Partnership for the Advancement of New Americans

SAN DIEGO COUNTY REFUGEE EXPERIENCES REPORT

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ABOUT PANA

The Partnership for the Advancement of New Americans (PANA) fights to advance the full economic, social, and civic inclusion of refugees in the San Diego region, throughout California, and across the country. PANA conducts a biennial survey with refugees in San Diego County to better understand the needs of our communities. The results of these surveys and discussions drive the organization's priorities for the following two years.

ACKNOWLEDGEMENTS

Tremendous thanks go to the refugee community across the San Diego region. They thoughtfully and diligently completed our surveys and trusted us with their stories and information. We would also like to thank the Karen Organization of San Diego for their support in surveying Karen and other ethnic minority refugees from Burma.

This report would not have been possible without the incredible PANA team—Jeanine Erikat, Mustafa Dib, Rahmo Abdi, Sara Al Agha, Ikra Awaleh, and Mumtaz Momand—who put countless hours into the house meetings, surveys, and community conversations that resulted in this report. Vinton Omaleki and Ashkan Hassani of UC San Diego did important research and statistical analysis.

Finally, we thank our philanthropic supporters. Without their investment and partnership our work would not be possible.

SUMMARY

After World War II, the United States began accepting refugees with the purpose of assuring that individuals forced to flee their homes due to war, famine, and other disasters have a safe and legal path to rebuild their lives in the United States. In 1980, when the refugee program was formalized, cash and medical assistance was made available to newcomers for up to 36 months. Once a worldwide model for welcoming refugees, the United States refugee resettlement program has seen several decades of underinvestment. Since 1991, assistance programs have been limited to eight months and requirements for eligibility have become increasingly restrictive.[1] The program was further decimated by the Trump administration through executive orders that systematically targeted key elements of the U.S. Refugee Admissions Program (USRAP), resulting in an 86 percent reduction in the number of refugees admitted into the country between 2016 and 2020.[2] The decline in U.S. refugee admissions comes at a time when the number of refugees worldwide has reached the highest level since World War II.[3]

Early employment has been a principal priority and policy for the U.S. resettlement program. However, this approach, when combined with cuts in cash assistance from 36 to 8 months, has meant that refugees are pushed into low-wage work and deprived of opportunities to upskill, recertify degrees from their home country, and get language support that could benefit their long-term economic and social wellbeing. As a result, refugee communities not only face significant barriers to family-sustaining employment, but also lack access to safe and affordable housing and health care.

PANA's biennial survey provides an in-depth look at the refugee experience. This year's report is particularly timely as it reveals how refugees are fairing through the global pandemic, the economic downturn, and the rise in white supremacy, Islamophobia, and hate crimes. The survey's key findings show that:

- **The unemployment rate in the refugee community is more than three times higher** than San Diego County's unemployment rate.
- **There is hidden homelessness:** 65% of refugees were living in overcrowded homes during the peak of the pandemic.
- **Fear persists** in the midst of xenophobic and anti-immigrant political rhetoric.
- **Refugees are facing a severe mental health crisis:** approximately 53% of respondents reported worrying about their emotional health, including feelings of anxiety or depression at least half the time or more.
- **Refugees may be more vulnerable to COVID-19** given low testing rates, lack of trust in health professionals, and high rates of vaccine hesitancy.
- **Refugees are experiencing an increase in food insecurity, job loss, household violence and issues related to school closures** since the start of the COVID-19 pandemic.

The survey findings can inform policymakers and community advocates as to the needs of refugee communities. To that end, we outline the following priority areas where policy reform is needed:

- **Dedicate resources to upskill refugees** into family sustaining jobs.
- **Prioritize rapid access to affordable housing** upon initial resettlement to ensure the health and safety of refugee families.
- **End law enforcement collaborations** that result in the heightened surveillance and harassment of refugee communities.
- **Invest in culturally competent healthcare providers** and in-person medical interpretation and translation services.
- Invest in culturally competent, affordable, and accessible **mental health care resources.**
- **Provide direct support to refugee families to navigate distance learning,** including language support and devices such as headphones for students.

After years of assault and systematic dismantling, we must strive to rebuild the U.S. Refugee Admissions Program. But we must also remember that while we hailed the U.S. program as a global model, in reality we resettled the most vulnerable families and children into conditions most thought they would leave behind in refugee camps. It is vital that we reimagine resettlement and build a program that not only increases the numbers of refugees resettled, but also ensures investment in strategies that enable families to rebuild their lives, their home, and achieve long-term success.

OVERVIEW OF METHODOLOGY

This survey was administered from September to November of 2020 by the Partnership for the Advancement of New Americans (PANA) with technical support from the University of California San Diego's Herbert Wertheim School of Public Health and Human Longevity Sciences. **The 77-question survey was completed by a total of 544 refugee community members living in San Diego and examined the following topics: health, employment, education, housing, COVID-19, safety and belonging.**

Consistent with PANA's practices and values, the project utilized a participatory action research (PAR) approach to data collection by centering refugee community members and staff as primary data collectors and interlocutors. The study utilized an interviewer-administered survey. The survey was developed by PANA, with technical support from the University of California, San Diego. Individual survey items were drawn from a number of sources, including the American Community Survey (ACS)[4] and the NIH PhenX toolkit.[5] The study team reviewed each item and the survey as a whole iteratively, considering how each item would translate both linguistically and culturally. The survey was developed in English and written translations were made into Spanish and Arabic. Translations were reviewed for accuracy by PANA staff, and questions about specific items were discussed with Dr. Fielding-Miller and the PANA team to modify wording.

All interviewers were trained on the purpose behind the survey and survey administration methods. Interviewers were linguistically and typically culturally matched with study participants to allow for any necessary interpretation (i.e., Somali interviewers interviewed Somali speaking participants, Karen interviewers administered the survey to Karen participants). Interviews were administered in Arabic, English, Pashto, Dari, Karen, Karenni, Burmese, Oromo, Somali, and Swahili. Minor modifications were made in the first week of survey deployment based on initial feedback from survey administration staff. Dr. Fielding-Miller also met with the study team weekly to provide feedback on oral translations and other questions by the survey interviewers. Participants were community members who had engaged with PANA in the previous year and provided their contact information. Data were collected using Qualtrics software and analyzed using STATA 15[6] and ArcGIS.

Taking a participatory approach to research provided an opportunity to engage community members in-language in online conversations and at outdoor, physically distanced meetings. In addition, a subset of 60 survey respondents were invited to a total of seven Community Conversations that focused on the priority issue areas of housing, safety and belonging, health, employment, and education. Two community conversations were conducted in Arabic with predominantly Syrian refugee community members on the issue of housing, one community conversation on belonging was held in Somali, one health COVID-19 conversation was facilitated in Oromo, one conversation on education was hosted in Karen and Burmese, one conversation on employment was done in Pashto and Dari, and one safety and belonging conversation was held with Somali youth in English.

Quotes from these Community Conversations were incorporated into the report to provide context and individual testimony behind the quantitative analysis. In addition, PANA's participatory action research (PAR) approach provided a means for the community to talk about pressing issues and strategize about action-oriented goals. In other words, the PAR approach provided a platform for data collection while also facilitating a space for the community and PANA to work together to envision and enact community-led solutions for change.

RESULTS

A total of 544 of 688 community members contacted agreed to participate in the survey, for a response rate of 80% (544/680). Surveys were typically completed in approximately 15-30 minutes. All responses were translated back into English for data analysis.

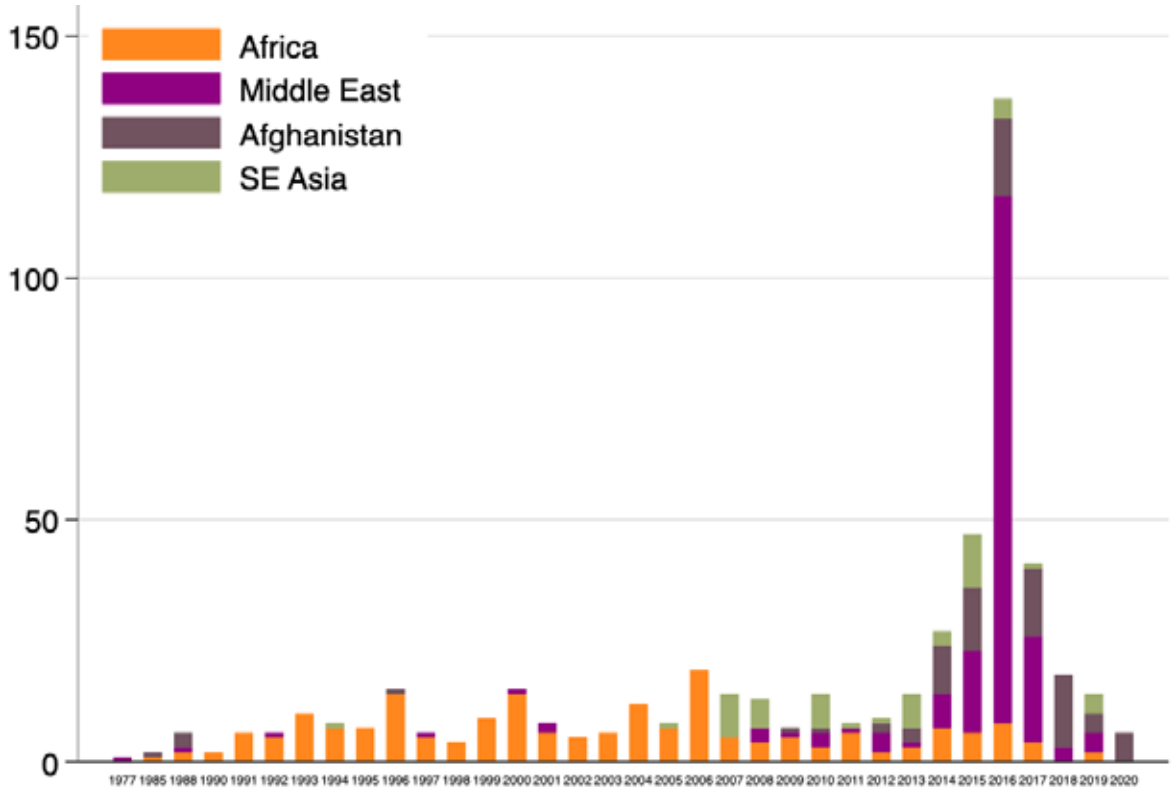
Approximately 38% of respondents were African, predominantly East African; 35% were Middle Eastern; 17% were Afghan; and 11% were Southeast Asian, predominantly Karen. Participants spoke over 25 home languages, including English, Somali, Arabic, Pashto, Dari, Farsi, Karen, Amharic, Oromo, Swahili, and Nuer. As shown in Table 1, participant ages ranged from 14 to 96, with a mean age of 39. While gender was distributed roughly evenly across the sample, there were significant asymmetries by region. The large majority of African and Southeast Asian respondents were women, while the majority of Afghan and Middle Eastern respondents were men. Participants had been in the United States for an average of approximately 10 years.

Table 1: Sample Demographics

REGION	AFRICA	MIDDLE EAST	AFGHANISTAN	SE ASIA	TOTAL
	N=205	N=184	N=90	N=56	N=535
AGE					
Median	37.0	42.0	36.0	35.5	39.0
Range	15.0 - 96.0	15.0 - 68.0	14.0 - 70.0	14.0 - 68.0	14.0 - 96.0
YEARS IN THE UNITED STATES					
Median	17.0	4.0	4.0	7.0	5.0
Range	1.0 - 35.0	1.0 - 43.0	0.0 - 35.0	1.0 - 26.0	0.0 - 43.0
ENGLISH SPOKEN AT HOME					
	82 (40.0%)	17 (9.2%)	73 (81.1%)	14 (25.0%)	186 (34.8%)
GENDER					
Male	51 (25.4%)	146 (79.3%)	79 (87.8%)	15 (26.8%)	291 (54.8%)
Female	150 (74.6%)	38 (20.7%)	11 (12.2%)	41 (73.2%)	240 (45.2%)

As shown in Figure 1, the arrival dates reported by participants reflect several decades of American refugee and asylum-seeking patterns. Survey participants who arrived from the early 1990s through 2006 were predominantly East African with a rapid growth in Southeast Asian arrivals from 2007-2015, and an increase in Afghan resettlement beginning in 2012-2013, likely reflecting the United States' special immigrant visa program for Afghans who were employed by or on behalf of the U.S. government. Middle Eastern arrivals grew exponentially beginning in 2014 as a result of the Syrian civil war. Syrian asylum seeking and resettlement was abruptly curtailed in 2017-2018 as a result of anti-immigration rhetoric and policies passed by the Trump administration in 2017.

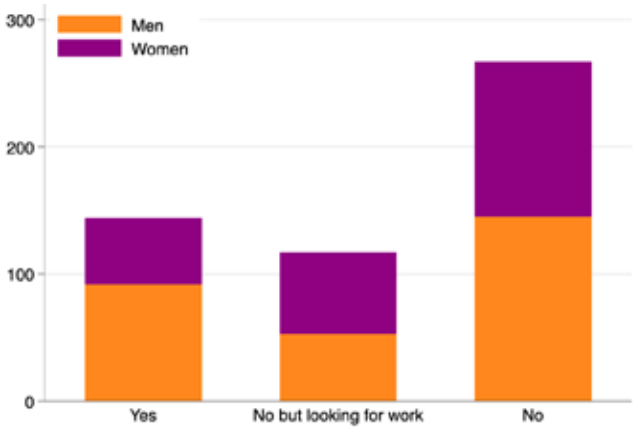
Figure 1: Year of Arrival by Region



THE UNEMPLOYMENT RATE IN THE REFUGEE COMMUNITY IS MORE THAN THREE TIMES HIGHER THAN SAN DIEGO COUNTY'S UNEMPLOYMENT RATE.

Survey participants were asked if they had "worked for pay at a job or business in the previous week." As shown in Figure 2, **only 27% of respondents (n=133) indicated that they "had worked for pay in the previous seven days," while 22% (n=106) indicated that they were "looking for work."** Over half of survey respondents (51%, n=253) were "neither working nor looking for work." In sharp contrast, the California Employment Development Department reported the unemployment rates in San Diego County as 6.6% during the same timeframe as this survey was taken, indicating that the unemployment rate for refugees in our sample was more than three times higher than the county average.[7]

Figure 2: Number of people who worked in the last week

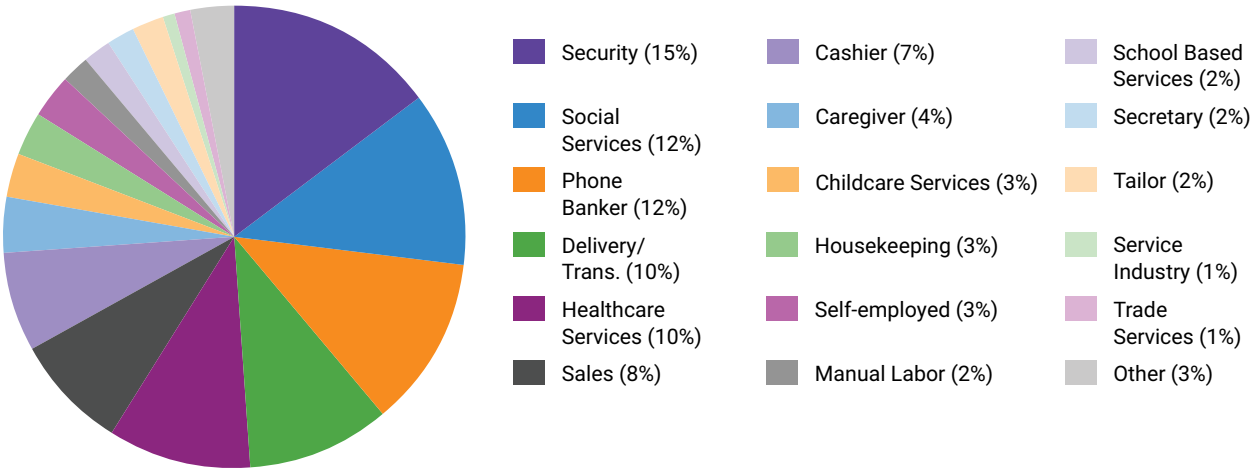


Of the 132 individuals who did work in the previous week, 44% reported working 30 hours or more and the median per capita income was a mere $1500 per month. Individuals who had lived in the United States longer reported

slightly higher salaries, and this remained true when accounting for the age of the respondent. For each year an individual had lived in the United States, they reported approximately $30 more in income per month (p=0.04). The median monthly income among individuals who had worked 40 hours or more in the previous week (n=24) was $2500, equivalent to $30,000 a year. In comparison, the average median household income was $68,703 nationally and $83,985 in San Diego County prior to the pandemic in 2019.[8]

As shown in Figure 3, the jobs most frequently reported by respondents were security (15%), social services (12%), and phone banker (12%). Delivery, transportation, and healthcare service jobs were also very common (10%). Delivery and transportation jobs included Uber, Lyft, truck driver, and any other delivery service. The jobs reported reflect the wide range of skills, qualifications, and language abilities of those in the refugee community.

Figure 3: Refugee Employment



In community conversations, participants described the ways in which technical barriers have exacerbated the struggles with employment. Now that many aspects of job searching have largely moved to a virtual setting, participants stated that some of their community members do not have the technological savvy or resources to be successful. Participants shared that they would like to see more technical support training being offered to help them succeed:

> "We are unfamiliar with technology, and the resume and job application process is very new to us and so we would really like trainings to be offered to help us learn more about it."
>
> – Afghan community member in community conversation about employment.

Participants also expressed their concerns about how their inability to find work may leave them unable to care for their families or pay rent during the pandemic. Some participants shared that they or their spouses had been laid off while others shared that they or their spouses were still working, but were unable to request additional hours from their managers due to COVID-19 concerns. Participants reported that it had been difficult to look for new positions due to limited skill sets and English proficiency, reduced access to largely entry-level positions, or fear of exposure to the coronavirus that may affect their entire family.

> "We don't want to apply to new positions because we are worried about the health risk and exposing our family to COVID."
>
> – Afghan community member in community conversation on employment

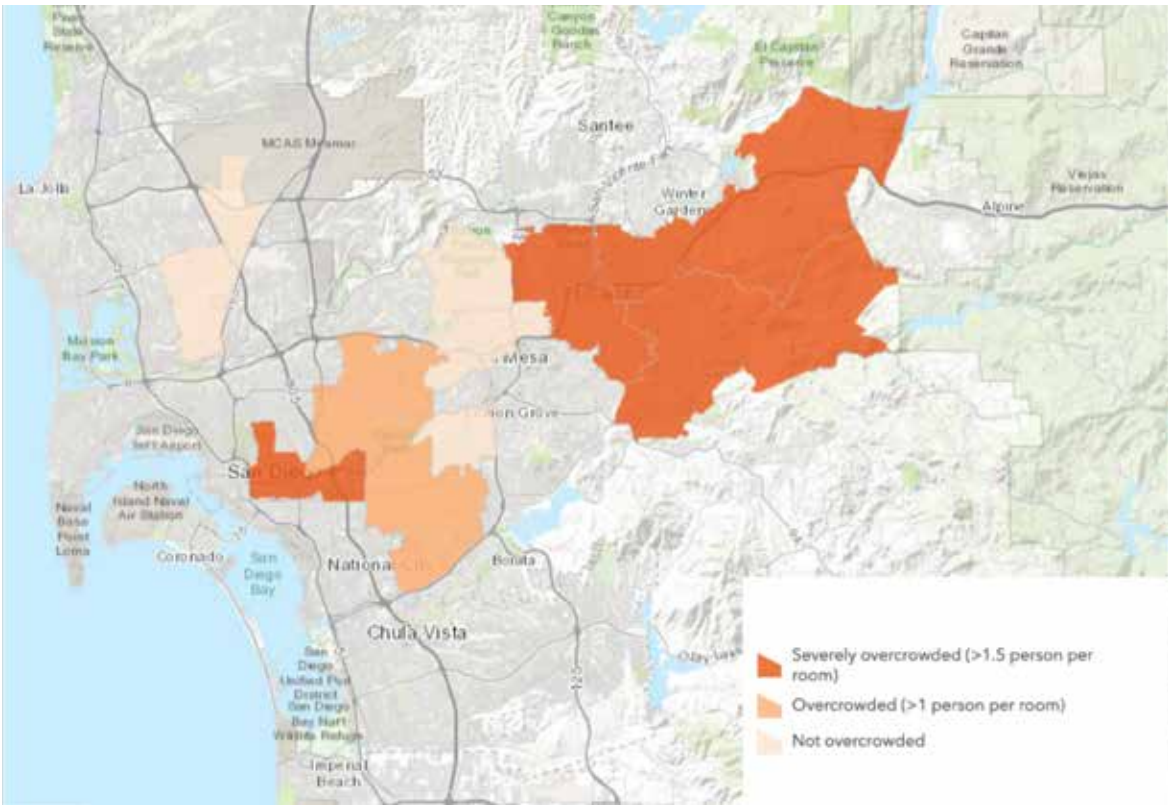
Similar to nationwide trends related to gender and unemployment during the pandemic, men were 80% more likely to report being employed than women – two-thirds of survey respondents who reported working in the last week were men, while 58% of those who reported they were looking for work in the previous week were women (p=0.003). This discrepancy may also have been exacerbated by the pandemic. One participant in an Arab speaking focus group explained that Arab women had been relying on their husbands to find work so that they could take care of their young children. This trend has been exacerbated by school closures brought on by the pandemic.

THE HIDDEN HOMELESS: 65% OF REFUGEES WERE LIVING IN OVERCROWDED HOMES DURING THE PEAK OF THE PANDEMIC.

The California Department of Public Health classifies overcrowding by the number of individuals per room in a household.[9] More than one person per room is considered overcrowded and more than 1.5 people per room is considered severely overcrowded.[10] This epidemic is often called "hidden homelessness," in which families are forced to live in overcrowded spaces just to live under a roof. Across San Diego County, individuals who rent are disproportionately impacted by overcrowding compared with those who own their own homes (6.4% versus 2% across the county as a whole).[11]

Survey responses suggest that overcrowding and hidden homelessness are dramatically worse in the refugee community, with 65% of respondents (n=348) reporting they lived in overcrowded housing conditions, and a disturbing percentage of those living in severely overcrowded conditions. A shocking 61% of respondents living in El Cajon (n=97) were living in severely overcrowded housing. Severe overcrowding was an issue in other parts of San Diego as well, with 20% of respondents living in City heights (n=31) and 6% of respondents in College Grove (n=10) reporting severely overcrowded living conditions.

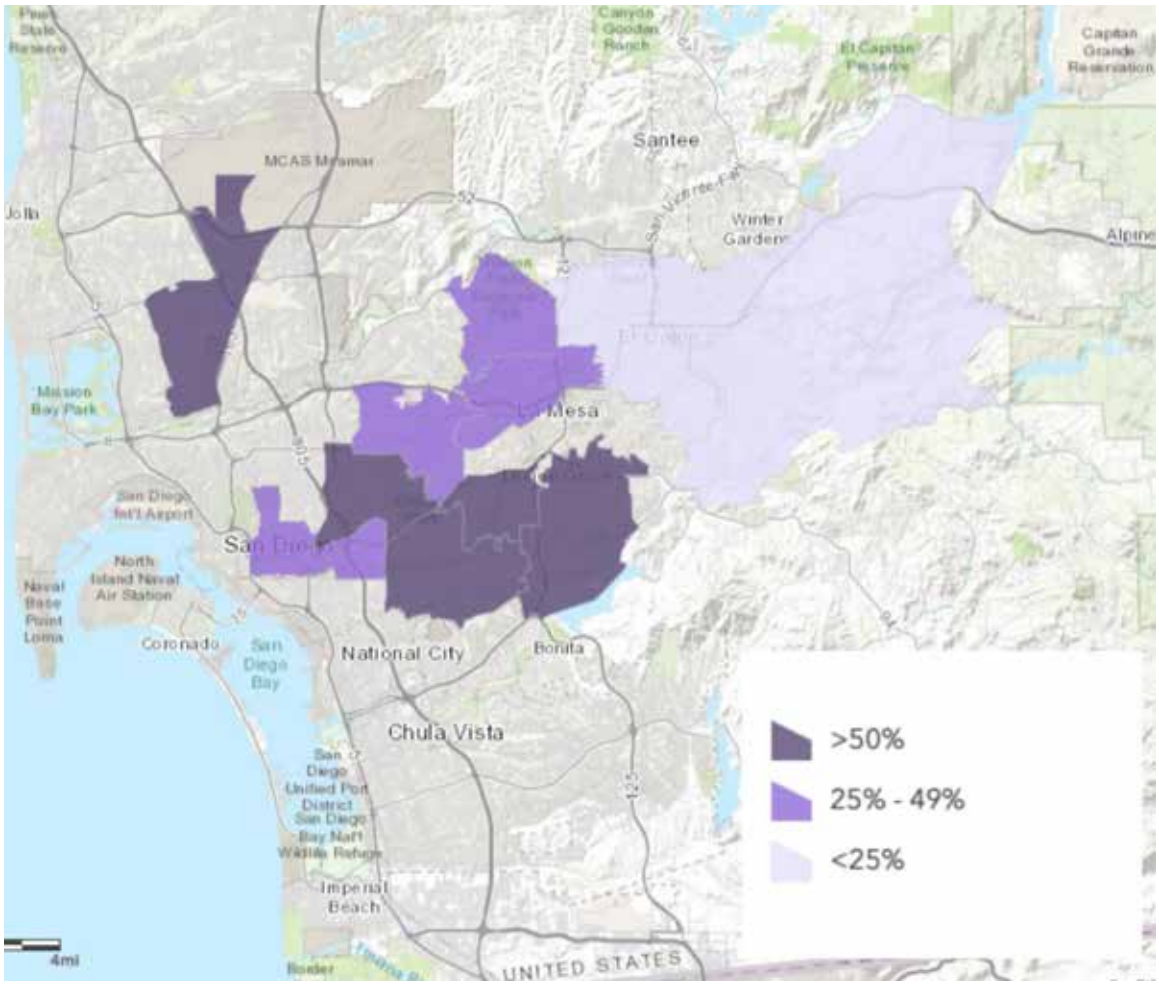
Figure 4: Levels of Overcrowding By Region



Nearly all survey participants (97%) rented their homes, which were typically 3-5 rooms and 2-3 bedrooms. The number of people in a home ranged from 0-13, with an average of 1.25 people per room. The majority of survey respondents lived in El Cajon (36%, n=197), City Heights (27%, n=146), and the College Grove area (14%, n=74), with additional small clusters of respondents in Encanto/Lemon Grove (5%, n=27), Linda Vista/Kearny Mesa (2%, n=12), and National City/Paradise Hills (2%, n=11).

After adjusting for whether a participant was married or cohabiting, access to affordable housing had the strongest effect on whether or not a participant was likely to live in severely overcrowded housing. **Individuals who reported living in affordable housing were 66% less likely to be living in a severely overcrowded setting** (adjusted odds ratio 0.34, 95% CI: 0.19–0.61). Only 31% of respondents reported living in affordable or subsidized housing, despite low rates of employment and low income among individuals who were employed. As shown in Figure 5, participants living in central San Diego were more likely to report living in affordable housing or having access to housing vouchers. Approximately 42% of individuals living in City Heights reported utilizing affordable housing resources, compared to just 5% of individuals living in El Cajon.

Figure 5: Percentage Living in Affordable Housing By Region



The longer an individual had lived in the United States was associated with a decreased likelihood of living in overcrowded housing, with each additional year in the U.S. associated with a 6% reduction in the odds of living in overcrowded housing (aOR: 0.93, 95% CI: 0.90 – 0.97).

Finally, overcrowding is not the only housing issue refugees face. Living conditions for refugees in general can be dismal. Over one-third of participants reported experiencing problems with "mold," "pests," "appliances that remained broken for over 30 days," or "other unhealthy conditions."

> "I got EDD the first couple of months but now there's been a mistake and now we only get $80 per month. We keep getting the same paper [notice] every month but we don't know what's going on and don't understand the process."
>
> – Syrian community member in community conversation on housing

Community members expressed major concerns over the combination of high rents and suboptimal, overcrowded living conditions. Community members were struggling to pay rent due to unemployment, loss of income, and issues with financial assistance. In house meetings, many participants described using non-housing related financial support, such as FAFSA, EDD, or food stamps to make up for lost income and pay off rent during the COVID-19 pandemic. Some participants stated they did not know there was financial support for housing for which they could apply; others described the process of applying as confusing and unclear. These issues were compounded by language barriers, technical barriers, and a lack of transparency from the agencies communities have been relying on for financial assistance.

> "When we sign a rent agreement, we sign it but we have no idea what we're agreeing to, we're just signing."
>
> – Syrian community member in community conversation on housing

Some participants felt like they were being taken advantage of by their landlords and expressed their frustrations with not being able to fully understand their rights as tenants due to language and technical barriers. Some participants felt they would benefit from attending a workshop on tenants' rights in order to better understand the conditions of their housing. Several participants described relying on children or other community members who spoke English well to help them navigate these documents.

FEAR PERSISTS IN THE MIDST OF XENOPHOBIC AND ANTI-IMMIGRANT POLITICAL RHETORIC.

> "We left our home country where we were around people that looked like me. We came to America to have a better and safer life for my kids but that is not the case. I don't feel that my children are safe in this country since they are outsiders even though they were born here."
>
> – East African Mother in City Heights

Ethnic communities shared varied experiences with racism, different perceptions of safety, and an array of concerns about anti-immigrant rhetoric. **African respondents were most likely to say that "anti-immigrant rhetoric strongly influenced their ability to participate in public life" – 65% felt "worried about being targeted by a hate crime," "speaking up in public," or "feeling welcome in public spaces."** Across all communities, approximately 12% (n=65) of respondents said that they had "definitely or probably" experienced a hate crime in the United States. Only 10% of Afghan and 33% of African respondents reported that they had "definitely not" experienced a hate crime, compared to 81% of Middle Eastern participants and 67% of Southeast Asian participants.

Comparatively, City of San Diego reports on hate crimes show only 26 reported hate crimes in the city for all of 2020, demonstrating significantly low reporting of hate crimes to law enforcement agencies.[12] In community conversations, victims of hate crime said they chose not to report to the police or authorities. Furthermore, refugees face extra barriers when it comes to reporting. Lack of English language skills,

mistrust of government, and lack of cultural understanding of the policing system in the U.S has made certain refugee communities less likely to report hate crimes of any nature.

The xenophobic rhetoric regarding national immigration policy has had a clear effect on the refugee community. Middle Eastern respondents were significantly more worried about immigration status – 72% expressed concern about their "own immigration status or that of their friends and family." In contrast, the vast majority of Afghan respondents (88%) reported that they felt no major concerns related to anti-immigrant rhetoric.

When asked what fears they have for their community, East African mothers reflected on the lack of safety and belonging they felt for themselves and their children: "I am a mother and I fear for my son who is black and Muslim. It is going to be harder for him in the world. I fear that when my son leaves the house that he won't come back safely. I always wait up and make sure he is home safe." Another mother stated, "I fear that I am not safe here in America because I wear a headscarf and that makes me a target."

In community conversations, Somali youth were asked if they felt they belonged. One participant responded, "I don't feel a sense of belonging here. In the Somali community I'm too American, and in America, I'm too Somali. So even though I was born here I don't feel like I belong here."

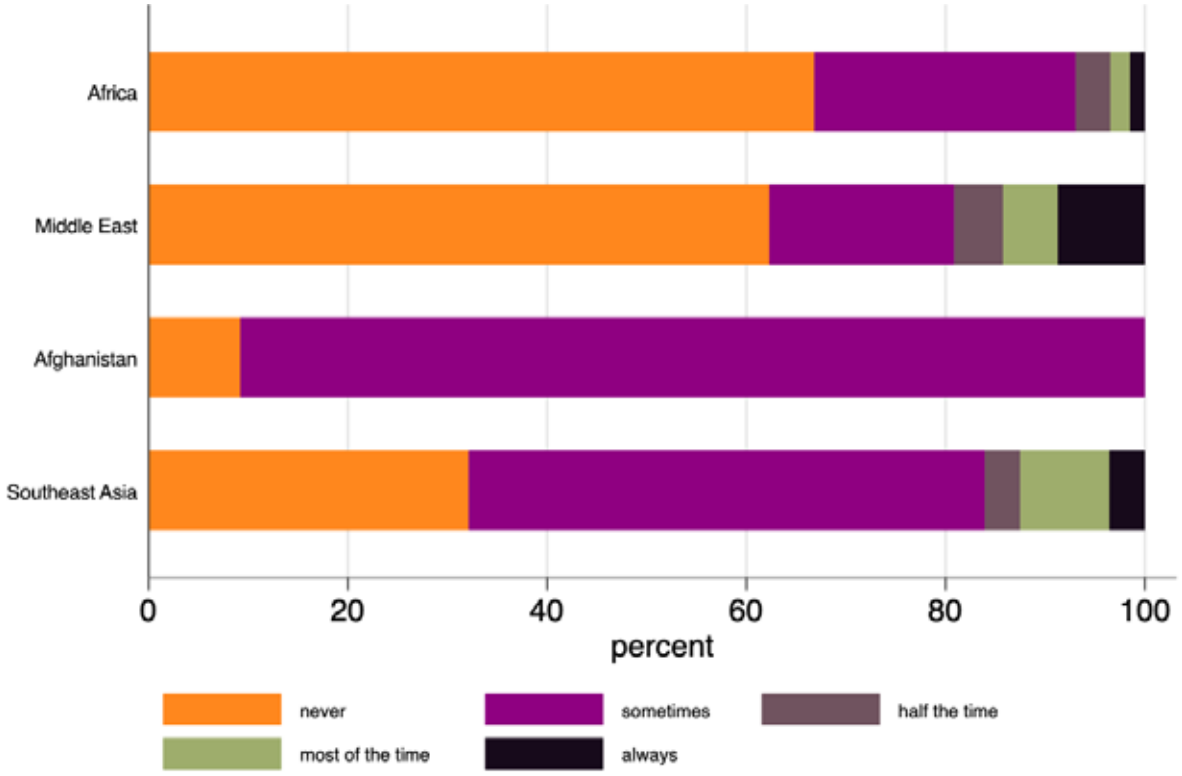
When asked about instances of discrimination by law enforcement, one respondent stated, "Coming to America we thought it would be better but it's not. Just being black, police are always gonna stop you and profile you, and you're always looking over your shoulder. I'm always going to have to live with that and my kids will too. I try to stay away from them [the police]. I know they hate us and it's never going to change. Whether rich or poor, they're always going to come after us because of our color."

REFUGEES ARE FACING A SEVERE MENTAL HEALTH CRISIS.

Although the majority of survey participants (87%) initially rated their overall emotional health as "extremely" or "somewhat good," when responding to more specific follow-up questions, **approximately 53% of respondents reported worrying about their emotional health, including feelings of anxiety or depression at least "half the time or more."** This is worryingly high, and nearly ten percentage points above the estimated 44% of Californians who reported struggling with mental health issues in the same time frame as report data were collected.[13]

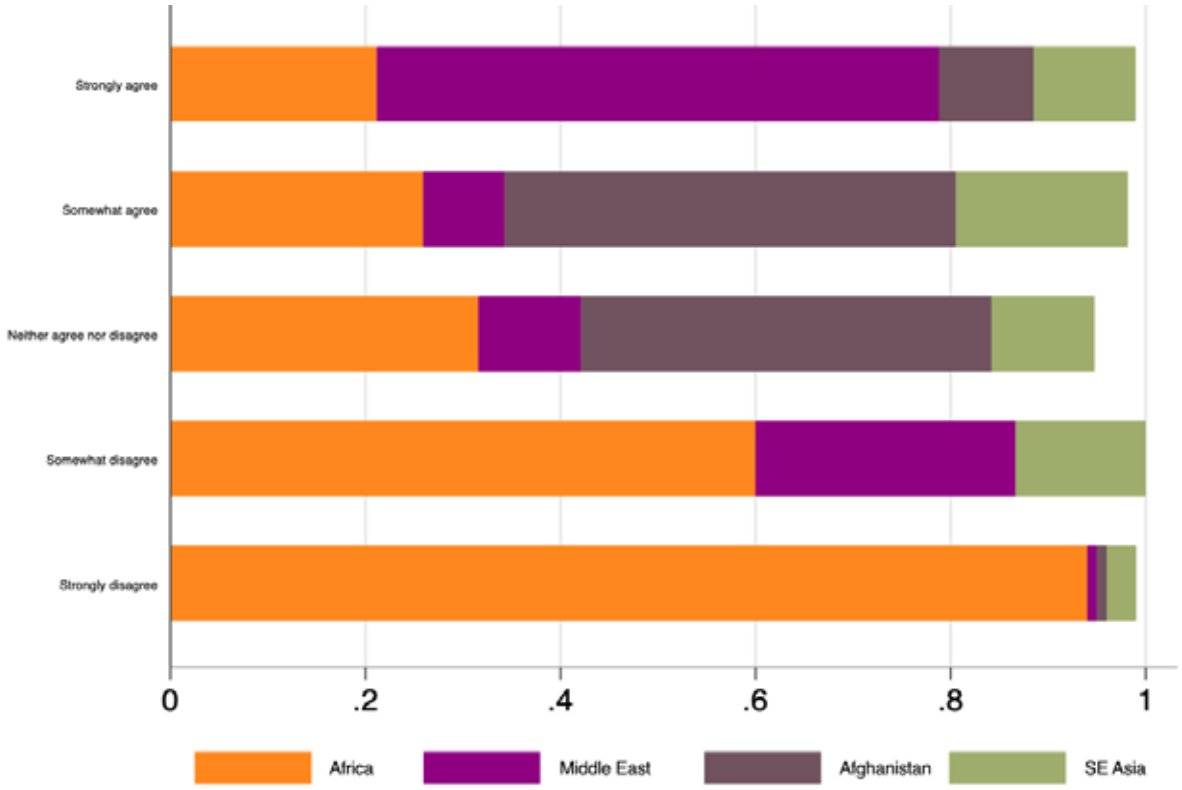
As shown in Figure 6, concerns about emotional health varied by region of origin. Nearly all Afghan respondents (90%) reported they were “sometimes” worried about their emotional health compared with 50% of Southeast Asian respondents, about 25% of African respondents, and approximately 20% of Middle Eastern respondents. Nearly 10% of Middle Eastern respondents reported that they were “always” worried about their emotional health.

Figure 6: How often are you worried about your emotional health?



Respondents were also asked about the degree to which the staff at their doctor’s office were culturally and linguistically competent. While on average 74% “agreed or strongly agreed” that staff at their doctor’s office understood their language and culture, there were significant differences by region of origin (see Figure 7). While 91% of Middle Eastern participants felt “strongly” that staff at their doctor’s office was culturally competent, only 31% of African, 32% of Afghan, and 54% of Southeast Asian respondents felt the same way.

Figure 7: Staff at my doctor's office understand my language and culture

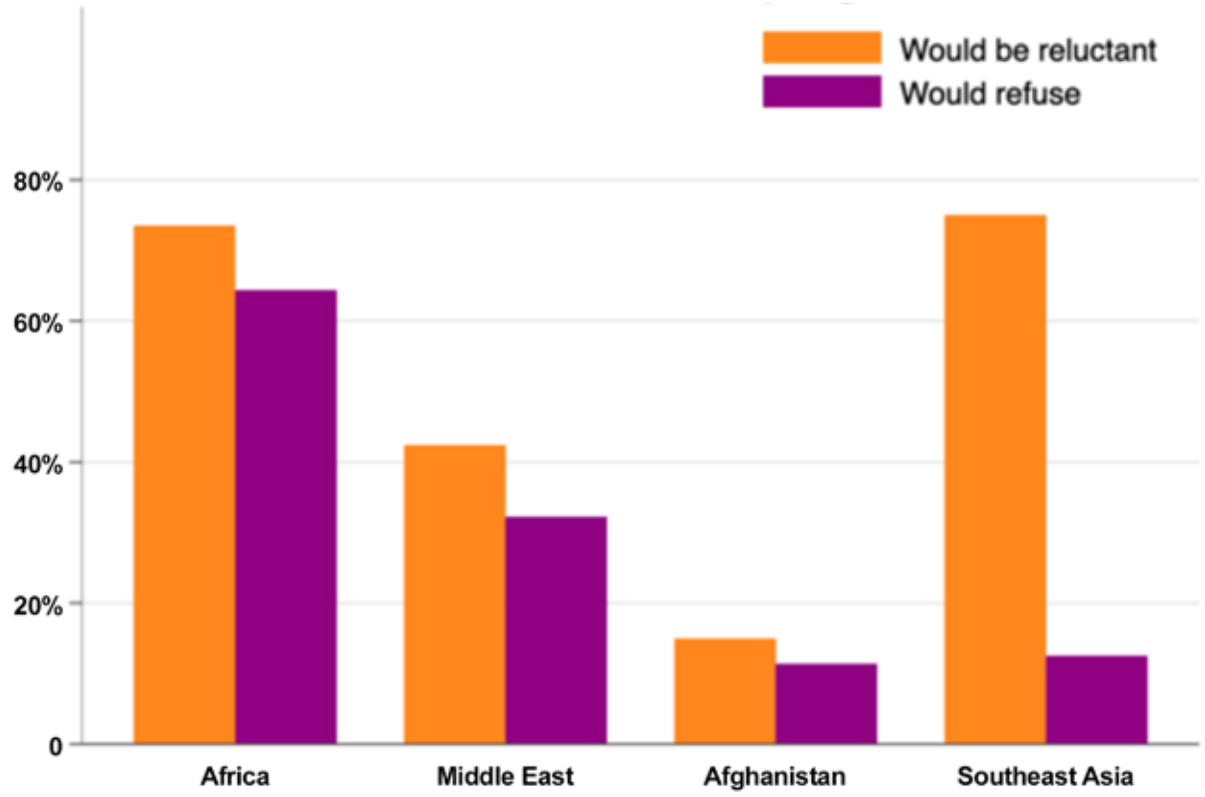


REFUGEES REPORTED LOW COVID-19 TESTING RATES, LACK OF TRUST IN HEALTH PROFESSIONALS, AND HIGH RATES OF VACCINE HESITANCY.

At the time the survey was conducted in October and November 2020, only one in four participants reported having ever accessed a COVID-19 test. Of individuals who reported "being exposed to COVID-19" or "being advised by a public health official or health care provider to test" (n=134), only two-thirds (n=88) reported that they had actually "accessed a test" at the time. The most typical reasons for not testing included "not having time to get tested" (44%), "not having transportation to a testing site" (34%), assuming that "there was little point in getting tested if there is no cure" (32%), "not wanting to know the results" (29%), "an inability to afford to isolate" (27%), and "not knowing where to get tested" (26%).

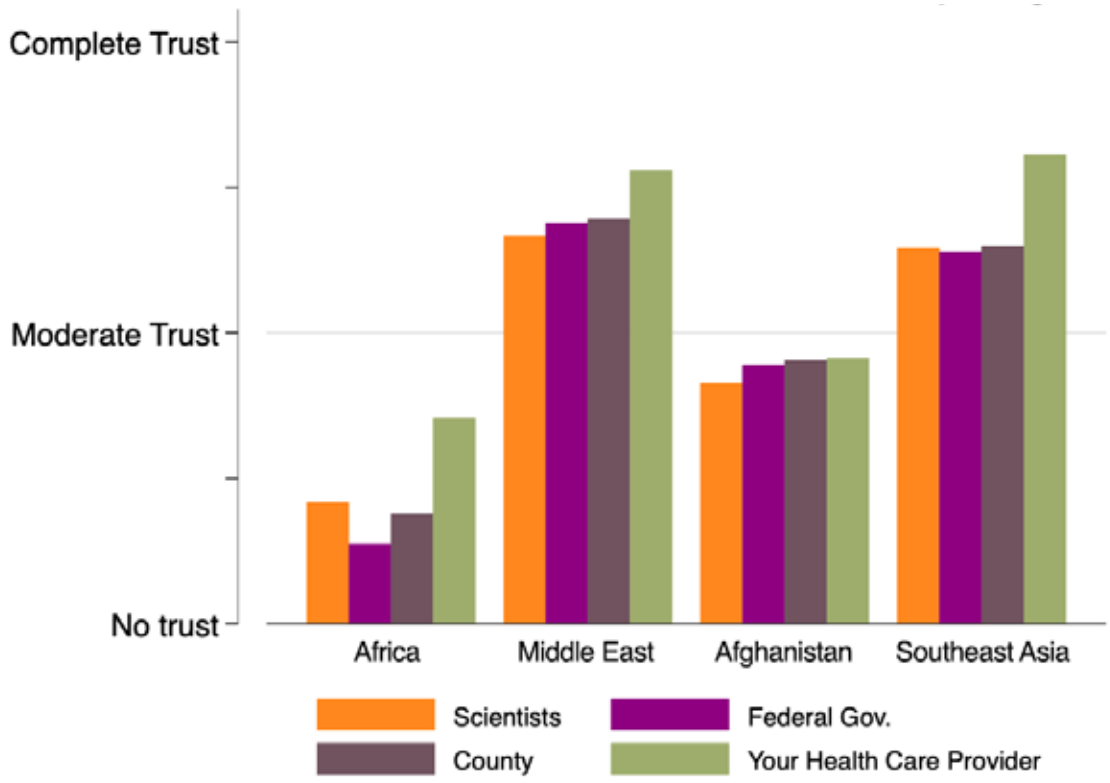
In addition to relatively low testing uptake after exposure or medical advice, there appear to be high rates of vaccine hesitancy in the San Diego refugee community. **Over half the sample (54%) reported that they would be "reluctant to access a COVID-19 vaccine,"** and 40% reported they would "refuse the vaccine." As shown in Figure 9, there were variations depending upon region of origin. Seventy-four percent of African respondents (n=147) and 75% of Southeast Asian respondents (n=42) reported that they would be "reluctant to access a COVID-19 vaccine," compared to only 15% (n=13) of Afghan respondents. And 64% of African respondents (n=130) reported they would "refuse the vaccine," compared to only 13% (n=7) of Southeast Asian respondents. African respondents were more than twice as likely to suggest they would "refuse a vaccine" than other groups surveyed.

Figure 8: Vaccine Reluctance by Region of Origin



As shown in Figure 9, all respondents were significantly more likely to trust their healthcare provider regarding vaccine advice than any other entity. Respondents found the federal government to be the least trustworthy, followed by scientists involved in developing the vaccine, county health officials, and their own provider. There were distinct cultural differences in levels of trust. African respondents were the least likely to trust any entity, followed by Afghan participants. Middle Eastern and Southeast Asian participants were more likely to "moderately" or "mostly trust" scientists, government, and their own healthcare provider.

Figure 9: Trust in Vaccine-Related Entities by Region of Origin



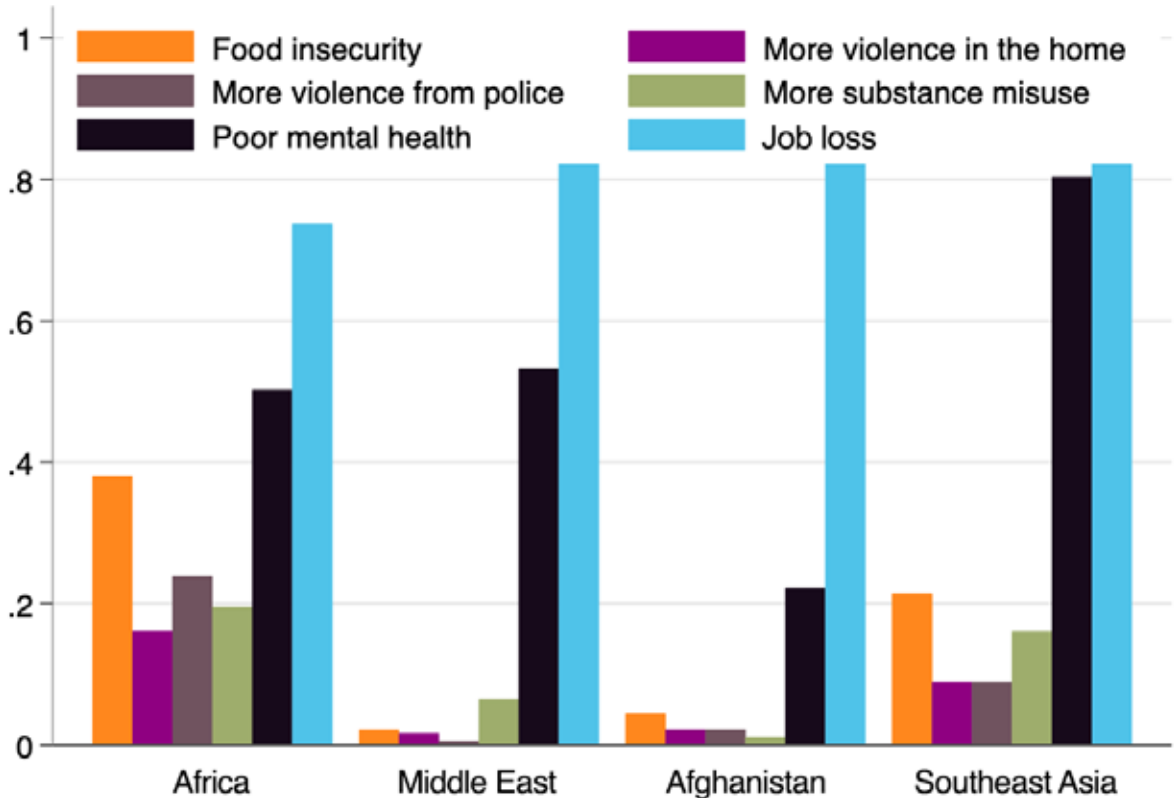
We conducted a multivariate logistic regression to assess the independent effects of provider cultural competence, language spoken at home, and participant demographics on how likely participants were to trust their health care provider's advice about vaccines. **We found that even after accounting for region of origin and age, participants who "strongly" believed that their health care provider had cultural competence, defined by understanding their language and culture, were 13 times more likely to trust their advice than participants who "strongly disagreed" that their provider was culturally competent (aOR: 13.3, 95% CI: 5.2–34.3).** Participants who "strongly disagreed" that their provider was culturally competent were 90% less likely to trust their advice regarding vaccines than participants who were neutral about their provider's cultural competency (aOR: 0.10, 95% CI: 0.02–0.46).

Participants who reported that English was spoken in their home were nearly 90% more likely to "mostly" or "completely" trust their provider's advice about vaccines, versus having "moderate," "little," or "no" trust (adjusted Odds Ratio 1.88, 95% CI: 1.02–3.51). After adjusting for perceptions of provider cultural competency and language spoken at home, Middle Eastern and Southeast Asian respondents were 3.8 and 5.4 times more likely, respectively, to trust their provider's advice about vaccines compared to African respondents (aOR: 3.8, p5% CI: 1.91–7.25 and aOR 5.4, 95% CI: 2.4–12.1, respectively). Afghan respondents were 78% less likely to trust their provider's advice compared to African respondents (aOR: 0.22, 95% CI: 0.11 – 0.45).

REFUGEES ARE EXPERIENCING AN INCREASE IN FOOD INSECURITY, JOB LOSS, HOUSEHOLD VIOLENCE AND ISSUES RELATED TO SCHOOL CLOSURES SINCE THE START OF THE COVID-19 PANDEMIC.

As shown in Figure 10, the COVID-19 pandemic has had a significant impact on the economic and social well being of the San Diego refugee community. **Over 80% of respondents reported significant job loss in their community since the beginning of the pandemic and one in five respondents reported that food insecurity had increased.** There were significant differences in reported community food insecurity. Nearly 40% of African respondents reported that food insecurity had increased in their community, compared to 21% of Southeast Asian respondents, and only 4% and 2% of Afghan and Middle Eastern respondents, respectively. Eight percent of respondents (n=43) reported that household violence had increased since the pandemic began. However, women were three times as likely to report an increase in household violence than men (12% vs. 4%), suggesting that increased gender-based violence may be a significant issue. Participants also reported significant increases in poor mental health (50%) and substance use (12%).

Figure 10: Consequences of the Pandemic in My Community

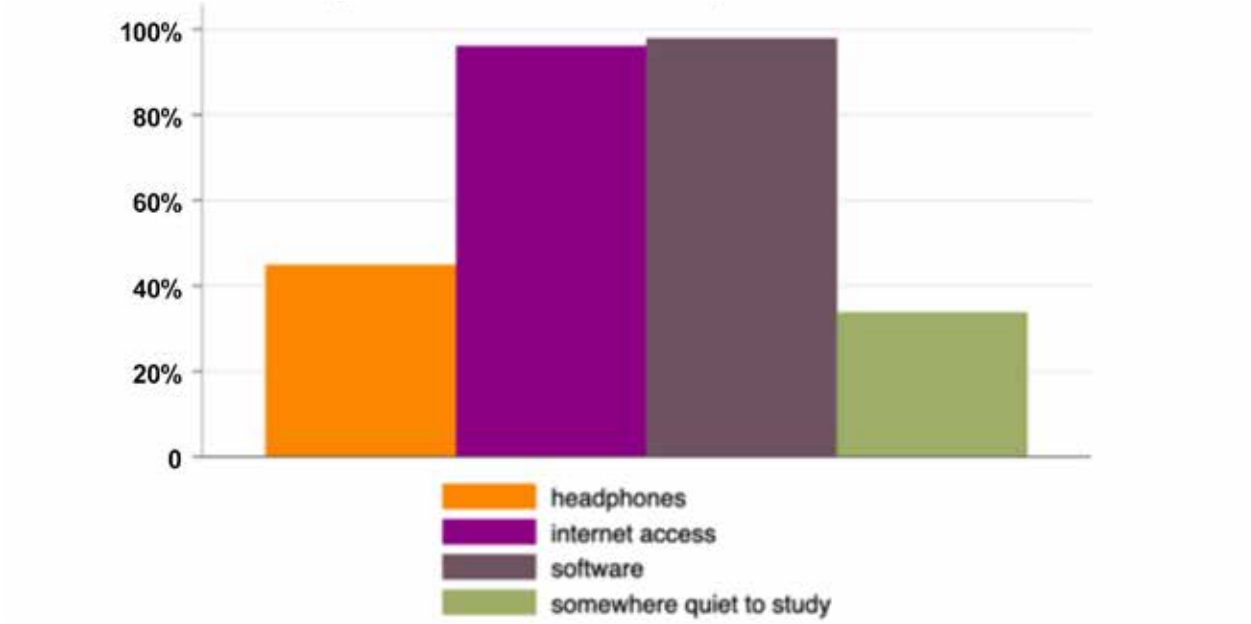


Many participants reported that the pandemic had resulted in job loss and severely curtailed their ability to seek new employment:

> "The scope of work we [the Afghan community] were doing and the fields we were working in such as hospitality, hotels, Uber, Lyft drivers, chef, etc. has greatly reduced due to the pandemic which means access to jobs has reduced."
>
> - Afghan community member in community conversation on employment

School closures and changes as a result of the pandemic have significantly impacted the refugee community. As shown in Figure 11, while nearly all parents (>96%) reported that their children have access to the internet and a computer or tablet to complete their schoolwork, only one-third reported that their children had somewhere quiet to study, and less than half (44%) reported that their children had headphones.

Figure 11: My children have what they need for school



Nearly all participants expressed their frustrations with remote learning, and some participants shared that they would be in favor of having their older children return to in-person learning at school for a few days a week. Parents talked about how online learning made it more difficult for their children to absorb

> "School is difficult. When we're in class physically it's easier for questions to be answered. Online schooling is hard to get questions answered"
>
> - Karen youth in community conversation on education

information, for parents to help their children with school work, and for children to stay physically active. Schools did not seem to be offering additional tutoring sessions for online learners. College students discussed how online learning made it difficult for them to keep in touch with their professors and to get in contact with counseling services.

POLICY RECOMMENDATIONS

DEDICATE RESOURCES TO UPSKILL REFUGEES INTO FAMILY SUSTAINING JOBS.

The refugee community across San Diego County is experiencing significant underemployment rates and the vast majority are living in severe poverty. Our survey found that 22% of respondents were unemployed and an additional 51% were "neither working nor looking for work." Amongst those that reported working full time in the previous week, their median monthly income was $2,500 monthly, equivalent to $30,000 a year, which puts the majority of respondents who were working below the federal poverty line.[14] Nearly half of respondents that reported working the previous week worked only 30 hours and made even less, with an average monthly income of $1500.

While the central goal of United States refugee resettlement policy is self-sufficiency, the emphasis has historically and mistakenly been on early employment, conditioning cash assistance on a requirement that refugees be actively seeking and accepting early offers of employment.[15] This laser focus on early employment, however, has pushed refugees into low wage jobs such as grocery workers, caregivers, transportation, and the gig economy. While these jobs are essential to local economies, for workers the time constraints of their employment make it difficult to enroll in education and job training programs that might result in career advancement and economic mobility. As a result, refugee families struggle to meet their basic needs and become mired in long-term poverty.

To address this issue and ensure refugee families are successful in attaining economic self-sufficiency, we must reimagine United States resettlement policy, turning the emphasis away from immediate employment in low wage jobs to greater investment in training and support for family-sustaining careers. As a first step, the Biden Administration and Congress should work together to amend current laws pertaining to refugees that make immediate employment a condition for receiving financial assistance. In addition, federal law should condition federal dollars on the development of resettlement plans that provide refugees with opportunities to enroll in degree, pre-apprenticeship, and apprenticeship programs that pipeline into meaningful employment that keeps families out of poverty.

The federal government must provide sufficient resources so that states and counties can develop and invest in refugee-focused education and employment opportunities. Additionally, local governments like the County of San Diego should invest their own funds in local education, apprenticeship, and employment programs and work with local refugee serving organizations to develop a realistic and robust Refugee Employment Service Plan.

PRIORITIZE RAPID ACCESS TO AFFORDABLE HOUSING UPON INITIAL RESETTLEMENT TO ENSURE THE HEALTH AND SAFETY OF REFUGEES.

Refugees do not currently receive housing assistance upon resettlement and must go to extraordinary lengths to find affordable housing in San Diego, where median rent for a two bedroom apartment is approximately $2,400,[16] and where average rents have increased by 3.3 percent in the past year alone.[17] Without affordable housing options, it is nearly impossible for refugee families to afford rent and basic necessities. Refugee families forced into early employment in low wage jobs upon arrival often experience substandard housing conditions, overcrowding, and hidden homelessness. This also makes them vulnerable to abusive landlords, evictions, and experiences of displacement. Finally, while lack of affordable housing was an ongoing issue for refugees prior to the pandemic, the health risks associated with overcrowded dwellings were only exacerbated by the spread of COVID-19.

Under the Refugee Act of 1980, the federal government was required to reimburse states for 100% of the cost of qualified refugee participation in state-level social assistance programs for the first 36 months after arrival in the United States.[18] In 1982, this support was cut in half to 18 months, and in 1991 it was again significantly reduced to its current level of only 8 months of support.[19] Congress must take action to extend support for qualified refugee participation in state-level social assistance programs so that cash assistance for resettled families is adequate to support housing costs for up to 36 months from initial resettlement. Extending cash assistance back to historic levels of 36 months is necessary to ensure families are not funneled into the unstable, poor housing and health conditions they hoped to leave behind in refugee camps or, even worse, do not become unsheltered immediately following resettlement. Families deserve to be resettled in quality and affordable housing that supports health and wellbeing. Providing extended social assistance will ensure that recently resettled refugees can focus on skills building, learning English, and acclimating to their new environment without the stress of rent they simply cannot afford.

Importantly, 36 months of government support would provide families the time necessary to be waitlisted for and to ultimately obtain affordable housing. As our survey revealed, refugees in affordable housing were 66% less likely to live in overcrowded conditions. Housing support would therefore have a real impact on the well being of refugee families and their long-term housing stability.

Local governments can likewise play an important role in ensuring housing stability for refugee families. For example, federal resettlement dollars should be conditioned upon counties developing clear plans for affordable housing opportunities for recently resettled refugees. The impact of affordable and secure housing is far-reaching, with implications for one's ability to connect with key employment and educational opportunities.[20] Without access to quality, affordable, and healthy housing, refugee families lack the basic foundation necessary to rebuild a sense of belonging and achieve economic success in their new home. Importantly, increasing affordable housing options for refugees allows cities and counties to be hubs for diversity and cultural inclusivity.

END LAW ENFORCEMENT COLLABORATIONS THAT RESULT IN THE HEIGHTENED SURVEILLANCE AND HARASSMENT OF REFUGEE COMMUNITIES, AND IMPLEMENT POLICIES THAT BUILD TRUST WITH REFUGEE AND IMMIGRANT COMMUNITIES.

Our data demonstrates that refugees are experiencing high levels of fear, feel unwelcome, and are worried about anti-immigrant policies. Sixty-five percent of African respondents felt "worried about being targeted by a hate crime," "speaking up in public," or "feeling welcome in public spaces." Approximately 12% of respondents said that they had "definitely or probably" experienced a hate crime in the United States and 72% of Middle Eastern respondents stated fear regarding their immigration status.

Policymakers at the local, state, and federal levels must end law enforcement collaborations that harass, surveil, and instill fear and feelings of being "othered" in refugee communities. Programs like the Joint Terrorism Taskforce (JTTF), Countering Violent Extremism (CVE), and Preventing Violent Extremism (PVE) have historically targetted predominantly Muslim and refugee communities and, when combined with the political turmoil under the Trump administration, have created layers of fear of deportation, criminalization, and hate crimes for refugee communities.

The Joint Terrorism Task Force (JTTF) is a collaborative and multi-agency law enforcement effort between federal, state, and local law enforcement agencies led by the U.S. Department of Justice and the Federal Bureau of Investigation. The JTTF utilizes intrusive investigative tactics to target and surveil Black, Arab, Middle Eastern, Muslim, and Southeast Asian communities, and the program often results in wrongful prosecutions and immigration consequences. Countering Violent Extremism (CVE) and its new iteration, Preventing Violent Extremism (PVE) are a series of government and private sector programs and policies designed to identify individuals susceptible to "violent extremism." CVE and PVE utilize a problematic "radicalization theory" that assumes everyday expressions of political dissent, as well as cultural and religious markers, are indicators for extremism. Concerningly, CVE and PVE funds go to local nonprofits and social service programs that become, sometimes unwittingly, intelligence gathering operations that result in disproportionate targeting of the communities that utilize these essential services.[21]

These surveillance programs not only make refugees fearful of law enforcement, but they make refugees feel unwelcome in their new home and result in an overall mistrust of government. Ending such programs would be a critical step toward truly welcoming refugees and ensuring they know they belong and can contribute to all parts of civic and social life in the United States.

INVEST IN CULTURALLY COMPETENT HEALTHCARE PROVIDERS TO PROVIDE EDUCATION ON COVID-19 TESTING AND VACCINATION TO REFUGEE COMMUNITIES.

Refugees and recent immigrants shoulder a dramatically disproportionate risk of COVID-19 compared to non-Hispanic white individuals for a variety of structural reasons.[22] Refugees and recent immigrants are more likely than non-Hispanic white individuals to hold low-paying "essential" jobs with higher risk of exposure to COVID-19.[23-25] Exacerbating this problem is the challenge of advocating for safety in jobs where employment status may be tenuous or where occupational safety and health is not prioritized by the employer. Families with limited English proficiency struggle to understand frequently-changing public health guidelines and mandates.[26] Moreover, public health guidelines advising individuals to "shelter in place" overlook the impossibility of this feat for communities that live in extremely crowded housing and disproportionately work frontline jobs. The severe overcrowding conditions revealed by this report suggest that the lack of space for isolation very likely increases the risk for transmission of the COVID-19 virus in refugee communities.

These structural disparity risks are exacerbated by structural racism for immigrants from non-European countries, including higher risks of comorbid conditions that could exacerbate COVID-19 severity and reduce access to testing.[27] Racial disparities in infectious disease exposure and outcomes, including but not limited to COVID-19,[28, 29] more often than not extend to vaccine coverage,[30-37] even down to the type of vaccine available.[38]

These health disparities resulting from the pandemic will only worsen unless equity is specifically addressed through a COVID-19 vaccination campaign tailored to the needs, concerns and characteristics of vulnerable communities. The emergence of new strains of the COVID-19 virus, which may limit the effectiveness of current vaccines, adds a new level of urgency that requires rapid mass vaccination across all populations.

As of April 2021, just under half of all residents in San Diego County ages 16 and up had received at least one dose of a COVID-19 vaccine. However, there were dramatic differences across race and ethnicity. Fifty-five percent of eligible Hispanic and Asian, and 45% of eligible white residents, had received at least one vaccine dose, but only 27% of eligible Black or African immigrant residents had accessed a vaccine.[39-41]

In line with these trends, our survey demonstrated high levels of vaccine hesitancy, particularly among African respondents, 64% of whom reported they would "refuse the vaccine." However, according to the

findings, those who "strongly" believed that their health care provider was culturally competent were 13 times more likely to trust their advice than participants who strongly disagreed that their provider was culturally competent. Cultural competency means a healthcare provider understands a patient's language and culture. In practice, the health care provider would speak the patients' native language, understand their culture, and have no preconceived notions or biases about the individual's culture or religion that would influence their care.

Having in-language education on COVID-19 testing and vaccination programs engenders trust and allows refugee community members to directly ask questions of healthcare providers without fear of mistranslation or even lack of understanding of cultural mannerisms. It is therefore imperative that testing and vaccination programs for refugee communities be delivered by culturally competent healthcare providers. This will not only effectively convey the importance of COVID-19 testing and vaccination, but will have the longer term benefit of building refugee trust in healthcare institutions, which could lead to better long-term health outcomes.

INVEST IN CULTURALLY COMPETENT, AFFORDABLE, AND ACCESSIBLE MENTAL HEALTH CARE RESOURCES.

The elevated risk of mental health issues in refugee communities is well documented and is a consequence of the significant personal experiences of torture, trauma, and loss they might have experienced.[42] Meta-analysis demonstrates high levels of post-traumatic stress disorder (PTSD), anxiety, and depression associated with experiencing war, torture, and turmoil.[43] This is compounded by stressors associated with flight, the resettlement process, and re-integration.[44]

Our survey found that refugees continue to experience mental health issues after resettlement. Across our sample, 53% of refugees reported worrying about their emotional health, including feelings of anxiety or depression at least "half of the time or more." Nearly all (90%) of Afghan respondents reported they were "sometimes worried" about their emotional health compared with 50% of Southeast Asian respondents, about 25% of African respondents, and about 20% of Middle Eastern respondents.

To address these issues, it is critical for refugees to have access to culturally competent mental care providers who can provide services in language, ideally come from the same culture, and have no preconceived notions or biases about refugees' culture or religion that would influence their care. Affordable mental health care resources should be covered by Medicaid, Medicare, or otherwise funded by state or local government so refugees do not have to pay out of pocket to access these services. Accessible mental health care resources means these resources are easy for refugees to navigate by being in-language and widely promoted. Dedicating population-specific behavioral health resources would be an important step towards mitigating the mental health crisis that resettled refugee communities are experiencing.

PROVIDE DIRECT SUPPORT TO REFUGEE FAMILIES TO NAVIGATE DISTANCE LEARNING, INCLUDING LANGUAGE SUPPORT AND DEVICES SUCH AS HEADPHONES FOR STUDENTS.

Nearly all survey participants expressed frustrations with remote learning. Distance learning has exacerbated the barriers already present for refugee communities in the educational system. This is consistent with a recent COVID-19 Refugee Community Impact Report by the San Diego Refugee Community Coalition that found that 85% of respondents with K-12 age children said their children were not getting the support they needed to participate in distance learning due to a number of factors including language barriers, not having privacy/space, and technology and connectivity issues, to name a few.[45]

Economists are pointing to a K-shaped model to demonstrate the current economic recovery.[46] Some have benefitted from the pandemic and are experiencing a quicker bounce-back and upward mobility, while others are facing a slower and more difficult recovery. In particular, workers in the service sector and jobs that are predominantly held by women and minorities are hit the hardest. This also affects children in education, where steep drops in state revenue are forcing schools to cut costs and will undoubtedly harm poorer students in largely minority schools the most. Further, distance learning has brought about many challenges to English learners and has widened the learning gap. These students will need more resources to fill the academic, social, and psychological gaps that have resulted from the pandemic.

Providing in-language support to students and their families can mitigate these barriers and facilitate a better learning experience for students. As schools open up, recognizing that these students have faced multiple barriers and are in need of immediate support will be critical. Resources should be provided and directed toward additional tutoring, in-language communication with parents, access to technology and devices such as headphones, and extended timelines for students. Dedicated support to refugee students and their families increases the chances that learning gaps exacerbated by the pandemic can one day be narrowed or eliminated, and that refugee students will have an equal opportunity to excel in school.

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