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An Interdisciplinary Analysis of Health Equity as Evaluated through the COVID-19 Response Concerning French-Speaking Refugees.

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Abstract

A collaborative approach is needed to understand the multifaceted medical bias and inequalities experienced by refugee camps of Francophone (French-speaking) nations. A combination of interest and passion for anthropology, medicine, and the French language presents a unique window of intersectionality to analyze this issue. Through a comprehensive review of literature published in both English and French languages, and connections with directors and leaders of refugee camps located in France and French-speaking African nations, we have elucidated a few examples of alarming medical bias experienced by both refugees and migrants. Although an exhaustive list of medical bias could be presented on this topic, in this project we chose to focus our attention on the following areas: lack of healthcare education, compounding medical conditions and financial inaccessibility to care. This research is highly essential given the current COVID-19 pandemic, as it has highlighted these inequalities even further and can provide real-time data to exemplify and explain the discrepancies Francophone refugees have experienced for generations. Overall, this project presents a consolidated but interdisciplinary review of health equity as evaluated through the COVID-19 response in Francophone refugee camps. The goals of this project are to raise awareness of the patterns of medical bias refugees and migrants in Francophone countries experience so physicians and other healthcare workers can be more prepared in the future to not only prevent the illness itself, but to consider the patient's background and position in attempt to better take care of the *whole* patient and those to come.

Keywords: Francophone, health equity, refugee, migrant, COVID-19

Background

At WMU, I am majoring in anthropology and minoring in biological sciences, chemistry, and French. Post-graduation from WMU I plan to pursue a career in the medical field. With a background in the French language amounting to eight years, my dream is to volunteer for *Médecins Sans Frontières* (Doctors Without Borders). This would primarily involve close collaboration with refugee camps and their medical outcries. Refugees and migrants have historically experienced a large discrepancy with awareness, education and quality of healthcare they receive. The COVID-19 pandemic is now exposing this problem on a much larger scale, proving that even when the world is facing difficult times, the stark difference in quality of healthcare poses a much greater problem for underprivileged refugees and migrants. Without proper education, access to resources such as personal protective equipment (PPE), and lack of equal opportunity healthcare, refugee camps experience a problem completely and utterly different than that of other nations. These are the reasons why I have chosen to create a project which brings together all of my interests and expertise: medicine, anthropology, French language, and refugee inequalities. This research project is not only something I have great interest in but is also highly important and applicable for all those in the medical field. Investigating medical bias experienced by refugees not only allows physicians to become more cognizant of the health services they provide but also raises worldwide awareness for fellow colleagues pursuing careers in medicine, so as to improve preparedness for future pandemics.

In the simplest terms, a refugee is defined as an individual who has been forced to leave his or her country as a direct result of civil unrest, persecution, or natural disaster. A migrant, most often illegal, differs from a refugee in such a way that he or she has chosen to leave their country for whatever reason. In the context of this study, we acknowledge the differences

between refugees and migrants, but seek to shed light on the healthcare inequalities that both populations experience. We understand the complexities and the subcategories that fall under refugee or migrant status, specifically those that do not completely fit the above roles. This includes both asylum seekers and immigrants. Asylum seekers include individuals forced to seek safety internationally but who have not yet undergone legal claims for refugee status. (International Rescue Committee 2018) Immigrants are those that relocate to a new country willingly and have intent to settle there and build a life. While specific refugee camps, like the French-based refugee camp in Calais, are not discussed at length in this study, it is implied that Francophone asylum seekers who have been legally declared as refugees and who were forced to flee to France, have been housed at a refugee camp, at some time and place no matter the duration.

Because each of these categories of individuals have differing legal classifications, each, consequently, has a variation of resources available to them. This literature review acknowledges that no two healthcare experiences are the same, whether that be for a refugee, migrant, immigrant, or asylum seeker. Healthcare resources are certainly more reasonable and more easily obtained by established refugees than by those asylum seekers who still are not legally declared refugees. The same goes for immigrants, who are established legally, in contrast to migrants, who are illegal. Bureaucratic democracy and common sense indicate that legally documented individuals (refugees and immigrants) receive more healthcare resources than undocumented individuals (asylum seekers and migrants). However, the path to healthcare resources for all four of these populations is severely hindered when considered proportionally to the healthcare resources for French citizens. This research project seeks to expose the healthcare inequalities that hold unfortunate roots in our world.

For generations and even to today, there are outcries from Francophone refugees, asylum seekers and migrants, who continue to face multifaceted and complex obstacles to receiving the care they need secondary to unwarranted racial, ethnic, and economic status. As seen in Figure 1, there are many interdependencies at varying hierarchies which affect an individual and their health; thus, even for non-refugees the pursuit to health and stability is complex and fragile. (Kohler 2018)

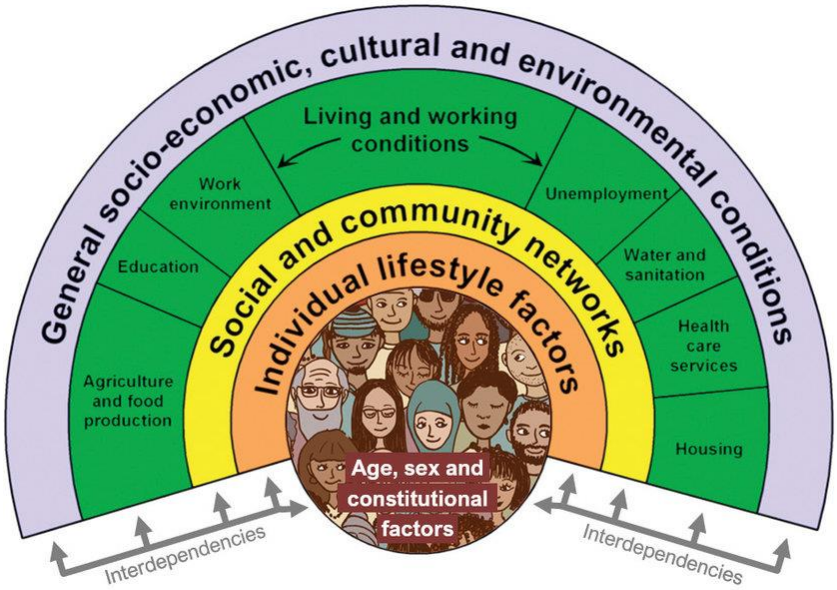

Figure 1. Visualization of the hierarchy of interdependencies which affect each individual (Kohler 2018)

Because these boundaries are at the forefront of primary healthcare, refugees and migrants struggle to receive proper and unbiased care. In light of the COVID-19 response, there have been, and continue to be, struggles and cries for testing, treatment and other necessary resources within refugee camps. In this project, we chose to focus our attention on the three areas of (1) lack of healthcare education, (2) compounding medical conditions and (3) financial inaccessibility to care. A brief description of the following focus areas are provided below:

1. <u>Lack of healthcare education:</u> Refugees don't have education about signs and symptoms of illnesses and how to prevent them. Refugees don't have education about where to go for help. Refugees don't have stable, educated community members to pose questions to.

2. Compounding medical conditions: Refugees often don't receive care for even minor illnesses, which can compound and become more complex. Refugees often have multiple chronic medical conditions, which makes treating a single illness harder.
3. Financial inaccessibility to care: Even if refugees have education and access to care, they often face the obstacle of financial inaccessibility.

To be clear, refugees in Francophone nations have experienced patterns of medical bias throughout generations. (André 2016) The COVID-19 pandemic is another example of illness which continues to show the stark differences between the care received by refugees versus other places with stable healthcare. This is an important point because this research is *not* stating that medical bias exists because of the COVID-19 pandemic; rather, this research uses COVID-19 essentially as a tool to demonstrate the discrepancies in care when comparing Francophone refugee camps to other places around the world.

The structure of this written thesis begins with an introduction of the problem, a presentation of the background needed to understand the position of the research, an explanation of the methodology, results based on translation and review of the relevant literature, and lastly a consideration of the results and comprehensive discussion of the immediate project and its relevance at large.

Methods

No consent was needed from Human Subjects Institutional Review Board (HSIRB) or Institutional Animal Care and Use Committee (IACUC) to perform this research project. Approval and support for the project were obtained by confirming Dr. Michelle Hrivnyak as the thesis chair and Dr. Vincent Desroches as the additional committee member. Dr. Hrivnyak was requested for fulfillment of the thesis chair role, as she is an anthropologist with extensive knowledge on other cultures and could provide niche advice and insight into this project's focus. Secondly, Dr. Desroches was requested for fulfillment of a committee member role, as he is highly fluent in the French language and could provide assistance when reading complex French literature that this interdisciplinary project would require.

Analyzing English-based, and often American perspective, studies about French countries and their refugee camps would not suffice for this project; rather, it demanded a closer look at the medical bias occurring in Francophone countries, which only French-based studies would be able to provide. To accomplish this, French databases from various Francophone countries were accessed in order to retrieve articles. All articles from the French databases were written in French and thus had to be read and translated independently. Once the French articles were read and translation was confirmed to be fully accurate and reflective of the original article, they each were analyzed for their relevance and implications to the overarching goals of this project. English-based articles were also utilized throughout this project to provide more general information about the history of refugee camps as a whole and to compare articles written from a Western culture perspective to the articles written directly by Francophone citizens in the midst of refugee camps.

Primarily, French-based articles were used to defend this highly important research project. Reading and translating each French article took extensive amounts of time for the essential reasons below:

- To ensure the information and explanations were accurate once reflected in a new language.
- In-depth articles and reviews often have a large set of niche vocabulary which is not taught in typical classes for French acquisition. New vocabulary in a second language had to be learned in order to complete this project.
- Francophone databases are hard to access and navigate to those who have never done so before.

An excerpt from one of the primary French research articles utilized in this study has been copied and pasted below to serve as a shorter, more concise example of the process of translation.

> "En France, au début des années 1980, Michèle Brahimi (1980)avançait aussi l'idée d'une détérioration progressive en comparant les taux de mortalité entre immigrants récents et plus anciens, et en montrant que la durée de résidence, mais aussi les conditions de vie et de travail – déjà corrélées aux causes des décès avec une surmortalité par accident ou par maladies professionnelles – réduisaient l'écart et occasionnaient même une surmortalité. Des travaux conduits au début des années 1990 sur les taux de mortalité des immigrés marocains montraient plutôt l'inverse (Khlat et Courbage, 1995).Mais ces recherches fondées sur l'étude de la mortalité sont à considérer avec précaution dans la mesure où elles ne peuvent prendre en considération les décès des immigrés retournés dans leur pays à l'âge de la retraite. De plus, les déclarations de décès en France ne permettaient alors pas d'identifier le pays de naissance des personnes immigrées ayant acquis la nationalité française et ces travaux ne portaient donc que sur les immigrés demeurés étrangers." (Cognet et al, 2012)

The selected passage is just one excerpt from the research articles I accessed that were written and published entirely in French. Outlining my method of translation, I first isolated each sentence. Within each sentence, I combed the phrase for words that I had never heard of throughout my eight years learning the language. This came as no surprise, seeing that these were research papers originally written in French, containing health-related vocabulary intended for professional use. To provide an example, I draw from the last sentence of the above citation. Within this sentence, two words I did not know off-hand, and thus had to look up, were *demeurés* and *acquis*. Searching through a reputable French-English dictionary, I was able to determine *demeurés* is the past participle of the verb *to remain* and *acquis* means *benefit/gain/knowledge*. Once combing through each sentence and defining each unknown word, I then had to reread the sentence and utilize my new knowledge of the word's definition to draw context clues. *Demeurés*, as situated before the word *étrangers* denotes *remaining foreign immigrants*. *Acquis*, as situated before *la nationalité française* denotes *acquired French nationality*. These context clues were then used to make sense of the complete sentence phrase and assimilate its meaning with the rest of the paragraph.

A consolidated table of references was constructed to clearly show the references used throughout the project. In an independent column, the language of each reference was listed for easy identification as to which references were originally published in the French language and were thus fully translated by me to apply to this English-based research project.

Table 1. References with Original Language Specifications

Full Citation	Article Title & Source	Language
Ran van der Wal, « Comment l'évolution des conflits implique	*Comment l'évolution des conflits implique de compter*	

de compter avec les maladies chroniques non transmissibles », *Humanitaire*, 41 | 2015, 88-95.	*avec les maladies chroniques non transmissibles* Source: Humanitaire	French
Florence Lot et al, « Trois pathologies infectieuses fréquemment rencontrées chez les migrants en France: le VIH, la tuberculose et l'hépatite B », *Institut de veille sanitaire* | 2012, 25-30.	*Trois pathologies infectieuses fréquemment rencontrées chez les migrants en France: le VIH, la tuberculose et l'hépatite B* Source: Institut de Veille Sanitaire	French
COGNET Marguerite, HAMEL Christelle et MOISY Muriel (2012) Santé des migrants en France : l'effet des discriminations liées à l'origine et au sexe, *Revue Européenne des Migrations Internationales*, 28 (2), pp. 11-34.	*Santé des migrants en France: l'effet des discrimination liées à l'origine et au sexe* Source: Revue Européenne des Migrations Internationales	French
Caroline Berchet, Florence Jusot. État de santé et recours aux soins des immigrés en France : une revue de la	*État de santé et recours aux soins des immigrés en*	

littérature. *Bulletin Epidémiologique Hebdomadaire - BEH*, Saint-Maurice (Val de Marne) : Institut de veille sanitaire, 2012, 2012 (2-3-4), pp.17-21.	*France: une revue de la littérature* Source: Bulletin Epidémiologique Hebdomadaire – BEH	French
Lebano A, Hamed S, Bradby H, et al. Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. *BMC Public Health*. 2020;20(1):1039. Published 2020 Jun 30. doi:10.1186/s12889-020-08749-8.	*Migrants' and refugees' health status and healthcare in Europe: a scoping literature review* Source: BMC Public Health	English
André, JM., Azzedine, F. Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance. *Public Health Rev*37, 5 (2016). https://doi.org/10.1186/s40985-016-0017-4	*Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance* Source: Public Health Rev	English

Results

Despite the many other examples of medical bias experienced by refugees and migrants, this research and literature review reflects three infrastructural disciplines: lack of healthcare education, compounding medical conditions and financial inaccessibility to care.

1. **Lack of healthcare education**

    a. **History**

Lack of healthcare education among refugees and migrants has been characteristically represented in numerous ways as evidenced through this study. At the forefront of a refugee's disconnect between knowledge and healthcare lies ignorance of a disease and its symptoms. (Cognet et al, 2012) The insufficient publication of educational resources has become a frequent occurrence among asylum-seeking migrants, thus implicating a miscommunication of a disease and its symptoms to the general public. Oblivion secondary to the absence of certified health information results in an incorrect understanding regarding the necessity for proper intervention. Moreover, the surrounding community lacks the same, basic healthcare knowledge. As represented in Figure 3, lack of healthcare education does not solely stem from lack of general education; rather, it stems from the lack of healthcare infrastructure, educational infrastructure, educated

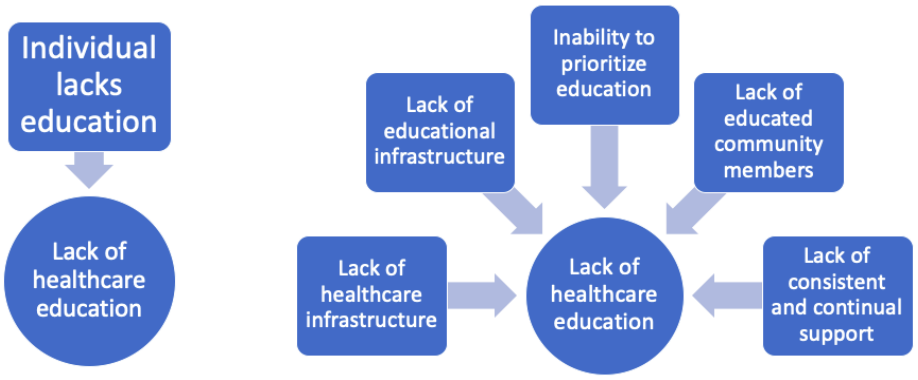

Figure 3. Expanding on the Factors Causing Lack of Healthcare Education

community members, inability to prioritize education, and consistent support. Should a refugee seek medical advice from those around them, the advice would be just as useless as their own understanding, seeing as though they share access to health education, or lack thereof. For use in this paper, lack of healthcare education is also defined as illiteracy regarding germ spread (including droplet and airborne prone diseases) and prevention (including proper precautions and common sanitary and hygienic practices).

As exposed by a recent research study, Francophone refugee, Conception, displays her understanding of asthma, its symptoms, and what leads to its exacerbation. She notes having breathing difficulties amounting to a few years but accredits that to her advanced age. It was not until she received medical care that she recognized she had a more serious diagnosis of asthma. Once she was finally educated about the condition and its symptoms, she was able to associate her poor living condition to the exacerbation of her symptoms. The substances coating the basement walls of her home elicited harsh breathing conditions and unhealthy inhalation of toxic substances that only worsened her condition. (Cognet et al, 2012) Had she received proper medical care upon arrival to her "safe home" in France, she would have likely been placed in a home more conducive to her asthmatic needs.

In addition to the lack of educational resources regarding a disease and its symptoms, refugees have lacked education providing important legal aspects relating to medical care. In reference to the same study above, there have been recounts of anonymous origin that illustrate how refugees do not know what basic medicolegal rights they are entitled to. (Cognet et al, 2012) Not only have refugees been ignorant to their legal rights, but they have also been ignorant to the administrative requirements for

access to healthcare. (Cognet et al, 2012) The lack of communication regarding legality issues of the health of a refugee has created an intertwined web of inexcusable quality of health provisions.

b. Application to COVID-19

The absence of proper health education concerning COVID-19 protocols lies at the forefront of health inequity among refugees and asylum seekers. As mentioned above, refugees have historically experienced little to no education regarding germ spread and infection prevention. (Cognet et al, 2012) The most important pieces of education with regard to the COVID-19 pandemic (and those that are not readily accessible for refugees) include how the virus spreads, proper social distancing guidelines, and correct usage of personal protective equipment. In order to slow the spread of the pandemic, it is essential that an individual is knowledgeable regarding how COVID-19 is passed from person to person.

COVID-19 is known to be passed via droplets that become airborne. Should a COVID infected patient cough, sneeze, talk or breathe without proper shielding, COVID droplet particles are released into the air of which others breathe. In accordance with the Centers for Disease Control and Prevention (CDC) in the United States, personal protective equipment (PPE) is the best way to eliminate the release of droplets into the air. PPE, such as masks, need to either be made based on surgical standards or if homemade, with at least two layers of fabric. In order for a mask to reach its peak effectiveness, it needs to cover both the mouth and nose of the individual and be tightly secured to each ear so as to eliminate gaps on the sides of the cheek. (CDC 2020) Along with use of PPE comes the practice of social distancing. An individual must be at least

six feet from anyone else to be at a safe distance from spread and contraction of the virus. (CDC 2020) Although the literature concerning COVID-19 is still being developed, refugees have not received published health recommendations for other diseases and viruses in the past. (Cognet et al, 2012) Therefore, it can be assumed that the continuation of health inequity among refugees has directly affected the equity in receiving recommendations for COVID-19.

2. Compounding medical conditions

a. History

Compounding medical conditions can be considered interchangeably with primary health conditions, co-morbidities, chronic health conditions, or pre-existing health conditions. Some of the most common compounding medical conditions, as observed in French-speaking refugee camps relevant to my research, are hypertension (high blood pressure), obesity, diabetes mellitus (a disease characterized by high blood sugar), sleep apnea (a breathing disorder prevalent during sleep), pregnancy, COPD (chronic obstructive pulmonary disease) and cancer. (Van der Wal 2015) The lack of quality healthcare in refugees means refugees live with multiple pre-existing health conditions that combine to decrease the wellness and stability of the patient. Therefore, the presence of compounding medical conditions renders a patient at an increased risk for potential infection and/or life-threatening situations.

For example, a study conducted in North African countries found that refugees and migrants were often diagnosed with acquired immunodeficiency syndrome (AIDS) at the same time they were tested for human immunodeficiency virus (HIV). (Lot 2012) Additionally, a similar situation occurred in endemic countries for HBV infection, and

because their disease was untreated for such an extended period of time, they suffered from severe chronic symptoms of hepatitis B virus (HBV) infections. (Lot 2012) In Syria, civil unrest resulted in destruction of health facilities, destruction of roads, and healthcare workers fleeing the country. (Van der Wal 2015) The civil unrest in Syria made Syrian refugees feel unsafe to seek out medical care, and in 2012 a study found that 70,000 cancer patients and 5,000 dialysis patients were not receiving the treatment they required. (Van der Wal 2015).

b. Application to COVID-19

Because of the lack of primary healthcare and routine follow ups, refugees are more prone to have advanced-stage co-morbidities, as these conditions go undiagnosed and untreated. COVID-19 has highlighted the importance of primary healthcare; individuals who have pre-existing health conditions are known to have a greater infection fatality rate (IFR), no matter their age. Children who are aged eleven and under and who have co-morbidities have a 1 in 14,000 chance of fatality when infected with COVID compared to the 1 in 1,200,000 chance of fatality in children aged eleven and under who do not have co-morbidities. (McConnell 2020) This data trend is also observed in individuals with advanced age. For those with co-morbidities aged eighty-five and older, there is a 1 in 20 chance of fatality when infected with COVID compared to the 1 in 50 chance of fatality in those without co-morbidities aged eighty-five and older. (McConnell 2020) These numbers strictly represent those individuals with a single pre-existing health condition. The aforementioned lack of primary healthcare and compounding of multiple co-morbidities renders refugees more susceptible to potential fatality.

3. Financial inaccessibility to care

a. History

Although there are many interpretations of financial inaccessibility to care, it will fulfill its purpose in this research project to describe the impoverished refugees, who have little to no funding to allocate towards proper healthcare. As indicated in a research project studying refugees' accessibility to healthcare, refugees experience a severely hindered route to accessing health insurance. This inaccessibility to health coverage and insurance policies comes as a direct result of the low socioeconomic status with which they enter their asylum country (Berchet 2012).

Not only does financial inaccessibility to care include an individual refugee not having money, but it also includes the immediate community surrounding the refugee and neighboring countries having unstable financial situations. As outlined by Figure 4, the route to financial accessibility to healthcare is much more complex than simply having insurance or paying a medical bill. In developing countries where healthcare facilities are few and far between, individuals not only have to account for their medical bill,

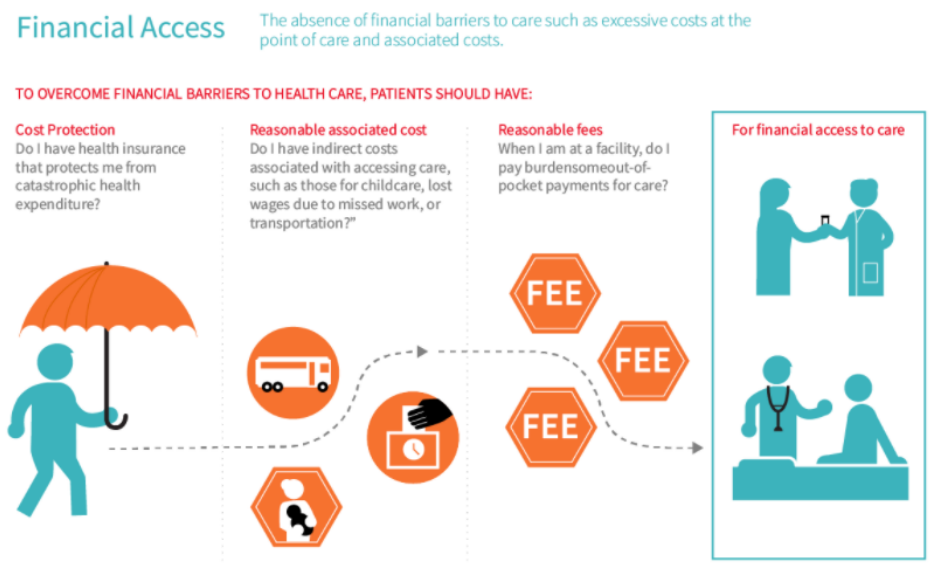

Figure 4. The Complicated Route to Financial Accessibility to Healthcare (PHCPI 2020)

but also for their transportation fees, childcare fees, and loss of work wages jeopardized to seek in-person healthcare. (PHCPI 2020) In 2014, the Middle Eastern country, Jordan, was receiving such a large influx of French-speaking Syrian refugees that both their healthcare and economic systems could not support the amount of money and resources needed to provide easily obtainable, free medical care (Van der Wal 2015). This resulted in the Jordanian government raising the prices of their medical bills, causing the already impoverished refugees to pay money for healthcare they couldn't even initially afford (Van der Wal 2015)

b. Application to COVID-19

One of the largest problems that continues to present itself as the COVID-19 pandemic evolves concerns the financial burden it elicits. This financial burden holds much worse economic indications for those living in developing countries as well as for those seeking asylum in a different country. As discussed above, the cost of medical care and treatment is simply unaffordable for refugees. Take, for example, a Syrian refugee seeking asylum in Lebanon. In Lebanon, the average monthly income of a Syrian refugee worker is $277 U.S. dollars. (International Labor Organization 2014) As the COVID-19 pandemic progressed in its beginning months, scientists and researchers developed two different types of testing: diagnostic testing and antibody testing. COVID-19 diagnostic testing is utilized when an individual is symptomatic or has been exposed to the virus. Antibody testing analyzes blood antigens to determine past exposure to COVID-19. Although both tests have different purposes, they have a similar, average cost ranging anywhere from $0-$850. (Advisory Board 2020) Moreover, this only accounts for the price of the testing itself. It is a common occurrence for a symptomatic individual to not

only receive diagnostic testing, but also to receive lab work and x-rays. This increases the average price of necessary COVID-19 medical care to about $2,300. (Advisory Board 2020) In reference to the average monthly income of a Syrian refugee, there is a substantial economic difference. A Syrian refugee may not even be able to afford the cost of a COVID test, let alone the additional lab work and x-rays.

Discussion

The results of this study evoke various important points of discussion in terms of the medical bias experienced by Francophone refugee camps for generations, but also how these patterns are being witnessed in current time. Unless action is taken to aid and correct the bias, these dangerous patterns of inequity will continue to be witnessed in the future.

The literature reviewed surrounding healthcare education in both French and English-based languages were congruent with each other - generally stating, refugees in Francophone refugee camps lack healthcare education. Reviews from both languages state this lack of education is not as simple as a child not going to school like most Western-thinking people assume. Instead, the problem is more complex. Lack of healthcare education for Francophone refugees can encompass lack of healthcare infrastructure, lack of educational infrastructure, inability to prioritize education, lack of educated community members, lack of ongoing and continuous support, etc. Healthcare education is not solved by a pamphlet and a one-time Saturday morning seminar hosted by a random volunteer organization on a relevant disease. These refugees each come from their own unique and tense global situations, and they should not be expected to come from a physical or emotional standpoint to be autonomously responsible for their health. Thus, the important point to discuss here is if refugees can't be expected to independently manage their own health, it is expected for third party resources to naturally step in and assist these individuals in what they lack. The problem is, the third-party care they are receiving is still subpar because it is difficult to create a plan of action for masses of people with various backgrounds. The solution to this problem is reliant on awareness. If the immediate communities expected to support these refugees are not *aware* how to best help the refugees, efforts will be futile. If the immediate communities expected to support these refugees are not

aware of the resources available to them to then help the refugees, efforts will be futile. If the larger communities and surrounding countries are not *aware* of these same things either, efforts will be futile. If people in other countries are not *aware* of the refugee struggle, or the presence of a medical inequity to begin with, no efforts or support will be given, and thus forward change is impossible. These are important points to keep in mind because awareness is the first step to improving any facet of the interdisciplinary, tense, and complex situation Francophone refugees face, and this project is a bold step in that correct direction.

Raising awareness not only gets more people involved, but it can also mean there is an influx of money, resources, and volunteers, which actually make a difference in real time on the grounds of these refugee camps. Because financial inaccessibility to care is another main driving point found in both French and English-based literature surrounding Francophone refugees, raising awareness is also a crucial first step to solving this problem. Similar as discussed above in regard to education, refugees come from various backgrounds, which means they often have little to no money once they arrive at a refugee camp. Even if certain care is established and available to refugees, if they cannot afford it they cannot receive the care. This is highly problematic because it is well known that Francophone refugees come from a place of high global stress that often results in uprooting, displacement, and no money. If a refugee needs care, they should be able to receive that care regardless of their financial status. To make this dream of universal healthcare for refugees a reality, more funding is needed to support the refugee camps. The problem with that dream is barely enough funding is able to be accessed to support the bare minimum needs the refugee camps require. Additionally, a steady increase in Francophone refugees keeps raising the bar for the amount of money needed to support the minimum necessities, which therefore makes the dream of universal healthcare for refugees seem even

more unreachable. However, with awareness, financial support from other countries, volunteerism, and donations of supplies, the dream of closing the gap on medical inequity can be made possible.

Other than financial stress on Francophone refugee camps, stressors as a result of compounding medical conditions also occur but could be made easier with early intervention and prevention strategies. Refugees come from unstable backgrounds and don't have the education, money, healthcare access, or ability to prioritize getting the care they need. Thus, when a refugee arrives at a refugee camp, they often don't just have one medical issue that needs treatment, they have multiple compounding problems which makes treating each individual problem even more difficult. If refugees had the ability to access care throughout many points in their lives, they could receive more frequent and wholesome care for problems as they arise. By dealing with individual problems, this puts less stress on the healthcare system of the refugee camp, which in the end would have more time and resources to disperse amongst other refugees - improving the quality of life for many.

Awareness is the common driving point which brings together all fundamental components of this research project- without awareness, there is no forward progress. The problematic obstacles endured throughout history by Francophone refugee camps is important to be discussed and valued, but it is also important to discuss how that cycle can be broken so future generations can live more wholesome lives. This reason is why performing this research project in light of the COVID-19 pandemic was so essential. COVID-19 has been a real time marker of how these three fundamental issues (lack of healthcare education, compounding medical conditions, financial inaccessibility to care) manifest into real problems that affect the daily lives of Francophone refugees. The results presented in this study support that Francophone

refugees lack basic healthcare education specific to the novel Coronavirus. It is not stating that all refugees are unaware of the importance of social distancing, mask wearing, and frequent and proper sanitation, although that is likely an additional factor; rather, they lack education on things such as how to wear a mask, where to go if experiencing signs and symptoms of COVID-19, or where to find other basic resources to uphold proper sanitation practices. Lack of healthcare education does not always stem from the individuals' mental capacity and previous knowledge; rather, it can also commonly be a result of restricted or absent information to them altogether. This is yet another reason why awareness of the issues Francophone refugees experience is so essential. If people are not aware that refugees don't know where to get a mask, or proper places to sanitize themselves, no other third-party individuals can help to facilitate those connections or provide those resources needed.

Conclusion

The goals of this project were to raise awareness of the patterns of medical bias refugees in Francophone countries experience so physicians and other healthcare workers can be more prepared in the future. Considering the patient's global position and not just their current medical status is vital and can, and should, direct the plan of care and treatment plan for the patient. This research project performed an in-depth analysis of literature from numerous countries in two languages, to help exemplify the patterns of inequality Francophone refugees experience and support those points with the real-time data of the COVID-19 pandemic. Lack of healthcare education, compounding medical conditions and financial inaccessibility to care are only a few of the vast reasons why Francophone refugees have a completely different experience and perspective on medicine and the world. By beginning to understand the challenges these refugees face on a daily basis, healthcare workers can be better informed of how they can be the best physician to each and every one of their deserving patients.

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