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Report from the Field

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An EMS Response to Refugees Arriving at an International Airport: A Report From the Field

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Abstract

Following Afghanistan's fall in August 2021, many refugees were settled in the United States as part of Operation Allies Welcome. They were flown from Kabul to the Middle East and Europe before continuing to the U.S. By late September Philadelphia was the sole destination. From there refugees were transported to Safe Haven military bases around the country. Philadelphia International Airport became the site of a months-long operation involving city, state, federal, and private agencies engaged in processing, medical screening, and COVID-testing of arriving refugees. The Philadelphia Fire Department played an integral role. Minor medical conditions were treated onsite. Higher acuity patients were transported to nearby hospitals. The goal was to maintain flow of refugees to their next destination while addressing acute medical issues. Between August 28, 2021, and March 1, 2022, the airport processed 29,713 refugees. Philadelphia's experience may serve as a guide for planning future such refugee operations.

After years of war, on August 15, 2021, Kabul Afghanistan, fell to the Taliban. The last American troops left Hamid Karzai International Airport (HKIA) on August 30. In July the United States (US) began evacuating embassy employees, Afghans seeking Special Immigrant Visas, and Afghans at risk.[1] Refugees were first staged at military bases, called "Lily-Pads," in Europe and the Middle East. On August 29, 2021, President Biden announced Operation Allies Welcome (OAW), the plan to settle vulnerable Afghans on arrival in the United States.[2] From the Lily-Pads they were flown to Dulles Airport in Virginia and transferred to 1 of 8 Safe Haven military bases. In September, Philadelphia International Airport (PHL) became the sole flight destination.[3] The months-long response based at PHL involved processing and medical care of refugees on their initial arrival in the United States and included federal, state, and local partners including the Philadelphia Fire Department (PFD). This Report from the Field presents the PFD Emergency Medical Services (EMS) perspective on this operation.

The Philadelphia Fire Department is the sole 9-1-1 EMS agency for Philadelphia and is one of the busiest systems in the country. Philadelphia annually hosts many special events and mass gatherings. The PFD plays a key role in medical coverage for these events. Despite prior experience, the nature, timing, and duration of OAW challenged the PFD and the city. Philadelphia received only 2 d notice it would be a destination city, with the first flight arriving August 28. The city was already amid its COVID-19 response. The PHL medical plan was developed by the Philadelphia Department of Public Health (PDPH) and included many partners. These were divided into EMS, the Medical Group, Public Health, and Area Hospitals. The PFD filled the EMS role, assisting with patient care and performing all transports. It deployed 4 ambulances and a supervisor around the clock. The Medical Group consisted of volunteers from area hospitals, including physicians, nurses, and pharmacists. Pharmacists oversaw a dispensary of over-the-counter and prescription medications.[4] The PDPH filled the Public Health role along with state and federal agencies, including the Pennsylvania Department of Health (DOH) and the Centers for Disease Control and Prevention. Three PFD receiving hospitals were selected based on proximity to PHL and ability to manage complex patients.

Other participating organizations at PHL included the Philadelphia Police Department, Customs and Border Protection (CBP), Federal Emergency Management Agency, US Department of Homeland Security, Transportation Security Administration, US Department of State, the US Army and Air Force, Pennsylvania National Guard, and the Red Cross. Close collaboration among partners was critical. The Philadelphia Office of Emergency Management served as liaison, coordinating daily meetings to provide updates and address issues that arose.

Terminal A at PHL handles international flights and houses CBP. Its baggage claim area became the reception center for refugees (Figure 1). Upon deplaning, they were processed by CBP and directed to baggage claim. There they were greeted by Dari, Pashto, Urdu, and Farsi interpreters. All were tested for COVID. Those testing positive were isolated and processed separately. All were asked about acute medical issues and if they needed prescription medication

Figure 1. Baggage claim area at Philadelphia International Airport configured to provide COVID testing and medical screening of arriving Afghan refugees.

refills. Those answering yes were directed to the Medical Triage and Treatment (MT&T) area. Others were bused to Joint Base McGuire-Dix-Lakehurst in New Jersey or flown to another Safe Haven.

Refugees in MT&T were triaged by a physician. Those with a medical emergency were transported to a hospital. Patients with non-emergent conditions or needing a refill were evaluated by medical staff or a pharmacist. Care was focused to expedite refugee flow. Medical Triage and Treatment initially had limited resources, which expanded as needs became clearer. Useful items included glucometers, thermometers, urine dipsticks and pregnancy tests, a cardiac monitor, and a portable ultrasound (US). Ultrasounds were valuable because of the many pregnant women. A reassuring study reduced emergency department (ED) transports. A curtained exam area was constructed for privacy during US studies. Those needing a prescription medication were given a 2-wk supply if available. Antihypertensives, oral hypoglycemics, antibiotics, and analgesics were frequently requested. Patients with suspected communicable diseases were evaluated by Public Health staff. Behavioral health personnel were available to address mental health issues. A paper chart was created for all patients and collected by PDPH staff. The Pennsylvania DOH's Health Incident Management System software, linking EMS, hospitals, and health departments, was used for patient tracking.[5]

A lead emergency physician on each shift oversaw care and oriented providers to cultural considerations when interacting with Afghans. These included proper greeting, the impact of Islamic faith on provision of care, respect for patient modesty, and the importance of providers being the same gender as patients.[6] Because many patients were female, the PFD attempted to staff female providers on all shifts.

Daily numbers of flights ranged from 0 to 8, arriving around the clock. The highest daily number of refugees exceeded 2200. Given the complexity of the overseas operation, flights were frequently cancelled or rescheduled and others added. Uncertainty made it necessary for the PFD to maintain its full resources, rather than adjusting based on anticipated need. On September 11, all OAW flights worldwide paused due to a measles outbreak at 1 of the Lily-Pads. Other infectious diseases had also been identified. The pause lasted several weeks. Flights to PHL resumed on October 5 but decreased in frequency over subsequent months. Emergencies were then handled by PFD assets permanently stationed there.

Between August 28 and October 23, a total of 24,000 refugees were processed, with over 1000 referred to the MT&T area. Most had minor issues such as respiratory tract infections, diarrhea, and requests for medication refills.[4] However, higher acuity patients were encountered. Refugees on early flights were more likely to have untreated or partially treated conditions because they had spent little time at Lily-Pads. Several had serious injuries sustained during their departure from Kabul. One man arrived at night with a distal extremity amputation from the blast at HKIA. He had boarded a plane and self-bandaged enroute. After discussing local after-hours options, it was believed his best plan was to continue to the destination Safe Haven for definitive treatment. In September, a baby girl suffered a cardiac arrest on an inbound flight. Upon arrival, she was met by EMS and transported to a pediatric hospital where she died.[7] As of October 23, there were a total of 84 EMS patient contacts and 77 transports. On March 1, 2022, when PHL's role in OAW ended, 29,713 refugees had arrived on 336 flights.[8]

Discussion

Afghanistan has experienced decades of violence including the Soviet-Afghan War, the rise of the Taliban, and the post 9/11 invasion by coalition forces.[9] Millions of Afghans have fled their country.[10] Lessons learned from caring for Afghan refugees in other countries informed planning at PHL. Previous studies found that infections, skin disorders, diarrhea, cardiovascular disease, posttraumatic stress disorder, and depression were common.[11,12] Many patients at PHL had similar issues, mostly mild. This was similar to the experience of the nearly simultaneous August 2021 consular evacuation operation from HKIA involving several European countries.[13] However, as illustrated by the child who suffered a cardiac arrest and patients with serious injuries, PHL had to prepare for high acuity conditions.

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Staffing the Medical Group with volunteers was easy initially but became difficult as time passed. Factors included the operation's duration, around-the-clock nature, and the changing flight tempo, with some shifts seeing few patients. These factors, and the lack of a clear end date, also created staffing challenges for the PFD. It relied heavily on overtime to meet the needs of OAW and those of the city. Medical supplies on site were generally adequate. The recent purchase of new ambulances meant there were enough to cover PHL and the daily 9-1-1 call volume.

Increasing geopolitical instability has caused a global rise in refugee populations. It is likely the United States and other nations will receive refugees in future operations such as OAW.[14,15]

Depending on the number and period over which they arrive, these may have an impact on local health-care resources. The operation challenged the PFD and several city partners. However, the impact of OAW on the local health-care system was small because PHL was a transit point en route to destination Save Havens. The city also has many hospitals and a robust public health infrastructure. Communities that are final destinations for refugees or with fewer medical resources may be more impacted. Planning for such operations should address the medical needs of refugees and the ongoing needs of the community. Mutual aid from outside areas may be required. Challenges associated with working with refugee populations should be considered, including language barriers, cultural differences, lack of routine health care, incomplete medical records, and increased incidence of infectious diseases and mental illness. From an EMS perspective, the system should prepare to dedicate resources for a protracted operation, potentially working in an unconventional setting using skills rarely used in 9-1-1 responses. This can be particularly difficult for a busy EMS agency. Lessons learned from Philadelphia's experience with OAW may benefit other communities planning for a similar influx of refugees.

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