

America's Wars and Iraqis' Lives

Toxic Legacies, Refugee Vulnerabilities, and Regimes of Exclusion in the United States

Marcia C. Inhorn

Introduction

I begin this chapter with an argument—namely, that America has failed in its moral duty to assist those whose lives it has destroyed through its own wars in the Middle East.¹ Focusing on Iraq, this chapter shows how America's two wars there have had a shattering effect not only for Iraqis who remain in the country, but also for those who have fled. In America today, few people connect the current Middle Eastern refugee crisis to the United States' military interventions in Iraq. In the United States, memories of war have faded, and the refugee crisis seems distant. Thus, my main goal in this chapter is to rekindle this moribund history of these American wars and to link them directly to Iraqi refugee flight.

As a medical anthropologist, I am particularly concerned about the health costs of war in Iraq—not only for Iraqis who have remained in the country, but also for those who have left. As I will show, the health costs of conflict in Iraq include massive loss of life and a toxic legacy of radioactive contamination. Wars' health effects also extend well beyond Iraq's borders, literally carried in the exposed bodies of Iraqi refugees. In this chapter, I illuminate the embodied dimensions of human suffering through the story of one Iraqi man, who attributes his own male infertility problems to the consequences of living through a toxic war.

Another major goal of this chapter is to expose the “structural vulnerability” (Bourgois et al. 2017) of Iraqi refugees who have been resettled in the United States. Based on a five-year ethnographic study carried out in metropolitan Detroit, Michigan (i.e., America’s poorest big city), I describe the various physical and economic hardships faced by Iraqi refugees, including precarious employment, deep-seated poverty, lack of social safety nets, and lack of access to affordable (reproductive) healthcare.

Structural vulnerability is, in part, the outcome of poorly planned and inadequately crafted resettlement programs. I detail the ten major systemic flaws in U.S. refugee resettlement policy—a policy that became increasingly restrictive under the presidency of Donald Trump. Indeed, although the United States has never been a particularly welcoming home for refugees from the Middle East, Iraqi refugees have been faced with additional regimes of exclusion—even for those Iraqis who assisted the U.S. military and were scheduled for U.S. resettlement. Unprecedented in the history of U.S. refugee admissions, such regimes of exclusion make crystal clear the lack of U.S. commitment to the lives of those Iraqis whose country it has destroyed.

America’s Middle East Wars

Throughout the twentieth and twenty-first centuries, the Middle East has suffered a disproportionate number of wars and protracted conflicts that have led to population disruption and turmoil. Even before the fateful 2011 Arab uprisings that led to the Syrian government’s war against its own people, fifteen of twenty-two Arab League nations—comprising 85 percent of the region’s overall population—had suffered from complex emergencies (Mowafi 2011), including the country of Iraq.

Indeed, it is fair to say that Iraq has lived through forty years of perpetual war and human suffering. Saddam Hussein came to power in 1979 and soon plunged his country into a crippling eight-year war with neighboring Iran. The Iran-Iraq war led to the death of as many as one million soldiers and civilians. In 1990, Saddam Hussein invaded another neighboring country, Kuwait, which led to Operation Desert Storm, the United States’ first military intervention in that country. Lasting only seven months, the first Gulf War in Iraq nonetheless led to as many as 120,000 casualties, followed by thirteen years of UN-imposed sanctions. In 1996, the United Nations implemented an oil-for-food program to prevent massive starvation in the country. But, the sanctions continued to cripple the Iraqi economy until they were removed at the start of the second U.S.-led war in Iraq in 2003.

Responding to the September 11 attacks on the World Trade Center and the Pentagon in 2001 and driven by a determination to eliminate Middle Eastern terrorism, the United States launched Operation Enduring Freedom

(OEF), its military campaign in Afghanistan. Less than two years later, in 2003, the United States launched Operation Iraqi Freedom (OIF), which we now know was based on false intelligence purporting Saddam Hussein's links to September 11 and his threats to U.S. national security through weapons of mass destruction.

In retrospect, the second U.S. war in Iraq is widely condemned as a U.S. military and foreign policy failure of massive proportions—perhaps the worst in modern U.S. and Middle Eastern history (Hanson 2013; Katz 2010). The U.S. military intervention in Iraq increased political instability in the country, leading to a power vacuum that was partly filled by Islamic insurgent groups, most notably ISIS. Furthermore, the U.S. invasion of Iraq served as a crucial “tipping point” in an unstable sectarian balance of power, unleashing deep-seated sectarian tensions between Sunni and Shia Muslim factions in the country—with consequences that have been truly profound not only for Iraq, but for the increasing sectarian divisions that are devastating the region as a whole (Nasr 2006).

This brings us to the present moment. The United States is still at war in Afghanistan—at twenty years, it is the longest declared war in modern U.S. history. And although an end to the Iraq war has been declared twice—first by President George W. Bush in his “mission accomplished” speech on 1 May 2003, and then on 19 December 2011 by President Barack Obama—the truth is that the U.S. military presence in Iraq has never ended. In 2016 alone, the United States dropped a total of 12,095 bombs on Iraq in its battle against ISIS (Zenko and Wilson 2017). At the beginning of 2020, nearly 1,000 additional U.S. troops joined the 5,200 troops already on the ground in Iraq in response to Iraqi protestors who stormed the U.S. embassy in Baghdad. In the Middle East as a whole, approximately 60,000 U.S. soldiers were deployed across the region by 2021. Indeed, the inconvenient truth—but one that few Americans seem to ponder these days—is that the United States has done more to produce and sustain deadly wars in the Middle East than to relieve them.

The Health Costs of War in Iraq

How has this ceaseless violence impacted the Iraqi people? The costs of war in Iraq have been acute, involving “syndemics,” or simultaneous, synergistic epidemics of human suffering (Ostrach and Singer 2013). In Iraq, war-related syndemics have involved civilian casualties and injuries, demographic and reproductive health effects, mental health disorders, and environmental illnesses due to war-related contamination. Here, I want to focus on two of these—namely, the “body count,” or the number of Iraqi dead, and the toxic legacies of war in Iraq, particularly the use of depleted uranium (DU), a

radioactive toxin that has been linked to a number of adverse health effects, including reproductive impairments. The health costs of war have real, long-lasting effects, as I will show in the story of one man, Kamal (a pseudonym), who fled Iraq and eventually made his way to the United States.

The Body Count

The most important impact of war in Iraq has been the high death toll. According to human rights observers, long-term U.S. wars in both Iraq and Afghanistan have been among the world's most fatal, with annual civilian casualties often exceeding 10,000. However, the "body count"—or the number of war-related casualties—has been, and continues to be, a highly controversial subject. In Iraq, no one can precisely say how many Iraqis have been killed, because estimates vary greatly and the accuracy of information coming out of Iraq is uncertain. However, another problem surrounds the U.S. military's total refusal to engage in Iraqi death toll estimates. Early on, U.S. general Tommy Franks, who led the 2003 U.S. invasion of Iraq and the overthrow of Saddam Hussein, famously stated, "We don't do body counts."

As a result of U.S. coalition indifference to the Iraqi death toll, a number of academic research groups and human rights organizations began tallying estimates of wartime casualties in Iraq. Perhaps the best estimates come from an international monitoring project called the Iraq Body Count, or IBC, which has updated and cross-checked reports of death ever since the beginning of the 2003 U.S. invasion.² The IBC reports that approximately one-quarter million deaths have occurred in Iraq due to direct war-related violence among both civilians and combatants. Of these, more than half are of Iraqi civilians. By 2015, in the midst of the ISIS siege, IBC was calling the massive death toll in Iraq "a catastrophic normal." Compared to the 4,500 cumulative deaths of U.S. military personnel between 2003 and 2015, the Iraq body count is at least 55 to 110 times higher than American casualties, depending on which death toll estimate is used. In other words, the United States started a war in Iraq that has been deadly for American soldiers, but *truly* deadly for Iraqis.

Depleted Uranium

Of all the destruction set in motion by the U.S. invasion of Iraq, the one with the longest-term health consequences may have to do with contamination of the environment. The United States has used multiple chemical toxicants in warfare—the most famous examples being the use of the defoliant Agent Orange and napalm bombs in Vietnam (Gammeltoft 2014). However, in Iraq, depleted uranium, or DU, which was used by U.S. forces in both the first and second Gulf Wars, may have the longest-lasting adverse effects.

Depleted uranium is the waste product of the uranium enrichment process and is about 60 percent more radioactive than natural uranium. Like lead, nickel, and other heavy metals, DU is chemically toxic to humans. It has been used since 1959 in the U.S. munitions industry because it is 65 percent denser than lead, has a high melting point, has a tensile strength comparable to most steels, and ignites when it fragments. The U.S. military has called DU the “silver bullet” for destroying enemy tanks and the “silver shield” for armoring U.S. tanks against enemy fire. However, when DU explodes, it creates “a fine, respirable size dust that contaminates an impact site and presents a hazard to combat troops and civilians” (Fahey 2004: 4). This DU dust in the environment has a radioactive decay chain lasting 4.5 billion years, thereby posing *very long-term* health risks to exposed populations. Thus, DU activists began to accuse the U.S. Department of Defense of gross negligence in using a weapon in Iraq “that distributes large quantities of toxic waste in areas where people live, work, grow food, or draw water” (Fahey 2004: 24).

The potential dangers of DU emerged as a social, political, and scientific issue after the first Gulf War. It is estimated that nearly 900,000 DU rounds were fired in Iraq by U.S. and British troops in that war, with Gulf War veterans eventually attempting to link DU contamination to so-called “Gulf War syndrome”—a cluster of health problems including, among other things, both reproductive and sexual health impairments (Kilshaw 2008). In a ten-year follow-up study of American veterans who were hit by “friendly fire” and thus had DU shrapnel embedded in their bodies, researchers showed that higher-than-normal levels of uranium were associated with perturbations in reproductive hormones, causing male infertility and erectile dysfunction (Maconochie, Doyle, and Carson 2004). Some evidence of neurological and genetic damage was also evident.

With the ongoing use of DU in the 2003 Iraqi invasion, the World Health Organization (2003) released a report titled *Potential Impact of Conflict on Health in Iraq*, which suggested that DU might be related to reports of increased cancers, birth defects, reproductive health problems, and renal diseases in the Iraqi population. A series of studies later carried out in the heavily bombarded city of Fallujah, which sustained some of the worst damage by U.S. forces, show a syndemic of health-related problems, including high rates of congenital malformations (15 percent of all births); higher than expected rates of cancer, especially leukemia and lymphoma in children; higher than expected rates of infant death, when compared to infant mortality rates across the region; and an anomalous sex ratio in children under age five, suggesting that genetic damage was sustained in the zero to age four cohort. Hair samples taken from the parents of so-called “Fallujah babies”—or Iraqi neonates with severe congenital malformations—show the statistically significant presence of DU in their mothers’ bodies (Alaani et

al. 2010, 2011). Additional studies of DU exposure in Iraq demonstrate the substance's genotoxicity, or ability to cause genetic damage even "greater than previously considered" (Durakovic 2016). The chemical's carcinogenic (i.e., cancer-causing) effects have led to an overall increase in breast, lung, thyroid, and blood cancers in Iraq, doubling or even tripling in incidence in some regions of the country (Fathi et al. 2013). Of importance to U.S. troops, inhalation and internalization of DU into the body has been shown to cause multiple health risks, especially among "crews of damaged tanks and rescue teams" (Jiang and Aschner 2015). Thus, the health costs of DU have affected soldiers and civilians alike.

Kamal—An Iraqi Refugee's Story

The synergism of these health-related effects can be seen in the story of Kamal, an Iraqi refugee I met in a reproductive health clinic in the state of Michigan.³ As I was to learn from Kamal, he had been conscripted into Saddam's army as a telecommunications specialist. "I was in a tank, *always* in a tank," he said, and continued:

I saw *everything!* The smells, the dead people. Sometimes we were sleeping with people who were dead in the tanks, injured people, with blood all around. We saw *everything!* So when we see [that] someone is dead, we don't even care. We saw *so many* dead people, *so much* blood. Sometimes, we had to eat with people who were dead beside us.

Eventually, Kamal joined the Iraqi resistance and made his way out of the country. But he was concerned about his relatives left behind in Iraq. He explained:

We heard that there is uranium everywhere. You know, Marcia? Cancer. *A lot* of people in Iraq got cancer. If you ask anybody here, "You got the flu?," the question there would be, "You got cancer?" Before, it was not easy to use the term *saratan* [cancer]. But now, it's easy to say, "I got cancer." My sister, she had a sixteen-year-old daughter. She died after two months from cancer, liver cancer. She found out, and then she died.

By the time I met him in Detroit, Michigan, Kamal had a happy story to tell. In the ten years since he had arrived in America, Kamal was able to accomplish many of the things in life that other Iraqi refugees could only dream of. These included a happy marriage to his Iraqi sweetheart, whom he had met in a refugee camp; American citizenship by way of naturalization; an economically stable life as the proprietor of two small barbershops; ownership of two "fixer-upper" homes that he and his two Iraqi refugee brothers had remodeled; and the joys of parenthood through the birth of a

baby. Pulling a photo from his wallet, Kamal smiled widely when he showed me the picture of little Haydar, his thirteen-month-old son. As he pointed out proudly, Haydar was an American citizen by birth—not born in exile—in a land that they now called home.

However, as Kamal also confessed, Haydar's birth was exceptional, in that Kamal suffered from a serious male infertility problem that could only be overcome through costly assisted reproductive technologies. Male infertility, he explained, was common in Iraq and among his refugee community in Michigan—a situation that he linked to war-related environmental exposure:

Marcia, I want to tell you something about me. I have no problem with sex, no problem with my body. I don't smoke, no drinking. I do exercise every day, and I'm healthy. But I know a lot of [Iraqi] men like me. They don't have kids, and they take a long time to get a baby. I know about fifteen to twenty people like that, here in Michigan. Some are friends of mine. We are all refugees. All of us Iraqi refugees, the same life we lived. The same war. The same camp. The same thing. And we began talking about the subject of [not getting] babies. I always tell them, "We don't want to be shy [about this] because we need a baby! Don't be shy! Go to the doctor. Don't stay at home. Tell him [the doctor], 'I'm sick, and I need to take medicine.'" I know somebody [with male infertility], and he was ready to make a divorce with his wife, and he's young! But I tell him, "Please don't do that! Go to the doctor. Do something!" In Iraq, we lost all our good doctors. But here in America, everything is good. The doctor is good. Technology is good. Medicine is good. But some men, they're embarrassed to say, "I have this problem." It's the *rujula*, the "manhood." But this is wrong.

As Kamal explained, many Iraqi refugee men feared their reproductive health problems were somehow due to irremediable war-related exposures and traumas. Not surprisingly, *al harb*, "the war," figured prominently in Iraqi refugee men's narratives, given that some men had been combatants, while others had suffered war, torture, and imprisonment in their home country. To that end, they felt grateful to have escaped alive, although life in America was not easy, as their stories reveal.

Narratives of Reproductive Exile

I collected such narratives of suffering and reproductive disruption over a five-year period between 2003 and 2008 through ethnographic fieldwork conducted in Arabic, English, or a mixture of both, with nearly 100 resettled Arab refugees in metropolitan Detroit, Michigan. I made my way on a weekly basis to Dearborn, Michigan, an ethnic enclave on the margins of Detroit and the so-called "capital of Arab America" (Abraham and Shryock

2000). My study began two years after September 11, 2001, continued throughout the first four years of the U.S.-led war in Iraq, and ended with the beginning of the U.S. financial crisis in 2008. By the time of the 2011 Arab uprisings and Detroit's own Chapter 9 bankruptcy hearings in 2013, my study had ended. However, through five years of nearly continuous ethnographic research in the heart of Arab America, I was able to meet nearly one hundred Arab men and women, most of them poor Shia Muslim refugees from Iraq or southern Lebanon.

As a medical anthropologist, I was interested in these refugees' reproductive health. Thus I located my study at IVF Michigan, the Midwest's largest infertility treatment and assisted reproduction center. Virtually all of the men and women in my study—some of whom came to the clinic together as couples, while others arrived alone—suffered from problems of infertility, with male infertility, of the kind faced by Kamal, the most frequent diagnosis. Like Kamal, all of the men and women in my study were dreaming of becoming parents, not only to achieve cultural mandates of adult personhood, but to make new lives and new families after all that had been lost. However, unlike Kamal, few of these men and women could afford the \$150 office visit, let alone a \$12,000 cycle of in vitro fertilization (IVF). Indeed, Kamal was the only person in my study who was able to self-finance three costly rounds of intracytoplasmic sperm injection (ICSI), a variant of IVF designed specifically to overcome male infertility. Kamal was thus one of only two men in my study who were able to father an ICSI or IVF child.

By the end of my study, I came to think of these poor, struggling, infertile refugees as “reproductive exiles” (Inhorn 2018). Banished from their home country by war, most remained in a kind of double exile—unable to return to Iraq because of ongoing violence and a shattered healthcare system, but unable to access infertility services in the most expensive country in the world in which to make an IVF baby. Every time I drove away from IVF Michigan—passing the gray facade of the Ford Rouge factory with its billowing smokestacks—I felt deep pangs of sympathy for these men and women. Living constrained lives on the polluted margins of Detroit, there was little that they could do to change their situations. They were stranded—impoverished, immobile, and barren.

By the time I returned to IVF Michigan in the summer of 2015 to undertake a follow-up visit, the world had fallen victim to the worst refugee crisis in modern history. Syrians—but also Iraqis and Afghans—were fleeing to Europe to escape the unrelenting violence in their home countries. However, Iraqis were also flowing into the United States in substantial numbers. Many of these Iraqi refugees landed in Arab Detroit. Yet, as we shall see, this crumbling “motor city” could ill afford any new refugee resettlement, given its inability to sustain the refugees in its midst.

Iraqi Resettlement in Arab Detroit

The arrival of a new wave of Iraqi refugees to Arab Detroit is not surprising, given that the Detroit metro area has been one of North America's largest refugee receiving grounds (Abraham and Shryock 2000; Schopmeyer 2011). Beginning in the 1950s, exiled Palestinians started resettling in the Detroit suburbs, a pattern that continued among Palestinians over the five ensuing decades. By the 1970s, Palestinians were joined by Lebanese, whose numbers swelled with each passing year of the Lebanese civil war. By the mid-1990s, Lebanese and Palestinians were joined by Iraqis, tens of thousands of whom came as refugees in the aftermath of the first Gulf War. Thus, over half a century, metropolitan Detroit absorbed three major populations of fleeing Arabs—Palestinians, then Lebanese, then Iraqis. By 2000, Michigan scholars dubbed the city's new ethnic enclave "Arab Detroit," highlighting the importance of a quarter million people of Arab descent now living in the area (Abraham and Shryock 2000).

However, in 2008—the same year as the Great Recession—the Iraqi population of Arab Detroit began to swell again as the second wave of refugees began to receive admission into the United States. As shown in table 10.1, Iraqi refugee admissions that year increased eight-fold (Svab 2015). By 2009, fully one-quarter of all refugees entering the United States were Iraqis, and Arab Detroit absorbed nearly as many as the cities of New York, Chicago, and Los Angeles combined. By 2014, Iraqis represented 28 percent of the refugees entering the United States, the single largest group. Indeed, from 2007 to 2015, 126,000 Iraqi refugees entered the United States. This was fully one-fifth of all refugees admitted, but less than one-half of the Iraqis seeking U.S. refugee admissions. As seen in table 10.2, Iraqis were settled in every U.S. state except Wyoming.

As shown in table 10.2, the state of Michigan was second only to California, taking in a disproportionate share of Iraqi refugees (Svab 2015). Yet, the local Michigan economy is poorly suited for such large-scale Iraqi refugee resettlement—

Table 10.1. Iraqi Refugees Admitted to the United States (2007–15).

Fiscal Year	Number Admitted
2007	1,608
2008	13,823
2009	18,838
2010	18,016
2011	9,388
2012	12,163
2013	19,488
2014	19,769
2015	12,676
Total from 2007–2015	Total Number 125,769

Source: Based on data from www.uscis.gov/humanitarian/refugees-asylum/refugees/iraqi-refugee-processing-fact-sheet and Zong and Batalova 2015.

Table 10.2. U.S. States of Iraqi Resettlement (2006–15).

Level	Number of Refugees	States (in Alphabetical Order)
1	10,000–25,000	California, Michigan, Texas
2	1,000–9,999	Arizona, Colorado, Florida, Georgia, Idaho, Illinois, Kentucky, Maryland, Massachusetts, Missouri, North Carolina, New York, Ohio, Oregon, Pennsylvania, Tennessee, Utah, Virginia, Washington
3	100–999	Alabama, Connecticut, District of Columbia, Indiana, Iowa, Kansas, Louisiana, Maine, Minnesota, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Vermont, Wisconsin
4	1–99	Alaska, Arkansas, Delaware, Hawaii, Mississippi, Montana, West Virginia

Source: Based on data from the U.S. Department of State, as reported in Svab 2015.

particularly the city of Detroit, where most of these refugees were placed. Detroit is America’s poorest big city, with 38 percent of its population, or roughly two-fifths, living below the federal poverty line (Kneebone and Holmes 2016). Two-thirds of all Detroiters live in a state of ALICE—“asset limited, income-constrained, employed” (United Ways of Michigan 2014). These poverty figures are replicated in Arab Detroit’s refugee community. Fully four-fifths, or 82 percent, of all Iraqi Muslim refugee families live on household incomes of less than \$30,000 per year. And nearly half, 42 percent, live well below the U.S. federal poverty line, on household incomes of less than \$10,000 per year (Detroit Arab American Study Team 2009).

Given these poverty statistics, it is not surprising that most of the Iraqi refugees I met in Arab Detroit were precariously employed and often desperately poor. Many of the men did not speak English fluently, nor did their wives, as few of them had attended school in the United States, and few had gone beyond high school in their home country. Without strong English skills or advanced educations, most of the Iraqi refugee men in my study were employable only in low-wage, blue-collar, or service-sector occupations, mainly as gas station attendants, dishwashers and busboys in Middle Eastern restaurants, truck drivers, construction workers, auto mechanics, or factory workers. Salaries and wages were generally low, with many men and their wives living in small apartments and generally eking out subsistence lives below the poverty line.

Without regular employment, most did not have private health insurance to cover the costs of their medical care. Most did not own credit cards. As a

result, virtually all of their financial transactions, including visits to medical clinics, were handled in cash. In cases of medical emergency, social safety nets were generally missing, forcing some participants in my study to rely on local Islamic charities for relief. In terms of their overall health, my interlocutors spoke to me of war traumas and deaths in the family, various health impairments and physical disabilities, separations from family members still back in Iraq, and feelings of loneliness, depression, and chronic stress.

The Iraqi refugees in my study were living in a state of “structural vulnerability”—a term put forward by medical anthropologists to describe “a positionality [within society] that imposes physical and emotional suffering on specific population groups and individuals in patterned ways” (Quesada, Hart, and Bourgois 2011: 340). Domains of structural vulnerability include one’s financial status, legal status, educational level, language ability, residence, food access, and social network, as well as considerations of whether the environment in which one lives exposes a person to risks or discrimination (Bourgois et al. 2017). Structural vulnerability is also about access to healthcare—or lack thereof—and how ill health is thus a product of one’s social location, especially exclusion from affordable public services and basic legal rights. Structural vulnerability also encompasses notions of “worthiness,” or whether individuals are deemed deserving of respect and quality care (Ticktin 2011).

Iraqis’ Resettlement Challenges

Unfortunately, structural vulnerability and reproductive exile are common elements of the Iraqi refugee experience in America. Resettled in the very country that caused their displacement and suffering, Iraqi refugees have been inadequately supported in the resettlement process—a process, as we shall see, that is deeply flawed. In 2009, at the height of the new wave of Iraqi refugee admissions, Georgetown University’s Human Rights Institute (2009) issued an alarming report, which documented ten major “systemic flaws” in Iraqi refugee resettlement policy. As outlined in the report, resettlement challenges include the following:

1. *Poor planning and coordination:* Many states, including Michigan, have received inadequate refugee funding, meaning that state agencies are constantly underfunded, with their caseworkers constantly pressured to deliver more assistance with limited means.
2. *Inadequate cash assistance:* Unlike Vietnamese refugees, who arrived in America in the 1980s and were fed and housed and given up to thirty-six months of cash assistance and other forms of support, Iraqi

- refugees today receive only eight months of cash assistance, the maximum allowable, after which they are left to fend for themselves.
3. *Lack of sustainable employment opportunities*: Given this time pressure, refugees are pressured to quickly enter low-paying jobs, which thrust most refugees into permanent states of chronic poverty and underemployment.
 4. *Lack of recertification and vocational training*: Educated refugees who worked as professionals in their home country rarely receive recertification and vocational training in order to re-enter their fields, such as engineering or medicine.
 5. *Inadequate English language training*: Learning English is often hampered by long waitlists for ESL courses, which are often of poor quality.
 6. *Unreasonable transportation options*: Many refugees are being resettled in communities with poor public transportation services, making it difficult to reach job interviews and access employment opportunities.
 7. *Inadequate medical care*: As with cash assistance, adult refugees are cut off from medical assistance after eight months, even though as many as 40 percent of Iraqi refugees come to the United States with pre-existing medical conditions.
 8. *Inadequate treatment of mental health issues*: As many as 75 percent of Iraqis are thought to suffer from mental health problems, primarily depression and anxiety. But these go unreported and untreated because the only mandatory mental health assessment occurs at the refugee's initial health screening.
 9. *Inadequate tracking of secondary migration*: Not surprisingly, Iraqi refugees may not thrive in their initial placements and choose to relocate. But these "secondary migrants" become "lost in the system," with no transfer of their case information from one state agency to another. When the Centers for Disease Control attempted to assess the health and wellbeing of the Iraqi refugee population through a survey conducted in the three most populous resettlement states of Michigan, California, and Texas, one of the major limitations noted by the CDC was an inability to locate Iraqis who were no longer contactable by state agencies (Taylor et al. 2014).
 10. *Failure to promote long-term self-sufficiency*: Although the U.S. Refugee Admissions Program has a legal obligation to "extend protection to the most vulnerable refugees, promote their long-term self-sufficiency, and support their integration" (Human Rights Institute 2009: 1), a decade worth of data suggests that U.S. efforts, modeled on domestic antipoverty programs, have failed to work in the best interest of Iraqi refugees and to promote their long-term self-sufficiency.

New Regimes of Iraqi Refugee Exclusion

Given these challenges, it can be said that America has never been a particularly welcoming home for Iraqi refugee resettlement. However, with the presidency of Donald Trump, America entered into an unprecedented period of anti-immigrant/anti-refugee sentiment, leading to new regimes of refugee exclusion. Indeed, in President Trump's America, Middle Eastern refugees were vilified as potential "terrorists," even though no act of terrorism has ever been committed by a refugee on U.S. soil, and even though many of the Arab refugees currently living in the United States fought valiantly alongside the U.S. military in Iraq.

To wit, only days after his January 2017 inauguration, President Trump kept his campaign pledge by issuing Executive Order 13769, officially titled "Protecting the Nation from Foreign Terrorist Entry into the United States," and based on the justification that the "United States must be vigilant during the visa-issuance process to ensure that those approved for admission do not intend to harm Americans and that they have no ties to terrorism." Executive Order 13769—soon known as the "Muslim ban" or "travel ban"—included seven countries, all Muslim, mostly in the Middle East, and initially including Iraq (i.e., Iran, Iraq, Libya, Somalia, Sudan, Syria and Yemen). At the time of its issuance, the Executive Order also suspended the U.S. refugee admissions program for 120 days, banned Syrian refugees from entering the United States, prioritized refugee claims on the basis of religious persecution, and lowered the total number of refugees in 2017 to 50,000, or less than half the number of 110,000 admitted annually under President Barack Obama's administration.

Yet the Executive Order excluded countries such as Saudi Arabia and Egypt, which were the nations of origin of the majority of the September 11 hijackers. The issuance of Executive Order 13769 thus sheds light on the motive behind the policy, which appears to be less of a means of combating terrorism than a way to stop Muslim refugees from entering the country. Immediately challenged and blocked by various U.S. courts, the Executive Order was nonetheless upheld in the U.S. Supreme Court, allowing the Muslim ban to proceed in full, even though the legal challenges against it continued.

Furthermore, by 2018, President Trump had dramatically reduced the number of refugee admissions to the United States overall by 75 percent—to the lowest level since 1980. In July 2019, he further pledged to reduce refugee admissions to *zero* in 2020, a threat that was eventually modified to an admissions cap of 18,000 refugees in total. Under the Trump administration, the only "silver lining" was for Iraqi and Afghan men who had served with U.S. forces and were granted SIVs, or "special immigrant visas," to the

United States in repayment for their service. However, with the extremely restrictive new admissions cap, the SIV program also came under threat. Many Iraqis and Afghans who had already been approved for resettlement were still waiting to be reunited with their families, or were still living in harm's way. Many were uncertain whether they would gain entry to the United States, even though many had risked their lives assisting U.S. forces.

On 26 September 2019, in an ever more restrictive environment, President Trump issued Executive Order 13888, which took into account “the preferences of state governments, and to provide a pathway for refugees to become self-sufficient.” The new order gave states such as Michigan the ability to refuse refugee admissions if they believed that they lacked the resources to do so. In effect, this new Executive Order further reduced the number of refugees resettled in the United States by shifting the focus of refugee responsibility from the federal government to individual states. As shown in this chapter, states vary dramatically in their levels of refugee support, based on their size, wealth, and commitment to refugee resettlement. Furthermore, states are subject to the political whims of changing leadership, which may significantly alter the wherewithal for resettlement.

Conclusion: The Beginnings of Re-inclusion

The U.S. president who openly declared his desire to end refugee admissions altogether was voted out of office at the end of 2020. Under a new presidential administration, the U.S. refugee admissions program has the potential to be reset from a regime of exclusion to one of inclusion. Indeed, on 20 January 2021, his first day in office, President Joe Biden repealed the Trump-era “Muslim ban,” which, by the end of Trump’s presidency, had restricted travel to the U.S. from thirteen predominantly Muslim Middle Eastern and African countries. In addition, President Biden directed the U.S. State Department to develop ways to address the harm that had been done to those, including refugees, who were prevented from coming to the United States under the travel ban. In this new beginning, President Biden effectively reconfirmed America’s moral commitment to Muslim immigrants and refugees, including those whose lives in their home countries were destroyed by America’s own wars in the Middle East.

In thinking about Iraqis who were put in harm’s way, it seems appropriate to conclude this chapter with a very moving quote from journalist Robert Guttersohn, a U.S. veteran of the Iraq War. In his article on “Michigan’s Iraqi Refugee Crisis,” Guttersohn (2014: 2) opined:

For the refugee, Iraq will always be home. But knowing he can never return to his native land, he must instead seek refuge in the country whose very military

invasion set off the domino effect leading to his displacement The refugee had the unfortunate luck of living there when the bombs began to fall. Taking in refugees is only half the job. Ensuring they have a fair opportunity to be active participants in the economy is another. An improved refugee program, whether run by the state or the federal government, would be expensive. So is war, though, and a country that starts one should feel the weight of those whose lives are uprooted by it—both its soldiers and the refugees.

Marcia C. Inhorn is the William K. Lanman Jr. Professor of Anthropology and International Affairs at Yale University, where she serves as Chair of the Council on Middle East Studies. A specialist on Middle Eastern gender, religion, and health, Inhorn is the author of six award-winning books, including her latest, *America's Arab Refugees: Vulnerability and Health on the Margins* (2018). She is (co)editor of thirteen books, founding editor of the *Journal of Middle East Women's Studies* (*JMEWS*), and coeditor of Berghahn's "Fertility, Reproduction, and Sexuality" book series. Inhorn holds a PhD in anthropology and an MPH in epidemiology from the University of California, Berkeley.

Notes

1. My use of the term "America" here is intentional. It reflects contemporary political discourses surrounding "American exceptionalism," as well as President Donald Trump's nationalistic campaign rhetoric of "Make American Great Again" (MAGA). I use the term "America" at various points throughout the chapter to reinforce these political dimensions.
2. See <http://www.iraqbodycount.org/> for more information.
3. Kamal's story and others like it can be found in my book, *America's Arab Refugees: Vulnerability and Health on the Margins* (Inhorn 2018), from which parts of this chapter are adapted.

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