Syrian Refugee Relief: A Recent Graduate's Volunteer Experience

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The Experience

With the Syrian crisis now pushing well into its fifth year, the refugee crisis that has resulted is part of the world's worst—comprising the highest number of forcibly displaced people since World War II, the greater majority of them being Syrians. Lebanon and Jordan are the countries hosting the largest number of refugees in relation to their national populations (Available from: http://www.refworld.org/docid/57678f3d4.html, updated 2016 Jun 20; cited 2016 Jul 22). Of a total population of 9.5 million, Jordan hosts 1.3 million Syrian refugees, of which 635,325 are registered with the United Nations Higher Commission for Refugees (Available from: http://www.unicef.org/jordan/media_10894.htm, updated 2016 Apr 30, cited 2016 Jun 21; https://www.amnesty.org/en/latest/news/2016/02/syrias-refugee-crisis-in-numbers/, updated 2016 Feb 3, cited 2016 Apr 30). As doctors-in-training at the primary medical center in the north of Jordan, these bitter realities have made their way through to us ever since the onset of events in Syria in 2011; we have seen an increasing number of patients arriving from war-torn regions only a few kilometers away.[1]

This has led me to seek opportunities where my background as a recent medical graduate proficient in the Arabic language would be of benefit to those seeking refuge, as well as help foreign health workers traveling from abroad to provide much-needed relief. One such opportunity presented with the then-upcoming mission of the Syrian American Medical Society (SAMS), a non-profit organization based in Washington, DC, that organizes such missions to Jordan thrice annually. In 2015, SAMS treated over 2.6 million people; comprising 2.3 million in Syria, 181,450 in Jordan, 86,932 in Lebanon, and 54,313 in Turkey (Available from: https://www.sams-usa.net/foundation/index.php/what-we-do/where-we-workhttps://www.sams-usa.net/foundation/index.php/what-we-do/where-we-work, cited 2016 Apr 30). After coming across a brochure at a local health facility, I submitted an application online as a medical volunteer. Several days later, I received acceptance as part of the SAMS sixty-member team—their largest to date—for the upcoming one-week mission in April 2016.

Following the orientation session provided on the first day, we learned about the dire status of refugees in camps as well as urban centers,[1] where some services such as dialysis and mental health care are not readily available to those needing them the most.[2] The reemergence of previously eradicated communicable diseases in Jordan, such as tuberculosis, polio, measles, and leishmaniasis has been of particular concern, and as such part of the objective was to help underserved locals (Available from: http://carnegieendowment.org/2015/09/21/jordan-s-refugee-crisis/ihwc, updated 2015 Sep 21, cited 2016 Jul 21). These findings come as a result of the disparity of health services received in Syria, especially following the onset of events in 2011; for instance, the prevalence of pulmonary tuberculosis in Syria during that year was 23 per 100,000 persons, compared to 7.7 per 100,000 persons in Jordan, approximately three times higher.[3] The majority of physicians with the mission were from the United States, with two being from the United Kingdom and one from Canada. Only two others were recent graduates like myself. Military and medical license checks were required of us all to process our entry permits to the Zaatari camp in the north (***Figure 1***), now being called Jordan's fifth largest city, and considered the second largest refugee camp in the world.[4]

Our time over the week-long April mission was spent in a multitude of settings, both rural and urban. Three of those days were spent at Zaatari, where the sheer size of the camp and miserable situation of its residents left the most impact on us. Although temperatures during the day were blazing hot, we noticed that the refugees were wearing mainly long-sleeve winter clothes, likely due to the cold desert conditions they had to endure at night. The first few days saw most of our team develop a transient depressive state; the realization hit us that we had been privileged in our upbringing; developed cities where all necessities had been provided, and yet we had managed to come forth with our own annoyances of "first-world problems"; whilst here even the most basic of services, such as access to clean water, health and a stable roof above one's head were matters in question.

The cases I witnessed at the make-shift medical facilities in the camp ranged from upper respiratory tract infections and chronic non-communicable diseases, such as hypertension and

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Figure 1. Zaatari Refugee Camp for Syrian Refugees in the North of Jordan as Seen on July 18, 2013

The population of the camp reached its maximum in April 2013 at 202,993 people. It currently hosts 79,900 persons (Available from: http://data.unhcr.org/syrianrefugees/settlement.php?id=176&region=77&country=107, updated 2016 Sep 18, cited 2016 Sep 25).

diabetes at the general medicine clinic; to complex murmurs, supraventricular tachycardia, a Tetralogy of Fallot, and long QT syndrome at the cardiology clinic. Although I was offered the responsibility of individually caring for patients, I preferred to work alongside more experienced physicians, as I felt I was not yet comfortable working in such a setting. In addition to extensively obtaining medical histories and performing physical examinations due to my good command of the language, I was taught the basics of operating an echocardiogram—this specific device being the sole one at the camp, a portable echo borrowed from the United States for this mission. Several translators were unable to attend, so I did serve as the primary means of communication between a few physicians and their patients, a task that was rewarding in itself. We also got to know a small number of nurses who were themselves refugees, although they told us that many of their colleagues and physicians in Syria had sadly not made it out of the war.

It is worth noting that the time spent was not devoid of hurdles. On multiple occasions, medication dosages had to be reduced because of the limited quantity of supplies. This also applied to essential medicines, such as antibiotics, which put both the patients and those in their vicinity at risk from possible bacterial resistance, and forced us to walk the tightrope between beneficence and nonmaleficence. In addition, a number of cases were in critical condition at our arrival, with some needing referral from one site to another with more equipped facilities. However, the admiration we developed towards these people and their uphill struggle for a dignified life was everything needed to push through and make this mission a success. On a personal front, the humble and yet momentous cardiologist, who generously gave me much of his time, instilled in me the desire to pursue a fellowship in cardiology upon completion of residency, and continue to offer my services as a physician to those most in need well-on into my career.

By the end of our mission, the SAMS team had seen over six thousand patients, and tertiary specialists had performed seventy-four procedures, including reconstructive surgeries and cardiac catheterizations. We had heard many heartbreaking stories about fleeing death, disaster and destruction; children of meager ages acting as guardians and providers for their younger siblings, but we were also showered with goodwill, honest smiles and words of appreciation for all that our mission had provided them with specifically, and generally to the other organizations and host communities that had shared what limited resources they had. During our final hours at Zaatari, a few of us were even invited into a refugee home, where we found our generous hosts had begun preparing lunch for us. We had to decline the offer, but were left with heartfelt wishes for us to visit upon their return to a peaceful Syria.

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