Refugee and Immigrant Health Toolkit

for Atlanta-area refugee and immigrant children

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With many thanks to Dr. Susan Reines for her leadership in teaching refugee health to Emory Residents and in caring for Atlanta’s refugee and immigrant children

And to all the others who contributed to or provided input on this project: Li De-Almeida, David Greenky, Lauren Hawkins, Kate McGlamry, Brittany Murray, Khristopher Nguyen, Brian Perry, Elizabeth Quincer, Elizabeth Robertson, Meera Shah, Laura Wang, and all of the faculty and staff who responded to our survey,

And to The Leila Denmark Foundation whose grant made this toolkit possible
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Introduction
Nearly 3000 refugees arrive in Georgia each year, ranking us in the top 10 states for refugee resettlement. Furthermore, 1 out of 6 DeKalb County residents is an immigrant, and on any given day, more than 130 different languages are spoken in the public school system. Children’s Healthcare of Atlanta (CHOA) is the largest pediatric provider in Georgia and serves as a safety net for our most vulnerable children. Immigrant and refugee families face unique challenges in access to care, language and communication, complex scope of disease, and lack of a medical home.

This toolkit was developed to link physicians and care teams with existing toolkits and local resources to make it easier for providers to access these resources and improve the care of immigrant and refugee children in Georgia. Content was based on feedback from a survey of providers conducted in 2018 and discussions with refugee resettlement organizations. The sections include many links to excellent existing resources, including:

- CDC’s Immigrant and Refugee Health: [https://www.cdc.gov/immigrantrefugeehealth/index.html](https://www.cdc.gov/immigrantrefugeehealth/index.html)
- CDC’s Traveler’s Health: [https://wwwnc.cdc.gov/travel](https://wwwnc.cdc.gov/travel)
- Kids New to Canada: [https://www.kidsnewtocanada.ca/](https://www.kidsnewtocanada.ca/)

The landscape of refugee and immigrant care is rapidly changing in the United States and Georgia. While more families are arriving on our southern border seeking asylum, the number of refugees resettled from overseas has plummeted. In its fiscal year 2018, the United States resettled its lowest number of refugees in 40 years. This dynamic has strained resettlement agencies and community partners, even as there is increasing public interest in supporting these groups. Some groups are being forced to close or cut back on services previously provided. We will try to keep contact information and resources up-to-date, but if you notice any out-of-date information or resources, or if you have any comments or suggestions for inclusion, please let us know. Email: contactghope@gmail.com
Background and FAQs

What is a refugee?
The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as a “person who has been forced to flee his or her country because of persecution, war or violence.” A refugee cannot return home or is afraid to do so for a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.1 They are protected by the 1951 Refugee Convention which asserts that a refugee should not be returned to a country where he or she faces serious threats to life or freedom.2

1 https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

What is the difference between a refugee and an immigrant?
A ‘migrant’ is “any person who moves, usually across an international border, to join family members, to search for a livelihood, to escape a natural disaster, or for a range of other purposes.”3 Like refugees, migrants may move to escape threats from natural disasters, famine, or extreme poverty, yet these individuals are not considered refugees under international law.

What is an asylum seeker?
An asylum seeker is a person who flees his or her country and seeks international protection in another country. An asylum seeker must demonstrate that fear of persecution in his or her home country is well-founded to be assessed as a refugee by a government or UNHCR.4


Who are unaccompanied minors?
An unaccompanied minor is a legal term used to define a child who has no lawful immigration status in the United States and has no available parent or legal guardian in the United States to provide care and physical custody. These youth receive some protections under U.S. law.5


What are the implications for insurance and public services?
International protection under the Refugee Convention stipulate that refugees should share at least the same rights as any other foreigner who is a legal resident - including access to medical care, schooling and the right to work.6 Undocumented migrants, and their children who are born outside of the United States, may not have access to employer-based health insurance and are excluded from federally funded programs.7

7 http://undocumentedpatients.org/
General Principles in Refugee and Immigrant Care

**Cultural sensitivity.** Approach all families without assumption and without judgment. It is impossible to understand the full, rich array of cultural practices and approaches to medicine in this world. In literature, the term “cultural competency” has been replaced with “cultural sensitivity” or “cultural humility” to reflect this truth in providing cross-cultural care. It is OK to ask non-judgmental questions, to learn from a family about their customs or approach to care.

**Support system.** All refugee families are assigned a case worker on arrival. Whether it is this case worker, a community group, or other family members, a family may have access to support from an individual or group who can help them navigate the overwhelming logistics of our healthcare system. Understanding a family’s support and incorporating it into your plan of care can help ensure that it is implemented as you had hoped for improved health outcomes.

**Complex care needs.** Our Statue of Liberty is inscribed with, the quotation, “Give me your tired, your poor, Your huddled masses yearning to breathe free, The wretched refuse of your teeming shore.” The U.S. refugee resettlement program reflects this sentiment. Refugee children and families with health conditions or political situations that would make it impossible for them to return home safely are prioritized for resettlement. Complex health and developmental conditions are frequently encountered in refugee children, making coordination of care across our system for these patients even more critical.

**Treat the family.** If you identify and treat an infectious illness or exposure in an individual child, consider whether the child’s siblings, parents, or other contacts need to be assessed and/or treated for the same conditions as well. Examples include lead poisoning, parasitic infections, hepatitis infections, vitamin D deficiency anemia, sickle cell disease and others.

**Use interpreters.** Consider team rounds when multiple services are involved in the inpatient care of a non-English speaking patient to clarify plan of care, especially on the day of discharge. Always use a medical interpreter when available. Some families may speak multiple dialects. If an interpreter cannot be found for a primary dialect, ask about fluency in any other languages.

**Health literacy.** Families may have a different approach to concepts like illness, measurements of medications, and storage of medications. Using hands-on demonstration of medication administration, marking syringes, and using pictographs can all be helpful adjuncts when conversing across different languages and cultures.

**Sign out complex patients.** As “sign-out” is given in the hospital at changing shifts, signing-out patients upon transition from the inpatient to outpatient setting, or even from one clinic setting to another, can improve continuity of care across our system for patients and save time for providers on the receiving end. Providers can discuss changes in plan of care, ensure follow-up appointments are kept, and consider any needed safeguards. Involving case management and social work can help leverage community support services to optimize care for these patients.
Country Quick Fact Sheets

In recent years, the largest numbers of refugees resettled in Georgia have come from the following countries of origin: Bhutan, Burma, Congo, Eritrea, Ethiopia, Iran, Iraq, and Sudan. Since then, refugees from Somalia, Afghanistan, and Syria have also arrived in larger numbers. For each of these countries, a brief summary of the spoken languages, religious and cultural information, and a description of the geopolitical situation leading to the refugee crisis is outlined below. The CDC maintains full Refugee Health Profiles for some of the countries mentioned; the link can be found below each respective country. For more information, see: https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html

Australia’s government maintains Refugee Community Profiles for some of these countries as well. While the immigration numbers will not be relevant, the information on background health concerns and cultural information contained in these reports is excellent. If no CDC report exists for a particular country, a link to the Australia report is included.

For additional information regarding the number and origin of refugees resettled in Georgia:

The Georgia Department of Health Refugee Health Program: https://dph.georgia.gov/refugee-health-program

The Georgia Coalition of Refugee Stakeholders: https://garefugees.wordpress.com/state-reports-data/
Bhutan

Background: Bhutan is a landlocked country in South Asia located in the remote Eastern Himalayas. It is bordered by China to the north, and the Republic of India to the south, east and west. The Bhutanese are of four main ethnic groups: The Ngalop, the Sharchop, the Lhotshampas, and Bhutanese tribal and aboriginal peoples. The Lhotshampas are people of Nepalese origin who migrated to the uninhabited areas of southern Bhutan in the nineteenth century and grew in numbers with continued migration. However, fears of demographic inundation lead the Bhutanese government to enforce laws prohibiting further migration of Lhotshampas/Nepalis into Bhutan in 1958. This was followed by the 1985 Bhutan Citizenship Act which identified ethnic Nepalese living in Bhutan as illegal immigrants and the enforcement of a district national identity of Tibetan-based Bhutanese culture was imposed to cement Bhutanese national identity. These policies alienated the Lhotshampas community living in the south of Bhutan and caused more than 100,000 Nepali-speaking Bhutanese to seek refuge in camps in southeastern Nepal.

Language: There are two dozen languages of Bhutan. The national language is Dzongha, and other smaller languages include Bumthangkha, Sharchopkha, and Nepali.

Religion: The official religion of Bhutan is Buddhism and it is practiced by approximately 70% of the population. Bhutan’s second religion, Hinduism, is practiced by about 25% of the population. Christianity and Islam are present in very small numbers, 0.5% and 0.2% respectively.

Priority Health Conditions: Vitamin B12 deficiencies, anemia, and mental health disorders. HIV is also present, although uncommon. Tuberculosis is a health concern, although the exact number of cases is difficult to determine.

Family: Family cohesiveness is very important in Bhutanese culture. Occasions such as childbirth and marriage are commonly social or family events. Traditionally, marriages may be arranged through family, however this is less common in the contemporary period. Elders in the family are highly respected and involved in most decision making. Bhutanese families are typically self-sufficient and often sew their own clothing, bedding, floor and seat covers, tablecloths and decorative items.

Cultural Approach to Healthcare: Bhutanese families tend to use traditional home remedies and healers as a first-line treatment and typically only seek Western medical treatment if other remedy efforts were unsuccessful. Patients may be uncomfortable sharing their traditional practices with American providers.

Burma

**Background:** Burma (also known as Myanmar or the Union of Myanmar) is located in the western portion of mainland Southeast Asia. It is bordered by Bangladesh and India to the west, China to the north, and Laos and Thailand to the east. The Burmese consist of eight main ethnic groups and 135 distinctive subgroups. The largest ethnic group, the Bamar, form about 68% of the population. The other ethnic minorities, including the Chin, Kachin, Karen, Mon, Rakhine, Shan, and Wa, make up the remaining 32% of the population. Following independence from Britain in 1948, the country became known as ‘Union of Burma’. Between 1962 and 1988, a military coup abolished the constitution and established a military regime enforcing the use of the name ‘Myanmar’ as the country’s official title. This ensued a series of military regimes and ethnic conflicts, internally displacing approximately 650,000 Burmese and at least 1 million individuals to flee to neighboring countries. In addition, persecution of the Rohingya people, a largely Muslim group in Myanmar, has forced over 700,000 to flee the country between 2016 and 2017.

**Language:** The official language of Myanmar is Burmese and is spoken by approximately 80% of the population. Each of the 135 ethnic groups have their own language and dialect, but English is taught in primary schools.

**Religion:** Buddhism is the predominant religion practiced by 89% of the country’s population, followed by Christianity practiced by 4%, Islam by 4%, and the remaining 3% practiced by Hinduism or animism.

**Priority Health Conditions:** Hepatitis B and intestinal parasites

**Family:** Arranged marriages are customary in Myanmar and are usually negotiated by a female family member. The notion of ‘family’ extends well beyond the immediate family such that cousins are referred to as one’s siblings. In rural areas, extended family members live together and children are expected to care for their elders. Families are generally matrilineal, meaning that they trace the family through the female line of heritage. They are also a patriarchal society such men tend to work and women tend to care for the family. Burmese names are personal names that may consist of one or more words - they are not divided into ‘first’ and ‘last’ but rather form a whole. In some cases, a person may have only one name.

**Cultural Approach to Healthcare:** The Burmese are indirect communicators and value politeness and modesty - this may lead to misunderstanding between the doctor and the patient. Directness, loud speech, and body language, such as touching others, sitting higher than an elder, and pointing, are considered taboos in the Burmese population.

https://reliefweb.int/sites/reliefweb.int/files/resources/0BB7BF12EDC31D1C125716A004E0456-idmc-mmr-10may.pdf
Congo

**Background:** The Democratic Republic of Congo (DRC) is located in central Africa. It is sometimes referred to as Congo-Kinshasa to differentiate it from its neighbor, Republic of the Congo. In this profile, ‘Congolese’ refers only to the people from DRC. The country is bordered by Central African Republic and South Sudan to the north; Uganda, Rwanda, Burundi and Tanzania to the east; Zambia to the south; and the Republic of the Congo to the west. In 1960, the country gained independence from Belgian rule and has experienced significant conflict and instability ever since. Between 1965 and 1997, the country was known as ‘Zaire’, but was reinstated to its original name ‘Democratic Republic of Congo,’ in 1997 due to a change in presidency. In early August 1998, a war of “liberation” broke out in an attempt to rid the country of the dictatorial and rule of then president, Mabutu Sese Seko. The war led to the internal displacement of approximately 1.8 million Congolese and 300,000 to flee to neighboring countries. Since 1998, over 5 million individuals have died as a result of conflict. The country remains unstable.

**Language:** The DRC is a multilingual country with up to 250 languages, most belonging to the Bantu family. The four national languages are Lingala, Kituba, Swahili, and Tshiluba. The official language, used in government and education, is French. While the DRC has the largest French-speaking population of any country outside France, only a small proportion of the population uses French as a working language.

**Religion:** Christianity is the predominant religion, practiced by about 80% of the population. Islam is practiced by around 10% of the population and traditional or syncretic beliefs practiced by the remaining population.

**Priority Health Conditions:** Parasitic infections, malaria, mental health disorders, sexual and gender-based violence

**Family:** Family is interpreted in a much broader sense compared to Westerners. A typical household consists of immediate family, extended family, and sometimes others as well. Children are often cared for and disciplined by the whole community, thus, it is not unusual for an adult, who is not biologically related, to provide input on their upbringing.

**Cultural Approach to Healthcare:** Congolese are generally not opposed to Western medicines but may also seek traditional therapies alongside of these. Herbal medicinal plants or consultation with traditional and spiritual healers may be the most affordable, easily accessible, and at times, the only therapy that subsists to the local community. Mental illness is not openly discussed and is believed to be caused by supernatural or religious factors.

Eritrea

**Background:** Eritrea is a small country in the horn of Africa (East Africa). It is bordered by Sudan to the west, Ethiopia to the south, the Red Sea to the east, and Djibouti in the south-east. It is a multi-ethnic country with nine recognized ethnic groups and a population of around 5 million. Prior to being colonized by Italy in 1890, the region was largely independent with periods of rule and influence by the Ottomans, Tigray Kingdom, and the Egyptians. As a result of the ‘Battle of Keren’ in 1941, the British expelled the Italians and took administrative role in the country. In 1952, the UN resolution to federate Eritrea with Ethiopia went into effect. This was overturned by the Emperor of Ethiopia in 1962, enticing ongoing border disputes between the two countries. Despite United Nations peacekeeping efforts along the border, Eritrea has endured heavy setbacks in its agriculture industry - frequent droughts and limited arable land has resulted in two thirds of the population requiring food aid. As a result of this turmoil, a large number of Eritreans have fled to neighboring countries.

**Language:** There are nine languages in Eritrea. Tigrinya and Arabic are the official languages, but many people also speak Tigre, English, and Amharic.

**Religion:** The population of Eritrea is almost equally divided between Christians (Roman Catholic, Orthodox Church, and Lutheran protestants) and Muslims.

**Priority Health Conditions:** Malnutrition, HIV/AIDS, intestinal parasites and worms, infectious disease from insect bites (malaria, dengue fever), TB, typhoid fever, malaria, trachoma, syphilis, diarrheal illnesses, and mental health issues (depression, anxiety, PTSD)

**Family:** Arranged marriages are common in rural areas, however, this is not the case in urban settings, where young people are more likely to choose their own partners. Living arrangement may at times extend beyond the immediate family and include uncles, aunts and grandparents. Respect and care given to the elders are a traditional part of the society’s values. In rural areas, much of Eritrean society remains traditional and patriarchal - such that men tend to work and women tend to care for the family.

**Cultural Approach to Healthcare:** The practice of modern medicine is uncommon and inadequate in many areas of Eritrea. Eritreans believe in the healing powers of herbs and other local ingredients to treat common illnesses, and usually do not see a doctor until a health problem is serious. Although their understanding of prevention and causes of disease is limited, most Eritreans respect a doctor’s authority. Gender concordance between the health care provider and the patient is considered important.

Ethiopia

Background: Ethiopia is a landlocked country in the Horn of Africa (East Africa). It is bordered by Eritrea to the north, Djibouti and Somalia to the east, Sudan and South Sudan to the west and Kenya to the south. Historically, Ethiopia has endured natural disasters, armed conflict, and political oppression - all of which has resulted in societal disruption, famine, and death. By the end of 1973, famine claimed the lives of approximately 300,000 Ethiopians. Back to back calamities in 1977 and 1978, the Ogaden War and the drought in eastern Ethiopia, respectively, led to refugee exodus into neighboring Kenya and Sudan. The collapse of Ethiopia’s Mengistu regime in 1991 brought conflict to an end. Since then, over 1 million Ethiopians were able to return home. Individuals who have resettled in refugee camps have often faced living situations that are, at times, over-crowded, rife with the threat of infectious diseases, and primitive in design, adding to the existing stress and trauma of their circumstances.

Language: Ethiopia is a multilingual country with up to 84 languages and 200 dialects. Amharic, English, and Tigrinya are the official and national spoken languages. The top nine languages are Amharic, Oromo (West Central, Eastern, Borana-Arsi-Guji), Somali, Tigrinya, Ometo, Sidamo and Afar. Arabic is also spoken in some areas of the country.

Religion: Christianity is the predominant religion practiced by 50% of the population, Islam practiced by over 40%, and minority religions including Judaism and Animism practiced by the rest of the population.

Priority Health Conditions: Malnutrition, HIV/AIDS, intestinal parasites and worms, infectious disease from insect bites (malaria, dengue fever), TB, typhoid fever, malaria, trachoma, syphilis, diarrheal illnesses, leprosy, mental health issues (depression, anxiety, PTSD)

Family: Traditionally, marriages are arranged by the family. Ethiopian families tend to be large, with each family having between 5 and 7 children. The concept of family extends past immediate family, and relatives often help one another in times of difficulty. Disputes are often settled by the elders in the family and their advice is always respected. Social injustices manifested by gender inequality include: domestic violence, abduction for marriage, rape, work prohibitions, and child marriage. Children may be subject to various forms of abuse including human trafficking, military recruitment, and child labor.

Cultural Approach to Healthcare: Traditional and herbal medicine is commonly used to treat a variety of illnesses. Some Illnesses are perceived to have supernatural causes. Injection is usually preferred over oral medication. Some traditional surgical procedures, such as female genital mutilation, take place outside of formal medical settings.

Iran

Background: Iran is the second largest country in the Middle East and 17th largest in the world. It is bordered by Armenia, Azerbaijan, and Turkmenistan to the north, Afghanistan and Pakistan to the east, the Persian Gulf to the south, and Iraq and Turkey to the west. A monarchy has ruled Iran continuously for 2,500 years, with the Pahlavi family being the last monarchs, ruling between 1925 and 1979. In 1979, nationwide unrest due to political repression and foreign influence, led to the ousting of Shah Pahlavi and the establishment of the Islamic Republic of Iran. This enticed widespread political and religious repression among religious minorities in the 1980s - causing several Iranians of the Bahá'í faith to escape their homeland. An eight-year war between Iraq and Iran further destabilized the region, and by the latter half of the 1990s, several Iranians fled the country due to recurring political and religious persecution.

Language: Farsi is the predominant and official language of Iran. Other regional languages include Azeri Turkic and other Turkic dialects, Kurdish, Gilaki, Mazandarani, Luri, Balochi, and Arabic.

Religion: Islam is the official religion of Iran and practiced by 99 percent of the population. The Muslim majority is comprised of 90% Shia and 9% Sunni (Turkmen, Arabs, Baluchis, and Kurds). Minority religions include Baha’is, Christians, Jews, Sabean-Mandaean, Zoroastrians, and Yarsanis.

Priority Health Conditions: Chronic disease (heart disease, stroke, cancer), infectious disease (hepatitis B, giardia, TB), malnutrition and vitamin deficiency, mental health issues

Family and Cultural Approach to Healthcare: Respect for elders is a common tradition among Iranians, especially between children and their parents. Often, healthcare decisions are made by family members and relatives may prefer that health-care related issues are discussed with the family first. Visiting sick family members is considered a communal obligation and Muslim requirement, therefore, Muslim patients may have large numbers of visitors, including those from outside their immediate family. Gender concordance between the health care provider and the patient is considered important. Females may be especially reluctant to be examined by a male healthcare provider for sexual or reproductive health issues and may also be reluctant to use interpreters for confidentiality purposes, hence, a telephone interpreter may therefore be preferred.

Iraq

Background: Iraq is a country in the Middle East bordered by Turkey to the north, Iran to the east, Kuwait to the southeast, Saudi Arabia to the south, Jordan to the southwest and Syria to the west. Gaining independence from Britain in 1932, the Hashemite monarchy (established in 1921), ruled Iraq until it was overthrown in 1958 by a coup d’état. A republic was then formed, with Brigadier General Abd al-Karim Qasim becoming the prime minister. His rule was short lived and was overthrown by a military coup in 1958. By 1980, wars with neighboring countries and hostilities abroad, led to economic sanctions resulting in over 3 million people internally displaced and a staggering 9 million people in need of humanitarian assistance. Since the 1980’s, approximately 7 million Iraqis have fled the country. US-led war, between 2003 and 2010, resulted in a further 2.5 million people to be displaced as a result of sectarian violence – most of whom fled to neighboring countries.

Language: The official language of Iraq is Arabic, with about 77% of Iraqis claiming Arabic as their first language. Other spoken languages include Kurdish, Anatolian Turkish, and Syriac. Historically, Iraq has had high literacy rates. However, in the past two decades, the literacy rate has declined - youth aged 15 to 24 are at about 74%. In addition, about 44% of Iraqi refugees reportedly speak English “very well” according to the US Census Bureau.

Religion: The predominant religion in Iraq is Islam - practiced by 95% of the population. The Muslim majority is comprised of 63% Shia and 32% Sunni. Minority religious groups include Christianity, Chaldo-Assyrians, Sabeans, Mandaeans, and Yazidis - many of whom have fled Iraq due to fear of religious persecution. Approximately 62% of Iraqis resettled in the US by 2008 identified themselves as Christian.

Priority Health Conditions: Diabetes, hypertension, malnutrition.

Family and Cultural Approach to Healthcare: Arranged marriages were common practice in Iraq, but this has become rare in recent years. Couples tend to live with the husbands extended family, or as a nuclear family. Generally, the eldest male heads the group and is the predominant decision maker in regards to education and medical care, and may accompany all women and children to their medical appointments. Good hygienic practices and a healthy diet are considered to be the main form of disease prevention. Hence, preventative care, such as annual physicals, screenings, or routine follow up appointments, are not a priority. Medication may be expected when the patient is ill - the patient may be dissatisfied with their care if it is not prescribed. Anxiety, depression, and Post Traumatic Stress Disorder (PTSD) are common mental health issues among Iraqi refugees. Stigma is a fundamental barrier to individuals seeking out mental health treatment in the Iraqi society. This may cause mental health issues to manifest as physical symptoms. Consanguinity is practiced by approximately 37% of the population, influencing the incidence of congenital and genetic disorders.

Sudan

Background: Sudan is a country in Northeastern Africa. It shares a border with Egypt to the north, Eritrea and Ethiopia to the east, South Sudan to the south, and Chad to the west. In 1956, Sudan gained independence from British-Egyptian rule. Since then, the country has been plagued by conflict and two civil wars, largely fought by the Arab North and the non-Arab south. South Sudan declared independence from Sudan in 2011, ending what was known as Africa’s longest-running civil war. However, the region is still plagued with ongoing disputes between Sudan and South Sudan over oil-rich territories as well as ethnic violence between various nomadic tribes.

Language: There are almost 400 indigenous languages spoken in the country. The official spoken language in Sudan is Arabic, and English in South Sudan.

Religion: Islam is the predominant religion in Sudan and is followed by over 90% of the population. South Sudan’s population adhere to traditional African religions, Christian, and Islam.

Priority Health Conditions: Tuberculosis, HIV, poor eyesight, diabetes, malnutrition, hypertension.

Family and Cultural Approach to Healthcare: Family ties are foundational for the Sudanese way of life. Marriages are traditionally arranged by family members, and the practice of polygamy is legal, although rare. In most family dynamics, the eldest male heads the group and is the predominant decision maker. Access to healthcare is limited in Sudan, so refugees are likely to be unaccustomed to a formal healthcare system. Gender concordance between the health care provider and the patient may be of importance (particularly among men). The prevalence of female genital mutilation in north Sudan is approximately 90%, but is considerably less common in the south, and the numbers are declining. Some tribes in southern Sudan still preform rituals which may include removal of teeth or facial scarring.

https://en.wikipedia.org/wiki/Religion_in_Sudan
Syria

**Background:** Since 2011, the conflict and refugee crisis in Syria has resulted in millions of Syrians fleeing their home country with millions more internally displaced with Syria. Many Syrians are living in refugee camps in countries in the region: Iraq, Jordan, Lebanon, Turkey and Egypt. This crisis has become an international symbol of the current refugee crisis and is the largest refugee crisis since World War II.¹ However, in its fiscal year 2018, the United States government resettled only 62 Syrians (compared to 12,587 in 2016). Prior to the conflict, Syria had a strong educational system and high literacy rate. However, the conflict has disrupted this educational system and many children have no access to formal education. Syrian families are typically large, close knit, and patriarchal, with men as the decision makers responsible for providing for and protecting the family. Over 90% of Syrians are of Arabic descent with individuals of Kurdish descent making up the largest ethnic minority.

**Language:** Arabic is spoken by 90% of Syrians and is the official language of Syria.

**Religion:** Most Syrians practice Islam (90%), with minority groups including Arab Christians and Syriac Christians.

**Priority Health Conditions:** Anemia, diabetes, hypertension, mental illness¹

**Family and Cultural Approach to Healthcare:** Compared with other refugee populations, most Syrians will be familiar with and engage with Western medical models and practices, seeking care for acute illnesses and injuries with health literacy. There may be a reluctance to continue medication for a chronic condition when symptoms are not present. Syrians may prefer physician-providers, trusting the physician’s advice. They may also have cultural preferences for same-gender providers, additional attention paid to modesty and privacy, and Halal formulas and foods.

Unaccompanied Minors from Central America

**Overview:** The Central American Minors (CAM) Refugee/Parole Program was created by former President Obama in December 2014. It was created due to the increasing numbers of unaccompanied minors coming from El Salvador, Honduras, and Guatemala over the preceding 3 years. This program allowed parents, who were lawfully present in the United States, to request refugee status for their children who remained in Central America and provided a safe means for their travel to the U.S. Those children who did not qualify for refugee status, were allowed parole status, which would allow them to live in the U.S. legally for a certain period of time without the benefits (e.g., Health insurance) that refugees receive. President Trump discontinued the parole portion of the program in August 2017 and new applications for the refugee portion of the program were disallowed after November 2017.

**Background:** El Salvador, Guatemala, and Honduras make up the Northern Triangle, which is the northernmost region of Central America that shares a border with Mexico. The area was home to many powerful ancient civilizations, including the Lenca, Olmec, and Maya civilizations. Spanish explorers arrived in the 1500s and the area came under colonial rule until the 1800s. After gaining independence, all 3 countries struggled with civil war, military governments, economic inequality, and social unrest. More recently, the region has been plagued by gang violence and drug wars, leading to the sharp increase in refugees entering the U.S.

**Language:** Spanish is the official language in all 3 countries. The majority of individuals from El Salvador and Honduras are able to speak Spanish, and both countries have literacy rates of ~88%. In Guatemala, only about 60% of the population is able to speak Spanish. The remainder speak native languages including Quiche, Cakchiquel, Kekchi, Mam, Garifuna, and Xinca.

**Religion:** Christianity is the predominant religion in all 3 countries, with the majority being Roman Catholic and the remainder Protestant. Many Catholic traditions and beliefs are blended with traditional culture to create unique religious traditions.

**Priority Health Conditions:** Anemia, Chagas disease, mental health issues, obesity, soil-transmitted helminth infections.

**Family and Cultural Approaches to Healthcare:** Family is an important part of Central American culture. It is a patriarchal society, so men tend to work and women tend to care for the family. Given the inadequate number of physicians and access to healthcare in their home countries, many people from Central America are used to depending on traditional healers and may continue to use traditional remedies.

Medical Evaluation of Refugee and Immigrant Children

Refugee Resettlement Pre-Departure Medical Evaluation

All refugees coming to the United States undergo a medical examination process that begins up to 6 months before departure. The medical screenings vary slightly based on the country where the refugee is undergoing evaluation. Figure 1 depicts the process for incoming Syrian refugees, and the general process is outlined below:

The **Visa Medical Examination** is required for all refugees and is conducted by physicians selected by the Department of State with oversight and training by CDC. The purpose is to identify applicants with inadmissible health-related conditions (Class A Conditions): Tuberculosis (TB), Syphilis, Gonorrhea, Hansen’s Disease (Leprosy), Quarantinable Diseases (i.e. cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, severe acute respiratory syndromes, and pandemic influenza), and those that are reportable as Public Health Emergency of International Concern (PHEIC) to the World Health Organization (i.e. currently polio, smallpox, SARS, influenza, etc). Serious mental health problems can also preclude admission including: any current health concern associated with harmful behavior, any past health concern associated with harmful behavior if the behavior is likely to recur, and drug abuse or addiction.

The **Pre-Departure Medical Screening** is required for refugees previously assessed to have Class B1 Tuberculosis (tuberculosis fully treated with directly observed therapy, abnormal chest XR with negative sputum smears and cultures, or extrapulmonary TB).

Fit-to-Fly **Pre-Embarkation Checks** are required for all refugees and are performed by International Organization of Migration (IOM) physicians within 24-48 hours of the refugee’s departure to the United States. Many refugees (depending on their country of origin) receive presumptive treatment for some intestinal and parasitic diseases.

*Figure 1: Medical Assessment of U.S.-bound Syrian Refugees*

*Figure from: https://www.cdc.gov/immigrantrefugeehealth/profiles/syrian/medical-screening/index.html*
For more information, see:
CDC’s Refugee Health Profiles with information on priority health conditions, pre-departure screenings, drivers of immigration and more for the following areas: Bhutan, Burma, Central America, Congo, Iraq, and Syria:  
https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html

CDC’s FAQs on the Medical Examination of Refugees:  
https://www.cdc.gov/immigrantrefugeehealth/exams/medical-examination-faqs.html#5

On-Arrival Domestic Refugee Medical Exam (DRME)

CDC recommends that all refugees undergo a DRME within 30 days of arrival. In DeKalb County, initial screening for all newly resettled refugees occurs at the DeKalb County Refugee Clinic at the DeKalb County Board of Health. A summary of recommended history, physical exam and laboratory evaluation is here:  https://www.cdc.gov/immigrantrefugeehealth/pdf/checklist-refugee-health.pdf

If you are caring for an ill child who has been recently resettled in DeKalb County and need to obtain records from an initial screening or pre-departure information, call the DeKalb County Refugee clinic at (404) 294-3818 and fax a consent for release of medical records to (404) 508-7844.

At the initial screening, children with complex medical needs are identified and prioritized for follow-up with a pediatrician. Children without complex medical needs are recommended to establish routine care for ongoing health maintenance with a pediatrician. After the initial screening, refugee resettlement agencies route newly arrived refugee children either to the Refugee Pediatric Clinic at the DeKalb County Board of Health (DCBOH) or a community provider for follow-up care. At this time, International Rescue Committee (IRC) sends children with complex healthcare needs to follow-up at the Refugee Pediatric Clinic at DCBOH and utilizes Oakhurst Pediatrics and other community providers for children without complex health and developmental concerns. New American Pathways typically uses community pediatricians for all children. Lutheran Services typically uses the Refugee Pediatric Clinic at DCBOH for all children. These rules of thumb represent the current practices of the primary resettlement agencies in our area and may change.

Topics typically covered at the initial screening exam for refugee children are included below. If you are seeing an immigrant child who has not yet had a health exam, consider covering these topics:

- Travel history - including country of birth/origin, country/countries of transit and length of time living in these countries
- Records of any pre-departure health screening or interventions
• Past medical history – birth history, neonatal history, hospitalizations, vaccinations, medications, allergies, history of female genital cutting (FGC), transfusions, surgeries, tattoos
• Prior interaction with modern or traditional medical practitioners, including use of herbal or imported medications
• Dental history
• Sexual history, including whether history of sexual abuse
• Experiences with violence, torture
• Tobacco, alcohol, opium/heroin, other drug use
• Dietary history - including habits, religious restrictions, and cultural dietary norms; and past periods of food insecurity to determine risk for specific micronutrient deficiencies
• Environmental hazard exposure history, including possible lead exposure risks
• Education: last year of school completed and literacy level of patient/parents as applicable, potential learning difficulty and/or need for special education
• Social history—including family structure, support in US, school environment, individuals who live in the same home as the child, primary care taker
• Mental health evaluation including use of validated screening instrument and specific screening for trauma
• Developmental screening (including use of age-appropriate screening instrument)

Sources and more information:
CDC’s summary checklist for the Domestic Medical Exam for Newly Arriving Refugees
https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/checklist.html

AAP Immigrant health toolkit section on Clinical Care

Health Considerations in Immigrant and Refugee Children

The AAP toolkit has an excellent guide to clinical care in refugee and immigrant children. This section is a quick-reference to some of the main considerations in that section. Please see Table 1 in the toolkit (linked below) and reference the full AAP toolkit for more information:

The following health conditions represent a distinct health burden for the specific refugee population. Dental disease is common across all groups.

• Bhutanese: anemia, vitamin B12 deficiency (mostly in adults), mental health
• Syrian: anemia, diabetes, hypertension, mental health, cutaneous leishmaniasis
• Burmese: hepatitis B, intestinal parasites
• Congolese: parasitic infections, malaria, mental health, sexual and gender-based violence
• Iraqi: diabetes mellitus, hypertension, malnutrition
Lead poisoning – CDC recommends testing all children 6 months to 16 years old upon arrival and children 6 months to 6 years old 3-6 months after they are placed in permanent residences for elevated blood lead levels. Refugee children have been shown to develop elevated blood lead levels after resettlement and require repeat testing (see toolkit below).

For more information, please see:
CDC’s immigrant and refugee health profiles by country:
https://www.cdc.gov/immigrantrefugeehealth/profiles/index.html

CDC’s toolkit on prevention of lead poisoning in newly arrived refugee children:
https://www.cdc.gov/nceh/lead/publications/refugeetoolkit/refugee_tool_kit.htm

A toolkit from Kids New to Canada on all aspects of care for refugee and immigrant patients:
https://www.kidsnewtoCanada.ca/

Approach to Laboratory Evaluation of Immigrant and Refugee Patients


Table from: AAP Immigrant Child Health Toolkit, page 13

<table>
<thead>
<tr>
<th>Tiered* laboratory screening/parasite treatment options for most immigrant children originating from resource-limited settings or from low socioeconomic circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tuberculosis testing: IGRA (TST if &lt;5 years old)*1,13</td>
</tr>
<tr>
<td>2. Cbc/Diff</td>
</tr>
<tr>
<td>3. Lead*1,14—Children 6mo–16 years</td>
</tr>
<tr>
<td>4. Hep B SAg*1,11</td>
</tr>
<tr>
<td>5. Intestinal Parasite Evaluation (NB: for refugees, may omit if received pre-departure treatment per CDC guidelines)</td>
</tr>
<tr>
<td>* Stool O &amp; P &gt;24 hours apart or x3 OR presumptive treatment with Albendazole</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>* Strongyloides IgG OR presumptive treatment with Ivermectin*</td>
</tr>
<tr>
<td>6. HIV</td>
</tr>
<tr>
<td>7. Syphilis EIA, reflex RPR if positive*</td>
</tr>
</tbody>
</table>

a. Consider laboratory tiering in this order when patients or health care facilities have no access to discounted financial coverage programs
b. Interferon gamma release assay (IGRA), tuberculin skin test (TST). Screen regardless of history of BCG vaccine*1. If IGRA unavailable, may use TST at any age. Repeat TB screening in 6 months. NB: Repeat if chronic disease, malnutrition once medical issues managed, given that energy may give a false negative result.
c. Screen for anemia, eosinophilia (NB: absolute eosinophilia >400 warrants further work-up).d. Repeat in 3-6 months in children 6 mo-6 years.d. Repeat in 3-6 months in children 6 mo-6 years.e. If never screened for infection, screen even if documentation of complete hepatitis B vaccine series. Vertical and horizontal transmission possible*1,11.f. Greater number increases sensitivity of test—most experts recommend 2 or 3 samples.g. Consider presumptive treatment with Ivermectin without serology if >15 kg, unless from Laos endemic countries*10.h. If 1 year old and no history of seizures or other signs/symptoms of neurocysticercosis*.i. If prenatal lab results or recent maternal results available with negative screens and no risk for horizontal transmission, may omit.
Consider the following baseline investigations if evaluating a symptomatic refugee or immigrant patient for the first time:

- Fecal sample for cysts, ova parasites including schistosoma and strongyloides
- Blood count noting especially anemia or eosinophilia
- Serology for schistosomiasis and strongyloides.

The appropriate test will usually be conducted on initial screening, but these may be helpful as reference when working up an acutely ill child as well. For positive results consider checking family members where appropriate for conditions related to infections or exposures.

Ongoing Health Considerations in Refugee and Immigrant Children

For individuals who have been in the United States for more than one year, special attention should be paid to diseases with long latency and associated severe morbidity such as:

- Tuberculosis
- Hepatitis B
- Strongyloides infection

Consider additionally any personal or family travel history and exposure that may have occurred since resettlement.

Developmental and Mental Health Resources

**Developmental concerns:**
In refugees or immigrants with developmental delay, undiagnosed congenital conditions should be considered and a full birth history should be elicited when evaluating a patient for the first time. Identifying developmental delay can be challenging when using an interpreter and in the face of cultural differences. Some developmental conditions are more prevalent in some refugee populations, such as autism in the Somali population.

Information from the University of Minnesota on Autism in Somali children, including Developmental Milestone handouts in Somali and Resources for parents of children with autism in Somali: [https://rtc.umn.edu/autism/](https://rtc.umn.edu/autism/)


Tip Sheet from Kids New to Canada on detecting developmental disabilities across cultures: [https://www.kidsnewtocanada.ca/mental-health/developmental-disability](https://www.kidsnewtocanada.ca/mental-health/developmental-disability)

**Mental health concerns:**
Refugee children have often experienced traumatic events and stress in their childhood, and most refugees are children. The National Child Traumatic Stress Network has a toolkit with resources on the Effects of Stress on Refugee Children, Screening and Assessment Tools, and Interventions: [https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma](https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma)

United States Department of Health and Human Services page on Trauma-informed care in refugee children and families includes the resource above as well as additional resources: [https://www.acf.hhs.gov/trauma-toolkit/immigrant-or-refugee-populations](https://www.acf.hhs.gov/trauma-toolkit/immigrant-or-refugee-populations)

Tip Sheet from Kids New to Canada on Mental Health concerns in refugee and immigrant children (as well as resources for parents seeking international adoption): [https://www.kidsnewtocanada.ca/mental-health](https://www.kidsnewtocanada.ca/mental-health)

Current outbreaks

CDC keeps a current list of outbreaks. This may be useful for families or children ill upon return from abroad or planning to travel home, a list of current outbreaks may be useful in diagnosing children or advising patients returning: [https://www.cdc.gov/outbreaks/index.html](https://www.cdc.gov/outbreaks/index.html)

HealthMap tracks outbreaks and is searchable by location and timeframe: [www.healthmap.org](http://www.healthmap.org)

Discharge Planning Checklist

Coordination of care on hospital or clinic discharge is critical for assuring successful plan of care and well-being for patients. Consider the following:

- Medications ordered and received or confirmed accessible to the family, including way to administer medications
- Family demonstrates knowledge of how to administer medications/feedings (quantity, timing)
- Durable medical equipment ordered and received
- Transportation home is available
- Disease-specific education given via interpreter on discharge instructions
- Return precautions and safety-plan reviewed with the family via interpreter
- Handouts given to reinforce discharge education planning in appropriate language at appropriate level of literacy (see Language Resources in this guide)
- Follow-up appointments scheduled
□ Sign-out given to provider to care for the patient in follow-up

□ Transportation is available for follow-up appointment/family understands how to get to appointment

□ For infections/exposures/nutritional deficiencies, plans made for other family members to be tested and treated, if appropriate

□ Case manager involved, if appropriate
Vaccination:

Immunizations in Resettled Refugees
Refugees are not required to have any vaccinations before arrival in the United States. In addition, in some developing countries and refugee settings vaccines may be inaccessible or unavailable. Families may also be uninformed or misinformed about the importance of vaccinations. Therefore, most refugees will not have had complete Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations when they arrive in the United States. If records are not available, the series will need to be re-initiated.

Overseas immunization schedule for U.S.-Bound refugees:

Vaccination Program for U.S.-Bound Refugees:
https://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/interventions/immunizations-schedules.html

Guide to interpreting foreign vaccine records to understand products and vaccines received:

Quick Chart of Vaccine-Preventable Disease Terms in Multiple Languages:

Global Immunization Schedules

WHO Vaccine Monitoring Summary: Searchable database of current immunizations recommended in every country. This is most helpful for visiting travelers who may be ill but are “up-to-date” without records, or who have records but not with them and have partially completed a vaccine series.
http://apps.who.int/immunization_monitoring/globalsummary/schedules

Pre-Travel Vaccination guidelines
CDC’s travel medicine website is searchable by location and offers site-specific guidance on vaccinations required and necessary as well as guidance that should be given to families. Be sure to select the “For Clinicians” side and check the option “Traveling With Children” if you are advising families of pediatric patients (as well as any other applicable options).

NOTE: Remember that live vaccines should not be administered within 1 month of each other. This is important if a child presents within 1 month of travel and needs Yellow Fever immunization for a planned trip and is due MMR or Varicella. The child should receive BOTH vaccines at the same time.
https://wwwnc.cdc.gov/travel/destinations/list
Immigrants Returning Home to Visit Friends & Relatives (VFRs) –

The resources below can help providers guide families returning home

- CDC’s Yellow Book section on immigrants returning home to visit friends and relatives (see specifically table 8-04, “Diseases for which VFR travelers are at increased risk, proposed reasons for risk variance, and recommendations to reduce risks.”

- CDCs travel medicine website (https://wwwnc.cdc.gov/travel/destinations/list) that is searchable by destination for all travelers. This includes pre-travel vaccination guidelines, site-specific indications on malaria prophylaxis or specific healthcare risks.

- CDC’s Yellow Book Section on Fever in Returned Travellers:

- CDC supported Heading Home Healthy program (www.headinghomehealthy.org) is focused on reducing travel-related illnesses specifically in VFR travelers. The program contains videos, informational resources, and health tools in multiple languages and was developed to assist not only VFR travelers but also their primary care health providers.
Cultural, Religious, and Traditional Medicine Pearls

Predominant religions practiced in refugee populations historically settled in Georgia:

**Syria**: Islam practiced by 90% of the population

**Iraq**: Islam practiced by 95% of the population

**Burma**: Buddhism practiced by 89% of the population

**Bhutan**: Buddhism practiced by 75% of the population

**Democratic Republic of Congo**: Christianity practiced by 80% of the population

**Somalia**: Islam practiced by 99.9% of the population

**Muslim religious or cultural practices:**
Physicians should be aware of the need for modesty and privacy, the appropriate use of touch, dietary requirements and use of medications:

- Provide the patient with a nurse and/or physician of the same sex when possible
- Dietary restrictions include pork, ham, lard, bacon, and alcohol
- Halal meals should be provided, if available. If not available, Jewish Kosher meals or vegetarian meals are acceptable
- Drugs that have porcine origins or that contain gelatin or alcohol are not recommended
- Fasting is performed once a year (from sunrise to sunset) during the month of Ramadan, and children, pregnant women, and those who are ill are exempt from fasting.
- Intravenous fluids or injections, total parenteral nutrition, intramuscular injections, or blood and blood component transfusions invalidate a fast
- Premarital sex is considered an immoral and sinful act. Sexually transmitted infections are highly stigmatized and hardly discussed in the community setting - emphasize to your patient that any discussions are confidential, private and without judgment
- Immunization as preventive mechanism is Halal (lawful) and necessary in Islam. Based on teachings of the Quran, ‘one has to avoid all that may cause harm to oneself or others’.
  - [Halal Baby Formulas](http://muslimconsumergroup.com/category_search_result.ph?t=l&p=17)

**Buddhism:**

- Some Buddhists may express strong, *culturally*-based concerns about modesty: for instance, regarding treatment by someone of the opposite sex.
- Some Buddhists are strictly vegetarian in refusing to consume any meat or animal by-product. For such patients, even medications that are produced using animals are likely to be problematic.

Additional cultural and religion resources:

Penn Medicine’s Religious Diversity: Practical Points for Healthcare Providers:
[http://www.uphs.upenn.edu/pastoral/resed/diversity_points.html](http://www.uphs.upenn.edu/pastoral/resed/diversity_points.html)

Interpreters and Communication Resources

Tips for Using Interpreters

- Touch base with your interpreter and provide some context prior to entering the room with a family.
- Use the same interpreter for each session, if possible.
- Use a medical interpreter – not friends or family.
- Use the most appropriate language and dialect. Some families speak multiple languages and may have fluency in a second language that has an interpreter available and provides for understanding when their primary dialect does not match the interpreter’s dialect resulting in misunderstandings.
- Speak slowly and clearly in small sound bites.
- Convey the pertinent information in plain language without use of figures of speech or idioms that may not translate well.
- Talk directly to the patient or parent and make eye contact with whomever you are speaking to.
- Be aware of cultural considerations or family dynamics.
- Be a good listener.
- Leave yourself plenty of time.
- Round as a team with all services involved, if possible.

For additional resources on using an interpreter, including online training modules on working with interpreters, see Ethnomed’s interpretation page: http://ethnomed.org/cross-cultural-health/interpretation

Using Interpreting Services at CHOA

Contact the unit secretary or charge nurse in clinic for instructions on using interpretation services at CHOA in your area. Most areas will have access to phone and iPad services, with some access to arrange in-person language translation services as well.

Community Language and Communication Resources for Patients and Families
- Bridging the Gap Project, Inc: https://www.immigrationadvocates.org
- International Rescue Committee, English as a Second Language Courses: https://www.rescue.org/what-we-do
- Jewish Family and Career Services - provides interpreters and translators, ESL classes
- State Refugee Health Program - interpretation for health services
Language-specific Patient Instruction and Education Resources

Extensive language-specific resources exist online. Especially for languages for whom in-person translation of patient education materials and discharge instructions is not available, consider using one of these databases to locate appropriate resources. Remember to assess a patient/parent’s literacy in their spoken language prior to selecting a resource. In some cases, like asthma action plan or medicine administration guidelines, pictoral resources aimed to address health literacy may be more appropriate than foreign-language resources.

**Medline Plus** – Publicly available database of common medical conditions and teaching sheets in 50 languages, from the US National Library of Medicine:
https://medlineplus.gov/languages/languages.html

**Ethnomed** - Patient education resources browsable by topic and by language from Ethnomed:
http://ethnomed.org/patient-education

**Asthma Australia** – Asthma specific resources including asthma action plan in several languages:
https://www.asthmaaustralia.org.au/national/about-asthma/resources/resources-in-other-languages

**Health Info Translations** - Educational resources translated into 18 languages:
https://www.healthinfotranslations.org
Local Resettlement Organizations, Community Groups, and Resources for Refugee and Immigrant Families:

This is just a partial list of resources available to immigrant and refugee families. Consult with your Social Work Department to identify additional resources and support services for each situation.


**Georgia Refugee Community** – Official blog sponsored by Georgia Coalition of Refugee Stakeholders that lists organizations, services, events, etc. in the refugee community. The mission is to coordinate Public and Private resources in a manner that encourages effective refugee resettlement and promotes refugee’s economic and social self-sufficiency and well-being as quickly as possible after arrival in the United States.

[http://garefugees.wordpress.com/](http://garefugees.wordpress.com/)

**DeKalb County Refugee Clinic** – Clinic in DeKalb County that provides domestic health screening to newly arrived refugees. Services include health screening, immunizations, referrals, x-rays, latent TB management, management of pathogenic ova and parasite, mental health and torture screening and referral, pediatric primary care, outreach and home visits.

[https://www.dekalbhealth.net/services/refugee-health/](https://www.dekalbhealth.net/services/refugee-health/)

**Center for Pan Asian Community Services (CPACS)** – Private Atlanta non-profit whose mission is to promote self-sufficiency and equity for immigrants, refugees, and the underprivileged through comprehensive health and social services, capacity building, and advocacy. Services include refugee advocacy, citizenship services, English services, family violence services, health services, housing services, parenting services, senior citizen services, short term assistance services, and youth services.

[https://cpacs.org/](https://cpacs.org/)

3510 Shallowford Road NE, Atlanta 30341
770-936-0969
Clarkston Community Center – Non-profit community center with the goal to aid the needs of the location refugee population. Services provided include education services, recreational services, senior citizen services, short term assistance services and youth services.

http://clarkstoncommunitycenter.org/

3701 College Avenue, Clarkston 30021
404-508-1050

Global Village Project (GVP)- Atlanta education program designed specifically for recently arrived refugee girls in secondary school (ages 11-18). GVP uses a strengths-based approach and intensive instruction in English language and literacy, academic subjects and the arts.

http://globalvillageproject.org/

Education services 205 Sycamore Street, Decatur 30030 404-371-0107

International Rescue Committee (IRC) – Non-profit organization that responds to some of the world’s worst crises, deliver aid that saves lives while paving the way for long-term recovery. Services include citizenship services, employment services, English and computer services, legal services, resettlement/case management services and youth services.

www.rescue.org

2305 Parklake Drive, Suite 100, Atlanta 30345
404-292-7731

Friends of Refugees – Non-profit organization with the mission to empower refugees through opportunities for well-being, education and employment. It is the member of the Christian Community Development organization. It supports the Café Clarkston (low-cost computer lab), provides employment services, English services, health services (pregnancy support), short term assistance services, youth services.

http://friendsofrefugees.com

P.O. Box 548, Clarkston 30021
404-292-8818

Lutheran Services of Georgia (LSG) – Guides individuals with refugee/asylum status on a path from surviving to thriving. They “empower those whose lives have been disrupted to discover their strengths and resilience, accompanying them as they grow into vibrant contributors to their community.” Services include, employment services, health services (disabled), Matching Grant, resettlement/case management services and youth services.
New American Pathways – Non-profit organization created by the merger of Refugee Resettlement and Immigration services of Atlanta and Refugee Family Services. Together, this new organization provides approximately 5,000 refugees per year with the necessary tools to rebuild their lives and achieve long-term success. Services include citizenship services, community organizing, employment services, English services, immigration services, Match Grant, parenting services, resettlement/case management services and youth services.

Refugee Family Assistance Program - Their services include health services (refugee children with disabilities), housing services, and parenting services.

Refugee Women’s Network (RWN) – Non-profit organizations serving refugee women resettled in the state of Georgia. The mission is to inspire and equip refugee and immigrant women to become leaders in their homes, businesses and communities. Their services include case management, life skills, and microfinancing services for women.

Somali American Community Center (SACC) - Case management, English services, youth services, Somali and Arabic interpretation, immigration services, afterschool programs, mentorship, physical activity events and tournaments. Until Dec 15 2018 registration for Obamacare.

Women Watch Afrika - Employment services, family violence services, health services, housing services, parenting services, youth services.

www.lsga.org

100 Edgewood Ave, Suite 1800, Atlanta 30303
404-875-0201

www.newamericanpathways.org

2300 Henderson Mill Road NE, Atlanta 30345
404-299-6217 or 404-622-2235

5405 Memorial Drive, Suite 1A, Stone Mountain 30083 404-296-8743

www.riwn.org

1431 McLendon Drive, Decatur 30033 404-437-7767

436 North Indian Creek Drive, Clarkston 30021 404-296-1308

Women Watch Afrika - Employment services, family violence services, health services, housing services, parenting services, youth services.

PO Box 208, Avondale Estates 30002
404-759-6419
World Relief – Non-profit resettlement organization that empowers the local Church to serve refugees and immigrants in the Greater Atlanta Area. In partnership with the local community and volunteers, World Relief provides a platform through which immigrants and refugees can achieve successful integration into their new home. Services include employment services, immigration services, resettlement/case management services.

http://worldreliefatlanta.org

655 Village Square Drive, Stone Mountain 20083 404-294-4352

Tapestri – Coalition dedicated to ending violence and oppression in immigrant and refugee communities. Coalition was formed to address the unmet needs of battered refugee and immigrant women in metro Atlanta. It offers a variety of services to refugee and immigrant women who have been the victims of domestic abuse, sexual assault, or trafficking.

www.tapestri.org

PMB 362, 3939 Lavista Road, Suite E,Tucker,GA 30084
(404)299-2185 or 1-866-56-ABUSE (9am to 5pm - Mon through Fri)

Center for Victims of Torture - extends rehabilitative care to refugees and asylum seekers, incorporating the specialized care that is most effective for survivors of torture, trauma, or domestic violence, who have fled their countries to the U.S. in search of safety and a new beginning. CVT offers psychotherapy and case management.

www.cvt.org [no address – call and email referral form] 470.545.2776

Positive Growth Clarkston – dedicated to improving the lives of children, youth, adults, and families during difficult life transitions by providing comprehensive residential and community-based treatment services. Provide multilingual and culturally sensitive mental health, social, and educational services to immigrants and refugee children, youth, adults and families in more than (20) languages from various ethnic and linguistic minority groups.

Multicultural Services
3155 E. Ponce De Leon Ave
Bldg A Scottdale, GA 30079
678-973-2005 – Office
678-973-2534 – Fax
http://www.positivegrowthinc.org

F.R.E.E., a non-profit organization that provides parochial school tuition, busing, and school lunches for refugee children in an environment where they are provided the individual attention they require. F.R.E.E. also provides transport to/from medical and legal appointments and arranges dental care.

https://freerefugees.org/about/
Family Heritage Foundation (FHF) is a Christian ministry focused on serving refugee families and at-risk children in Clarkston, Georgia. Their mission is “building safer communities and stronger families with the Message of Hope.” FHF offers after-school programs, summer camp, adult computer classes and youth development program.

http://fhfi.org  404-299-7766

Clarkston Area Foodbanks and Community Kitchens
Clarkston First Baptist-Food Program
3983 Church Street
Clarkston, GA 30021
404-292-5686 Ext 310
http://clarkstonfirst.org/ministry/connections/food-pantry/

Clarkston Community Center Food Pantry and Co-Op
3701 College Avenue
Clarkston, GA 30021
404-508-1050
https://clarkstoncommunitycenter.org/programs-old/food-security

HALAL CLINICS – no-cost clinic every Sunday 12-2pm.
Al Farooq Mosque Masjid of Atlanta
442 14th St, Atlanta 30318 404-874-7521 ext. 226 http://alfarooqmasjid.org/ Sundays
12pm-2pm; FREE

Masjid Omar Bin Abdul Aziz
955 Harbins Road, Lilburn 30047 770-279-8606 www.masjidomar.org

Majid Al-Momineen
837 N. Indian Creek Drive, Clarkston 30021 404-294-4058 www.masjidalmomineen.com