Syrian Refugees in the United States - History and Cultural Considerations that Influence Healthcare Utilization

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Abstract: Since the onset of the Syrian civil war in 2011, millions of people have been forcibly displaced. Syrian refugees arrive to the United States with complex health needs shaped by trauma, disrupted care, and prolonged instability. This paper examines the historical, political, and sociocultural context of Syrian displacement, the challenges of resettlement, and the specific barriers faced within the United States healthcare system. It explores how cultural values, language barriers, and family dynamics influence healthcare utilization, and underscores the importance of trauma-informed, culturally competent care. Through a multidisciplinary approach and partnerships with resettlement organizations, healthcare providers can more effectively support this vulnerable population and work toward equitable, responsive care.

I. Introduction

Since the Syrian civil war began in 2011, 14 million out of the 22.4 million people in Syria have been forced from their homes and nearly 7 million have fled the country entirely, becoming refugees. [1,2] A refugee is defined as "someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group".[3] Syrian refugees bring with them complex health profiles shaped by trauma, displacement, and disrupted healthcare access. While many Syrian refugees have sought safety in neighboring countries, a smaller number have been welcomed into the United States. The trauma of war, instability of displacement, and prolonged disruptions in healthcare access are woven into their life experiences. As a result, many arrive with multifaceted health needs that require thoughtful, culturally sensitive care. Past experiences, cultural values, language differences, and structural barriers in the US healthcare system all play a role in how and when refugees seek care. This paper explores the history of Syrian refugee resettlement in the US and highlights the cultural and systemic factors that healthcare providers should consider to better support this community.

II. History of Syrian Refugee Resettlement in the United States

Located in the fertile crescent, thought to be the birthplace of civilization, Syria has long and rich history. This paper will explore only the most recent century and the events leading to displacement of its modern residents.

A. Political Environment in Syria Leading to the 2011 Civil War

The Syrian civil war can be traced back to decades of authoritarian rule, suppression of political opposition, and growing economic and social divides. The Ba'ath Party took

power in 1963 through a military coup and established a one-party state under an emergency law that effectively suspended most constitutional rights and protections. In 1970, Hafez al-Assad, an officer in the government, seized control.[4] Over the next thirty years, he centralized power in the presidency, suppressed dissent using a strict police state, and expanded the influence of the Alawite minority (which makes up 10% of the population in Syria and to which the Assad family belongs). [4,5]

When Bashar al-Assad assumed power in 2000 following his father's death, there was initial hope for political and economic reform given Bashar's western exposure in the United Kingdom. However, these expectations were quickly crushed as political opposition remained tightly controlled, media was censored, and human rights violations worsened. [6,7] The country then experienced a record-setting drought from 2006-2010, pushing rural families into urban areas, increasing unemployment, and aggravating an already precarious economic situation. [4] The catalyst for the civil war came in March 2011, during the broader wave of a pro-democracy movement, the Arab Spring. Peaceful protests broke out in the southern city of Daraa after teenagers were arrested for anti-government graffiti.[2,4] The regime's brutal crackdown on demonstrators, using live ammunition and mass arrests, ignited nationwide protests. The Assad regime responded by escalating its use of force, deploying military units against civilians, and releasing tanks into cities.[4,6]

Within several months, the uprising had grown into a full-scale civil war. Multiple factions emerged, including secular opposition groups, Kurdish militias, Islamist groups, and jihadist factions such as ISIS. The Assad regime used tactics such as airstrikes, bombs, chemical weapons, and cutting off food and supply chains to rebel-occupied areas. Extensive involvement of outside powers resulted in further escalation of the war. Russia and Iran backed the Assad government, while various rebel groups received intermittent support from Western and regional countries.[4,6] The result has been a devastating conflict with civilians at the center of the suffering and the collapse of vital infrastructure.

B. Syrian Government Actions Since the Start of the War

Over the past 14 years, the Assad government increased military control and targeted rebel-held cities such as Homs, Aleppo, Douma, and Ghouta. Human rights organizations have documented extensive war crimes, including torture, the use of chemical weapons, and attacks on medical facilities and schools. [7,8] It is estimated that the Assad regime has killed more than 300,000 Syrians during this time.[8] To maintain power, the regime implemented policies of forced displacement, particularly in cities like Damascus where the Assad regime had strongholds.[9] Entire communities were forced to flee, and property laws allowed the government to confiscate homes of displaced people, complicating the possibility of return for millions of refugees.

Meanwhile, the Syrian economy collapsed under the weight of war, corruption, and international sanctions, decimating essential services, including healthcare, education, and clean water.[4] More than 90% of Syrians live in poverty, and humanitarian needs have remained critical although not always deliverable due to violence and government restrictions.[2,4] In December 2024, the Assad regime was overthrown by the rebel group Hayat Tahrir al-Sham (HTS), which has been classified as a terrorist group due to their jihadist past.[10] Despite this, over the past 8 months, 1 million Syrians have returned home and 80% of displaced Syrians report hope that they may also return home someday.[2,8] The new regime comes with a complicated past and mixed messages as to what their plan for Syria is, so more time will need to pass to understand the trajectory of the country under President Ahmed al-Shara, the leader of HTS.[10]

C. Early Syrian Immigration (Late 19th–Mid 20th Century)

Syrian migration to the United States dates back to the late 19th century, involving Syrians escaping political and religious oppression under the Ottoman Empire or those looking for a more prosperous life.[11,12] By 1940, 350,000 persons of Syrian or Lebanese birth were living in the US.[12] These early migrants generally assimilated into American society over generations. In contrast, the post-2011 refugee influx has involved a different demographic in larger numbers: mainly Sunni Muslim families, many with children and limited resources.

D. Post-2011 Refugee Influx in the United States

It is estimated that 27,000 Syrian refugees entered the US between 2012 and 2022.[13] The United States Refugee Admissions Program (USRAP) played a large role in facilitating this.[14] On arrival, refugees receive short-term aid through programs such as Refugee Medical Assistance (RMA) and Refugee Cash Assistance (RCA). RMA was set at 8 months in 1992, increased to 12 months in 2022, and was proposed to be reduced to 4 months in May 2025.[15] In Charlottesville, incoming refugees enter through the International Rescue Committee (IRC), who assist during a 90 day resettlement period with accessing housing, benefits (Medicaid and SNAP), work authorization, and obtaining a social security card.[16] Additionally, Medicaid benefits in Virginia generally cover children under 19 and pregnant persons, and because Virginia has Medicaid expansion, many of the resettled adult refugee in Charlottesville are able to stay on Medicaid past 8 months.[17]

Political policy changes have impacted resettlement trends in the past decade. The 2017 Executive Order on immigration, better known as the “Muslim Ban” for its disproportionate impact on Syrians and six other predominantly Muslim countries, sharply curtailed refugee admissions.[13,18] Current Trump policy has suspended the USRAP once again, preventing entry of new refugees under the claim that the United States lacks the resources to absorb and support these refugees.[19]

III. Sociodemographic and Health Profile of Syrian Refugees

Syrian refugee populations in the US include a high proportion of children.[20] This

distribution reflects the tendency for resettlement programs to prioritize vulnerable populations like women and children as well as the relatively high population of children in Syria. Many households are multigenerational, and extended family often contributes to caregiving and decision making.[12]

A. Educational Attainment

The degree of education among Syrian refugees varies. The UNHCR estimates that in Syria today, only two-thirds of children are enrolled in school and many more are expected to drop out prior to completing their education.[2] While many adult refugees have completed some level of secondary education or beyond, they are often unable to transfer their credentials to the US.[12] Difficulty navigating licensing and certification, lack of English proficiency, and limited access to job training programs can land many refugees in low-wage or labor-intensive jobs.[20,21]

B. Pre-Existing Health Conditions

The health needs of Syrian refugees are shaped by a complex mix of life before the war, the trauma of conflict, and the hardships of displacement and resettlement.[21] Health records may have been lost throughout their displacement and health conditions gone without treatment.[22] Upon arrival to the US, refugees undergo mandatory health screening which includes checking for tuberculosis, hepatitis B, lead poisoning, anemia, intestinal parasites, and other communicable diseases.[22] Dental abnormalities like cavities and gum disease as well as untreated visual impairments are the most common noncommunicable diseases, present after years of inconsistent care and lack of access to routine hygiene.[23] Refugees are then set up with a primary care clinician to manage their acute needs, address any chronic conditions such as hypertension and diabetes, and catch them up on missed vaccinations.[12,22] Adjusting to a new medical system presents its own limitations, and if not carefully guided, patients can easily become lost to follow up.[12,21]

C. Prevalence of Mental Health Concerns

Mental health is another pressing aspect of refugee health, especially among women and children.[24] Refugees have been found to experience very high rates of PTSD, depression, and anxiety due to the lived experiences of violence, displacement, and grief.[23–26] In one study of Syrian refugees newly resettled in Kentucky, nearly 40% reported having either personally experienced violence, torture, or imprisonment, or having witnessed those events happen to others.[23] In addition to past traumas, adjusting to life in a new country introduces stress through isolation, language barriers, and job insecurity.[21]

Altogether, Syrian refugees face a complicated set of health challenges that go far beyond the results of an intake screening. Providing effective, compassionate care means addressing not just urgent medical needs, but also long-term wellness. That includes attention to mental health, socioeconomic conditions, and the kind of community support that helps people truly heal, not just survive.

IV. Cultural Considerations That Influence Healthcare Utilization

The way Syrian refugees interact with the US healthcare system is deeply shaped by their cultural background. Language barriers, religious beliefs, traditional healing practices, and community norms all influence care seeking behavior and must be recognized in order to build trust and deliver effective care.[12,20,27,28]

A. Language Barriers and Health Literacy

The majority of Syrians speak Arabic as their primary language and arrive in the US with limited English proficiency, which can make even basic healthcare interactions confusing and overwhelming.[12] Many first rely on resettlement agencies, then on family and friends to help navigate the system.[27] Limited understanding of medical terminology, insurance procedures, and scheduling systems contributes to delays in care and frequent miscommunication.[20,21,28] Investing in professional interpreters, providing staff training in culturally competent care, and offering translated educational materials may improve access and safety.[22,27]

B. Religion, Beliefs About Illness, and Traditional Medicine

The majority of Syrians practice Islam, which frequently plays a central role in health perceptions.[12] Illness may be seen as Allah's will or a preordained event, influencing how individuals view their condition and their willingness to pursue certain types of treatment.[12] Many find comfort in faith, turning to prayer and spiritual practices during times of illness.[12] Traditional remedies such as honey, black seed, olive oil, prune juice, and herbal teas (mint, chamomile, anise) are commonly used and should be seen not as oppositional to Western medicine but as a complement to it.[12,28,29] Nutrition is another aspect of health that Syrians tend to emphasize, with meals typically featuring a wide variety of grains, meats, cheeses, and seasonal fruits and vegetables.[30] Providers who ask about, acknowledge these practices in a respectful way, and incorporate them when appropriate, can strengthen patient relationships and promote better adherence to treatment plans.[31]

C. Cultural Norms and Family Structure

Family structure and societal norms greatly influence healthcare. For example, Syrian women may be more comfortable receiving care from female providers.[27] Providers who are sensitive to these preferences can help avoid unnecessary discomfort and build rapport. Syrian families also tend to be collectivist, meaning that health decisions are often made within the family unit rather than by the individual alone. The husband or his parents may have a strong influence over decisions, especially in regards to birth control and child bearing.[12,27] In an individualistic society like the United States, this can lead to misunderstandings or perceived noncompliance.[28] Recognizing the importance of family dynamics and involving key decision-makers when appropriate can foster more collaborative care and greater patient trust.

D. Perceptions of Mental Health

Mental health is a sensitive topic and remains stigmatized in many Syrian communities.[21] Emotional distress is often not labeled as a mental health issue, and there may be hesitation to seek help. Suggestions of counseling and psychiatric medications may be mistrusted unless introduced through a lens that aligns with a patient's cultural values.[28] Refugee patients with mental health conditions such as depression or PTSD are also more likely to report somatic concerns like chronic pain, relying more on primary care services than mental health resources.[21,26] Culturally tailored approaches such as narrative exposure therapy, which allows participants to process their trauma by telling their story, faith-integrated counseling, and group support sessions that focus on shared experiences, resilience, and healing can increase engagement, reduce stigma, and build community.[21,28] Beyond formal therapy, educational programs, interactive discussions, and media resources (written, audio, or web-based) tailored in Arabic and designed with cultural sensitivity in mind, have improved mental health awareness and helped normalize seeking support.[28] These strategies work to educate, build trust, reduce isolation, and create a supportive environment where recovery is possible.

V. Structural and Systemic Barriers to Healthcare Access

In addition to cultural differences, Syrian refugees resettled in the US encounter several systemic obstacles that limit their ability to access healthcare. These include challenges related to insurance coverage, affordability, transportation, discrimination, and a shortage of providers who understand their linguistic and cultural needs.[27,28]

A. Insurance and Affordability

Access to health insurance remains one of the most pressing barriers for newly arrived Syrian refugees. Refugee Medical Assistance (RMA) is available for the first few months after arrival, often before families are able to find steady employment, establish with primary care providers, or manage chronic health needs.[15] Medicaid is then available to refugees who meet eligibility requirements, however with recent changes to the national budget and Medicaid cuts, this group may be among those impacted. Navigating public insurance options like Medicaid or the ACA marketplace, both of which involve complex systems, can be confusing- especially for those who do not speak English fluently. Many forms and instructions are not available in Arabic, which only increases the difficulty of understanding eligibility requirements or completing enrollment.[12]

B. Transportation

Even when healthcare is available, getting to a clinic or hospital can be a challenge. Many newly arrived refugees do not yet have driver's licenses or cars.[32] In areas where buses or trains are available, navigating the system can be difficult due to language differences, unfamiliarity with routes or the transit system, or safety concerns.[27] As a result, some simply forgo care rather than risk getting lost or overwhelmed in transit. Lack of reliable transportation has also been linked to higher rates of social exclusion.[32] Providing orientation to the public transport

system, connecting with medical transport services, or access to private cars could greatly improve access to healthcare and overall wellness.[32]

C. Provider Competency

As of 2017, just 4.1% of physicians in the US reported speaking Arabic, making it difficult for Syrian refugees to communicate clearly with their providers or feel truly understood.[33] Interpreter services are often used to bridge this gap, but they come with limitations. Connectivity issues of remote interpretation services, sporadic availability of in person services, short appointment times, and female patient discomfort if a male interpreter is present all complicate this process.[12,27] Language barriers aside, many healthcare providers lack training in the cultural, religious, and social norms that shape Syrian patients' expectations and decision making. Lack of cultural awareness can lead to care coming across as rushed, dismissive, or disconnected from patients' values and lived experiences.[28] Additionally, concerns about discrimination, whether due to past experiences or anticipated bias, can deter refugees from seeking care. This is especially relevant when it comes to mental health or reproductive issues, where privacy and cultural sensitivity are important.[12,20,28] Utilization of Syrian health advisors or community workers is one strategy that has been used to bridge this gap. These individuals may speak the language, understand the culture, and can help patients navigate an unfamiliar health system.

VI. Conclusion

A journey of resilience, hardship, and hope, Syrian refugees enter the United States after fleeing one of the most brutal conflicts in recent history. They bring with them physical wounds, chronic illness, and the invisible weight of trauma, displacement, and loss. Once here, they face more barriers shaped by language differences, the shock of a new culture, financial challenges, and a complex healthcare system.

Healthcare providers hold a unique position to make a meaningful difference in this difficult journey. Beyond clinical knowledge, clinicians must show compassion, cultural humility, and a willingness to listen. By recognizing the importance of family structure, faith, and traditional healing practices as well as de-stigmatizing mental health concerns, providers can build trust and encourage compliance to lead to better outcomes. As a broader society, investing in language services, expanding healthcare funding, and partnering with resettlement agencies can help broaden access to care.

This paper offers a brief history of modern Syria and highlights just a few of the complexities that come with caring for this population. It is intended to help providers better understand the context in which Syrian refugees have found themselves in the United States and the unique sociocultural identities they may bring with them. Through continued research and a reactive approach to the dynamic crisis in Syria, we can develop more effective strategies to support and improve healthcare outcomes for Syrian refugees. In the International Family Medicine Clinic, we

strive to provide a responsive approach to support our Syrian patients through a multi-disciplinary care team and collaboration with the IRC, Health Department, and Cville Tulips, a local program aimed at connecting the community and providing educational opportunities.

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