, as well as the efficacy of follow-up, are unclear. Some health clinics in Za'atari perform their own screenings and have occasionally trained mental health providers who can identify and treat the refugees. Overall, the limited number of trained providers is a major barrier though, especially in psychotherapy. Some NGOs, such as Save the Children and Bright Future for Mental Health, and community centers within the camp provide psychosocial support services, mainly for children. The limited options for adults to access counseling and behavioral therapy are a major area of concern. Mental health screening on arrival in Lampedusa is burdensome owing to the sheer numbers of refugees and time constraints, making it extremely difficult to screen everyone for psychological disorders.¹⁸ Most refugees do not stay in the migrant centers for long, so mental disorders may not be diagnosed if they do not present themselves immediately. Moreover, most refugees arrive in essentially good health—other than the infections, burns, and malnutrition that may have resulted from the time in transit. However, many health problems can develop as they settle into new communities and possibly begin to deal with unfavorable and unfamiliar living conditions, as well as the traumatic experiences of their pasts.¹⁹

The most prevalent mental health disorders among refugees in Za'atari are depression, anxiety, and posttraumatic stress disorder. These often manifest in sleep impairment, hypervigilancy, uneasiness, social

withdrawal, and feelings of hopelessness and uselessness.²⁰ The refugees have, in general, been open about their medical conditions rather than showing signs of embarrassment or stigmatization, which is important to note. Most notably, however, is that many are unaware of or confused about the symptoms, especially parents with affected children.²¹ Better communication, which could be achieved through providing a list of available follow-up services and resources for psychosocial therapy, would help improve coordination among organizations and assist healthcare providers in making better referrals—especially those who may be unfamiliar with the camp, such as physicians working as part of mission trips. In addition, psychoeducational materials should be made available to refugees in order to raise awareness about mental health conditions and complications, to provide basic management techniques, and to bolster community support with the goal of improving long-term health outcomes.

Interagency Coordination

Providing healthcare to refugees is a complex task that involves many stakeholders, including international institutions, national governments, and NGOs. However, lack of coordination makes delivery of high-quality care difficult and costly. Communication lapses result in deletions or duplications of services. While the organization that leads coordinating efforts may vary depending on the context, the one providing the largest funds and resources will generally be in the best position to assume this role. The lead agency should also have mechanisms for delegating responsibilities to cover and monitor services and programs. In both Jordan and Italy, leaders have called for a more coordinated and centralized approach to delivering care.²²

Starting with the influx of refugees in 2010, the Italian government implemented a health information system, including public health surveillance mechanisms, which allows for the reporting of 13 conditions to the Italian Ministry of Health (MOH). This program is still in place and has been expanded to include monitoring in Croatia, Greece, and Malta.²³ The MOH has also adopted a World Health Organization (WHO) toolkit to conduct a series of assessments on the health system impact of the influx of migrants and crisis management, including in Lampedusa.²⁴ In addition, the International Medical Corps's efforts in Za'atari to integrate mental health services into primary healthcare are an important step to identifying gaps where needs are still not being met. These efforts should be recognized for their improvement of

coordination and healthcare delivery. Such a model would be beneficial in Italy, where the management of care is fragmented across a variety of organizations. On arrival, NGOs such as the Red Cross, Save the Children, and Doctors Without Borders triage patients with assistance from the MOH, but within the migrant centers that house refugees, the provision of services is the responsibility of the Ministry of the Interior.²⁵

In Italy, since the funding is provided by the national government with some assistance from the European Union, coordination efforts must be led by the government. More specifically, in Lampedusa, centralizing control of health services with the Servizio Sanitario Nazionale could improve coordination among different organizations and allow for more collaboration and input from the WHO, which is working to develop guidelines and best practices for European nations dealing with an influx of refugees.²⁶ Providing healthcare to refugees in Jordan is much easier inside the camp than outside in urban settings because of the centralized framework and geographic proximity.²⁷ The UNHCR, which receives funds from international donors and the government, is the coordinating arm of Za'atari camp. It manages the healthcare services of its implementing partners, including funding and technical support, and mediates on issues with the Jordanian government. One of the greatest successes so far in Za'atari has been reducing health gaps and improving coordination by implementing tools and standard operating procedures, such as the cholera preparedness plan, a national guideline now adopted by the Jordanian MOH.²⁸ While areas of need remain, Za'atari has been recognized for its coverage of primary and secondary health needs of refugees, especially in light of the fluctuating levels of refugees, NGO participation, and funding.²⁹

The UNHCR has bimonthly management and coordination meetings for overseeing all sectors, including health, in Za'atari.³⁰ Regular meetings between stakeholders are a key way to ensure good communication and coordination among service and care providers, as well as transparency, with the meeting minutes publicly available online. However, in order to promote better coordination of care, these meetings should be a launching pad for focus groups within the health sector to address, for example, mental health services, women's health, and pediatric health issues. The groups could meet separately to discuss issues and develop strategies. This model of multisector meetings and focus groups are also applicable in the context of Lampedusa, where a number of NGOs are involved in the humanitarian response effort.

Documentation is also an important aspect of centralized coordination. Syrian refugees arriving in Jordan are given general health screenings at the registration center run by the government and may be referred for follow-up services in the camp. Communication between the registration center and camp appears to be done on a largely informal basis, and it is unclear if screening results can be accessed by healthcare workers inside the camps.³¹ Particularly when handling personal health information, there must be a formal process for communicating and maintaining privacy. In addition, the UNHCR has a web page with an extensive list of its implementing partners and short descriptions of their missions.³² However, no comprehensive compilation of services or facilities exists for healthcare providers to use in the field in either Za'atari or Lampedusa.³³ Such a document would help physicians make referrals, identify gaps in services, and improve utilization of available resources in the camp. It would also improve integration of temporary volunteers, such as healthcare providers arriving for short mission trips, and continuity of care between mission trips and long-term providers. Similarly, a comprehensive list of medications and medical supplies should be maintained so that available and depleted resources are identified.

First responders, such as healthcare providers in Lampedusa, must coordinate their efforts with the agencies and organizations responsible for long-term and sustained assistance to refugees. For example, healthcare providers must coordinate with the Italian navy, which launched a search-and-rescue operation at sea, Mare Nostrum, that helped to save 166,000 people in its first year (2013).³⁴ Documentation of disease conditions should be based on screenings, and immediate response should include emergency care, medications, and vaccinations. Since refugees can be especially vulnerable to poor health outcomes—including sexual exploitation, infections, and chronic disease complications—if not fully integrated into their host communities, quality healthcare provision should be a top priority.³⁵ Disease surveillance programs in Jordan have proven to be invaluable tools for obtaining health-related data and allocating health resources, but they also require multisector coordination, standard protocols, and database repositories.³⁶ Readily available technology, including short message service (SMS) texts, should be utilized for providing health-related updates and reporting.³⁷ As in any other health system, the availability of inpatient and outpatient healthcare providers is critical for refugees, especially as the current crisis continues.

In addition to programmatic and structural changes, an intangible aspect of coordination is interpersonal skills. Having a strong team and good working relations is key to

providing high-quality, coordinated care to refugees, especially in the stressful environments of the Lampedusa and Za'atari health clinics. These skills are difficult to measure but can be maximized through increased opportunities for communication and collaboration. As is currently being seen in Za'atari, healthcare services will need to be streamlined for efficiency as funding decreases, thus integrated models of care will become increasingly important. In addition, multisector surveillance initiatives, such as for communicable diseases, and improved documentation will be crucial for identifying gaps in care, preventing public health disasters, and improving health outcomes for refugees.

Training in Cultural Competencies

Oftentimes, refugee healthcare providers do not have linguistic or cultural concordance with the patients they see. For example, physicians from around the world volunteer on service trips to provide critical medical expertise at Za'atari camp, but many of them are unfamiliar with the culture and do not speak Arabic. Similarly, the refugees arriving at Lampedusa come from dozens of countries with unique languages and practices, increasing the complexity of healthcare provision by local physicians. More resources for identifying and training high-quality interpreters are important so that language is not the primary barrier for refugees to access quality care. In addition, training programs for healthcare providers in refugee healthcare and humanistic competency are an underutilized but valuable tool.³⁸

Often the best interpreters may be the refugees themselves. In Lampedusa, culturally competent translation was achieved through the help of cultural mediators. In one example, a Somali woman who was serving as a cultural mediator was not only able to translate between the patient and physician but was also able to reassure the patient, amid her fears, that the physician would be able to safely address her concerns regarding being a survivor of female genital mutilation.³⁹ Similar sentiments were expressed by those who had provided medical care in Za'atari. Some of their best interpreters had been residents of the camp, so they understood the culture of the camp, including extra resources for patients to access.⁴⁰ In Jordan, Syrian refugees are not legally allowed to work, so opportunities to utilize their capabilities, as well as make an income from NGOs (e.g., as interpreters) are invaluable. These types of services are key to not only helping refugees as patients but also for empowering them to be involved in the provision of services.

The provision of quality healthcare requires more than just physicians. For example, healthcare teams in Lampedusa include a physician, nurse, psychologist, and anthropologist.⁴¹ In Za'atari, many organizations have multidisciplinary models, such as Bright Future for Mental Health, which utilizes psychiatrists, psychologists, social workers, students, and volunteers to coordinate its mental health services.⁴² Cross disciplinary teams are critical for the integration of healthcare services to not only help patients more effectively but also to maximize the limited resources.

Training in cultural competency can be difficult to design and implement since it may require years of experience. In responding to the current crisis, many healthcare providers do not have this level of training. In addition, allocating resources toward cultural competency training may be difficult since these skills are not easily measurable as technical skills. Nevertheless, this area has been identified as an important focus for individuals, organizations, and governments. For example, formal certificate courses for refugee health and trauma have been established, such as Unite for Sight's Certificate in Refugee Health and Harvard Medical School's Global Mental Health: Trauma and Recovery Certificate Program.⁴³ Other local solutions include case-based learning, shadowing opportunities, and Internet courses for remote learning.

Before healthcare providers work with refugees, improved training can help them manage the difficult situations and stressful experiences they may encounter in the field. They should be equipped with coping techniques in order to avoid burnout, feelings of anger, cynicism, and trauma.⁴⁴ While not directly related to healthcare provision, advocacy is a critically important method for spreading awareness about the support needed for refugees, especially due to the huge scale of the crisis. For example, physicians, nurses, and other volunteers who return from service missions have a unique opportunity to become advocates for refugees, whether by telling their stories to colleagues or organizing awareness events. They should have access to different resources for engaging their communities and effective methods for communicating their experiences. In addition, local responses to refugees can have broader, positive effects on the host communities. For example, Bright Future for Mental Health was the first organization in Jordan to provide mental health services for Syrian refugees and has since been able to raise awareness about the pressing need for similar services for Jordanians.

Recommendations

The above findings have been used to develop recommendations for improving healthcare for refugees in the following four areas:

1. Integrated healthcare models

The coordination of healthcare services should be centralized with one entity, whether in response to refugee arrival in Lampedusa or in Za'atari. By doing so, services can be integrated into an overarching model of care. In the case of mental health, screening and treatment should be combined with primary healthcare services. This model would replace the vertical model of mental healthcare in place and create a more integrated approach to make mental health an important component of general healthcare. This would also require increasing the availability of psychiatrists and psychologists, as well as having them trained in cultural competency. Counseling options for pediatric and adult patients should also be provided, as well as educational materials to help refugees understand signs and symptoms of mental health disorders, to reduce stigma and confusion surrounding these disorders, and to improve utilization of health services.⁴⁵ However, as recent international guidelines suggest, psychotherapeutic treatment should not be started when there is no infrastructure in place for necessary follow-up.⁴⁶

2. Training healthcare providers

Training local healthcare providers will help increase cost effectiveness and sustainability. In the case of Za'atari, Jordanian physicians have higher linguistic, religious, and cultural concordance with the Syrian refugees compared to physicians who come from other countries. Furthermore, the hiring of the local workforce can contribute to the local economy. Therefore, the refugees themselves should be trained to act as interpreters, especially in camp settings, where such opportunities can lead to local empowerment as well as sustainable delivery. In addition, healthcare providers may encounter liabilities and risks by providing services in areas not covered by their medical licensures and insurance. Certificate programs in refugee trauma and healthcare, as well as tools like that provided by the National Child Traumatic Stress Network, are tremendous resources that should be encouraged for use by students and professionals. These programs could be part of the larger initiative in cultural competency training, which

can help improve recognition of medical problems, build trust and relationships, provide a context for seemingly unusual behaviors, and improve communication between patients and providers. In fact, some European universities are already moving to include cultural competence training in their medical school curricula through the CHANCE consortium, which has developed courses focused on migrant health.⁴⁷ In addition, on November 23–24, 2015, Italy's MOH and the WHO/Europe organized a meeting on Refugee and Migrant Health.⁴⁸ Such meetings are critical because they promote continued communication among the various actors involved in the response as well as public dissemination of the results to governments and NGOs.

3. Robust documentation mechanisms

An important barrier to providing healthcare to refugees is poor documentation. A system for tracking the top health issues, including infectious disease outbreaks, and the utilization of resources has been put in place in Za'atari and Lampedusa. This has helped to identify gaps in care and training, and should be a priority in all other settings. However, health record documentation, which is currently minimal, requires more attention in order to improve continuity of care, especially if refugees are always seeing different providers. Organizations should be encouraged to develop standard operating procedures that require documentation and transparency, which could be facilitated by utilizing mobile technology. For example, "one-stop shops," which gather all the main public services needed by refugees, have been used in Portugal and could serve as an example for improving documentation. This model not only facilitates access and navigation for refugees but also makes it easier to document, coordinate, and track services provided to refugees.⁴⁹

4. Funding and advocacy

Continued funding from the international community is a major factor in providing adequate services and resources for refugees. Efforts by the UNHCR in Za'atari and the Italian government in Lampedusa to coordinate activities will help utilize funding efficiently to increase integration, reduce duplication, and address gaps. Advocacy efforts can increase awareness and help maintain adequate levels of funding from the international community. For example, healthcare providers who work with refugees, such as through volunteering with the Syrian

American Medical Society in Za'atari, can participate in conferences, give interviews on the radio and other forms of media, write opinion articles or blog posts, and mentor students and colleagues in order to advocate for and increase awareness of the need for better health services for refugees locally and internationally.

The Emerging Leaders Program

The Emerging Leaders Program prepares the next generation of leaders in Chicago's public, private, and nonprofit sectors to be thoughtful, internationally savvy individuals by deepening their understanding of global affairs and policy. During thought-provoking discussions, dinners, and other events, participants gain a broader worldview, hone their foreign-policy skills, and examine key global issues. Emerging Leaders become part of a network of globally fluent leaders who will continue to raise the bar for Chicago as a leading global city.

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Their efforts have resulted in another great group that the Council is proud to have as Emerging Leaders. Our sincere appreciation goes to the Patrick G. and Shirley W. Ryan Foundation for their support of the Emerging Leaders class of 2016.

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Dr. Sethi is on the steering committee and is an assistant director of outreach for the Center for Global Health at the University of Chicago. After attending medical school in Pakistan, she completed her postdoctoral fellowship, internship, and residency in dermatology at Yale University, where she also was chief resident. Her interests in tropical medicine, immigrant minority and refugee populations, and global infectious diseases with dermatologic manifestations have led her to field work in Pakistan, Malawi, the Hospital for Tropical Diseases in London, and Tanzania. She is especially interested in addressing global access to medical care, medical diplomacy programs, and improving medical training and dermatologic therapies in developing countries. In 2010, Dr. Sethi was chosen for the leadership program sponsored by the American Academy of Dermatology. She has set up a dedicated dermatology elective exchange program with Kamuzu Central Hospital in Lilongwe, Malawi, for medical students and dermatology residents since 2007. Her albinism awareness work in Malawi has been featured by national media in the country several times and has been recognized and supported by the Malawian government. In 2010, Dr. Sethi was awarded the Presidential Volunteer Service Award from the White House Council on Service and Civic Participation for her volunteer efforts.

Endnotes

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