



MODULE I: APPLIED LIFE SKILLS

Overview

This module has been developed to meet the particular needs of newly arrived refugee families, with particular emphasis on refugee women. It has not been targeted at a particular ethnic group.

- Section 1:** General Orientation
- Section 2:** Cultural Orientation
- Section 3:** Banks & Bank Accounts
- Section 4:** Laundry
- Section 5:** Shopping
- Section 6:** Cleaning
- Section 7:** Chemical Storage
- Section 8:** Budgeting
- Section 9:** Transportation
- Section 10:** Driver's Licenses
- Section 11:** Housing

While each section's curriculum is fairly complete, trainers must adapt the curriculum to reflect the following:

1. The cultural norms, values, beliefs, and experiences of the ethnic group(s) represented by the participants.
2. The specific needs of the participants.
3. The particular community environment.

Towards that end, it is recommended that the following steps be taken to maximize effectiveness in the use of this curriculum:

1. Only individuals who are familiar with and have experience in the resettlement location should deliver this curriculum. While every attempt has been made to design a complete and thorough curriculum, the trainer(s) should be at least familiar with the area and the issues prior to offering the training.
2. The first section is critical to the development of future sections in the module. The series of questions posed in this beginning section are not designed to be just an ice breaker activity, but rather to help the trainer(s) understand the participants' particular needs and any issues they may be facing. Trainers should consider this section as an opportunity for the participants to educate the trainer(s). The answers to these questions





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should be used to inform future sections of the curriculum. Trainers should expect to make modifications in the curriculum based on the outcomes of this first section, as well as knowledge of community issues, prior to commencing the program.

3. Modifications should be made in the curriculum to reflect the specific cultural norms, values, beliefs, and experiences of trainees. Any time references are made to cultural norms, values, beliefs, and experiences of refugees from particular countries it is for illustrative purposes only. Such references are, by necessity, generalizations, and therefore should be used cautiously. Nuances related to the specific cultures of trainees should be incorporated where appropriate. Answers to the questions posed in Section 1 should provide some insight to such cultural norms, values, beliefs, and experiences. Community leaders and literature should also be consulted.
4. The curriculum is written in a style of English suitable for trainers, but which will need to be simplified for clients for whom English is not their first language. Finding simple ways to communicate some of these concepts is important to gaining participants' understanding.





Section 1: General Orientation

Objective

To introduce newly arrived refugees to their new home, answer their questions, and provide them with basic knowledge/information to help them with their new life.

Materials

1. Life Skills Assessment Questionnaire
2. Bus Schedule and City Map
3. Flipchart
4. Markers

Introduction

Refugee women usually have a lot of questions when they first arrive in the United States. They have many different impressions about the United States and it is very important for them to be able to talk and ask general questions about their new home.

The trainer needs to help them put all their worries behind them and prepare for their new life in the United States. This first session should address basic issues about life in the United States and life in the city where they have been resettled.

The trainer should meet the refugee women for the first time a few days after their arrival. Since this initial meeting will provide the refugees with their first impressions about their sponsors, it is very important to keep the atmosphere very comfortable. In order to ensure their cooperation, they should be made to feel welcome and wanted.

Note to Facilitators:

If two or three families arrive at approximately the same time, it is best to first meet each family privately.





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Questions Raised by Refugee Women:

At the initial meeting, the refugee women usually try to ask all their questions at once. They want to know

- ❖ When their children will start school.
- ❖ When their husbands (and they themselves) will start work.
- ❖ When and how they can learn English.
- ❖ How to apply for public housing.
- ❖ How to meet their living expenses.

It is very important that they be given clear and comprehensive answers to all of their questions. Never give vague answers. If you do not have enough information to properly answer a question, ask a coworker, such as the employment counselor or housing coordinator, or do the necessary research.

Assessment

If the participants are literate, the Life Skills Assessment Questionnaire could be translated for the class to work on in small groups or individually. If the participants are preliterate, you may use one large, translated questionnaire on a flipchart and discuss it together as a large group.

Use the participants' answers as a guide to how to use the curriculum. The material should be adapted or added to as the participants' needs indicate.





Life Skills Assessment Questionnaire

1. What do you know about American culture?
2. What are some differences between your country's culture and that of the United States?
3. Are there any aspects of your culture that might cause a problem in the United States?
4. Are there any aspects of American culture that might cause problems within your family?
5. Are you familiar with banks and bank accounts?
6. Did you have a bank account in your country? Would you like to have one here?
7. How did you do laundry in your country?
8. Are you familiar with washing and drying machines? Laundry detergents?
9. Do you know how to wash different fabrics and/or colors?





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10. Where/how did you get everyday necessities (i.e.: food, toiletries/baby items, etc.) in your country?

11. How did you shop for/obtain food in your country?

12. List three health benefits of cleanliness.

13. What methods, products, and/or equipment did you use to clean in your country?

14. What household chemicals did you use in your country?

15. How do you store household chemicals?

16. What is budgeting? List 3 benefits of budgeting.

17. Have you ever created and followed a household budget?

18. Did you have/use public transportation in your country?

19. Have you used public transportation in the United States? In this city?





20. Do you know how to drive? If not, would you like to learn?

21. Did you have a driver's license in your own country?

22. How would you find an apartment that suits your needs?





Section 2: Cultural Orientation

Objectives

Participants will—

1. Be introduced to some basics of American culture.
2. Discuss which aspects of their culture are and are not accepted in the United States.
3. Learn how a lack of understanding of cultural attitudes or modes of behavior can lead to problems.

Materials

1. Videos, posters, slides (*see activities below*)
2. Flipchart
3. Markers

Introduction

A basic cultural orientation for newly arrived refugees is very important. While refugees increase the cultural diversity of the United States, in order to avoid cultural conflict they need to be aware of the general rules and concerns of American culture.

Explain that culture exists throughout daily life: in the house, on the street, in stores, etc. Provide them with as many examples of American culture as possible. Explain that they need to adapt themselves to the different aspects of their new culture by incorporating the relevant parts of their own culture into this new one.

Note to Facilitators:

This type of information is best explained and discussed in a group setting.

Questions Raised by Refugee Women:

The refugee women who participated in the Immigration and Refugee Services of America (IRSA) orientation program generally asked questions about the following:

- ❖ How to prepare school-food for their children.





- ❖ What kinds of child discipline are acceptable.
- ❖ How to work in a co-ed environment (i.e.: with men).

In order to ensure a basic understanding of American culture, such questions need to be answered in as simple and detailed a manner as possible. For instance, many cultures in which obedience to parents and elders is emphasized both accept and use corporal punishment (beating, etc.) as a method of child discipline; however, in the United States it is generally considered unacceptable and may constitute child abuse—which is against the law (*see Module II: Parenting*). In this situation, alternate forms of discipline need to be suggested and possible pitfalls averted.

Many refugee women may have never been employed, nor have they worked alongside men. Since they may become employed in the future, U.S. employment rules and regulations and the standard expectations of the workplace need to be explained clearly.

Activities

Videos, posters, and slides are a comprehensive and effective way to provide the participants with basic information about U.S. culture.





Section 3: Banks & Bank Accounts

Objectives

Participants will—

1. Learn about the benefits of financial independence.
2. Discuss the advantages of having a bank account.

Materials

1. Handouts and brochures from a variety of banks.
2. Flipchart
3. Markers

Introduction

Many refugees may not be familiar with banks and they (or their family members) may have never had a bank account. It is important, therefore, to explain in general the purpose of banks, how the banking system works, and the different kinds of bank accounts. The advantages of having a bank account and the importance of financial independence need to be highlighted.

Many refugee women are not initially interested in opening a separate bank account in their own name. If there are women who are interested in pursuing this issue, however, it is important to explain in more detail and answer any questions they may have.

Note to Facilitators:

This type of information is best explained in a group setting.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ The conditions/requirements necessary to open a bank account.
- ❖ How to fill in a check.
- ❖ How to balance a checkbook.
- ❖ How to read a bank statement.
- ❖ How to use an ATM (Automatic Teller Machine) machine.





Since many refugee women may have never had an opportunity to have a bank account, it is important to answer such questions thoroughly. It is also useful to have a number of handouts on hand that explain different issues and to go over them in detail.

Field Trip

A field trip to the bank is the best way to fully answer the participants' questions and to demonstrate daily banking procedures. Arrange to meet with the bank manager for a short tour and a review of what kinds of services banks provide to their customers. Many banks have brochures describing their services—it is useful to translate and go over the brochures in a class following the field trip. Another alternative is to role-play in class.





Section 4: Laundry

Objective

Participants will learn about the different methods and products available for doing laundry.

Materials

1. Flipchart
2. Markers

Introduction

Many refugee women have only ever done laundry by hand. As such, it is important to explain how to operate a washing machine and discuss its timesaving advantages.

Note to Facilitators:

This information can be taught either in groups or individually at home.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ What a Laundromat is and where one is located.
- ❖ How to operate washers and dryers.
- ❖ What kinds of laundry soap/detergent, etc. are available, and which to use for washing whites vs. colors, silk vs. cotton, etc.
- ❖ What kind of clothes are machine washable/dryable.

Since this is such a practical topic, such questions are best answered through demonstration and practice.

Field Trip

Take the participants to a Laundromat (or set up a demonstration at their home) and let them practice how to operate washing and drying machines after explaining what types of cloth can be washed and/or dried by machine and what types might be ruined, such as silk. Be sure to bring samples of different laundry detergents, softeners, bleaches, etc. and explain their uses.





Section 5: Shopping

Objectives

Participants will—

1. Learn how to shop for necessary items in supermarkets and grocery stores.
2. Determine the locations of shops in the neighborhood.

Materials

1. Flipchart
2. Markers

Introduction

Since most families need to go to the store at least once a week to buy necessities (food, toiletries/baby-care items, etc.) knowing how and where to shop is very important. This is especially the case for refugee women as they may have to be completely self-reliant if their husbands or sons are away or if they are alone.

Note to Facilitators:

This type of information can be taught either in groups or individually.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ Finding desired items.
- ❖ Determining the price of selected items.
- ❖ How/where to pay.
- ❖ How to use food stamps.
- ❖ How to purchase Women, Infants, and Children Program (WIC) items.
- ❖ How to buy in bulk and bargain shop.

Since this is such a practical topic, such questions are best answered through demonstration and practice.





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Field Trip

Take the group/individual to the neighborhood grocery store. Begin the lesson at the front entrance and explain the use of shopping carts and/or hand-baskets. Walk them through the store to demonstrate how the store is organized, and explain how to find different items and determine their price.

After walking through the store, answering any questions, and choosing some items to purchase, take everyone up to the cashier and explain the different methods of payment.

Two or three hours of shopping is a valuable lesson for refugees who may not be familiar with large stores. Additional field trips may be made to: Costco/Sam's Clubs, health food stores, international markets, farmers' markets, delicatessens, etc. it is a good idea to have a group session to discuss the relative benefits of each of the different types of stores available in your community. (*For further discussion of shopping on a budget, see Section 8: Budgeting.*)





Section 6: Cleaning

Objectives

Participants will—

1. Discuss the importance of cleaning in keeping homes and items germ- and pest-free.
2. Learn different methods and chemicals/products used for cleaning a variety of household items.

Materials

1. Samples of different cleaning materials and equipment
2. Flipchart
3. Markers

Introduction

Many refugee women may not be familiar with the methods, appliances, and chemicals available for keeping their homes, themselves, and their families clean. As a result, they often need intensive training in why and how best to do this.

Be sure to explain that general cleanliness will reduce the likelihood of problems from pests and diseases (including food poisoning), and that, since clean items/equipment tend to last longer, it helps save money.

Note to Facilitators:

It is advisable to make regular home visits to discuss the issues of cleaning and/or to work with them as a group to encourage questions and feedback.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ What kinds of cleaning materials they have to use for kitchen appliances, dishes, carpets, and the bathroom.
- ❖ Whether there are special products for cleaning furniture.
- ❖ How to use and store the different chemicals, materials, and equipment.





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The best way to answer such questions is through practical demonstrations during home visits.

Show the participants samples of the different cleaning materials and explain the instructions. Pick an appliance and demonstrate how to clean it. The stove is always a good example since many people are unaware of the importance of turning off all burners on the stove and letting them cool before cleaning, or of the hazardous and caustic nature of oven cleaners (see *Section 7: Chemical Storage*).

Discuss the use of Lysol and bleach (or other disinfectants) to disinfect the home. Be sure to demonstrate basic things such as how to dust, vacuum, and clean glass, kitchen counters, and dishes.





Section 7: Chemical Storage

Objectives

Participants will—

1. Become familiar with the different kinds of chemicals that they will probably use in their daily lives, and with the advantages and disadvantages of using them.
2. Learn that chemicals can be very dangerous and are often poisonous.

Materials

1. A selection of standard household chemicals.
2. Flipchart
3. Markers

Introduction

Show the participants samples of all the chemicals they are likely to use in cleaning their kitchen, bathroom, furniture, and clothes. It is very important to explain their proper use and storage as such chemicals are often hazardous to health and can even be fatal, especially for children. It is also very important to point out that certain common household chemicals (such as ammonia and bleach) must not be mixed, as dangerous chemical reactions result.

Note to Facilitators

This information can be taught either individually through home visits or through group sessions.

Follow-up

Follow-up on this issue occasionally to make sure that cleaning supplies are being stored properly.





Section 8: Budgeting

Objective

To explain to the participants the principles and purpose of budgeting.

Materials

1. Working Budget Sheets
2. Shopping on a Budget Sheets
3. Pens (*see activities below*)
4. Tables and chairs (*see activities below*)
5. Pictures of consumer items with prices (*see activities below*)
6. Signs that label shopping areas (*see activities below*)
7. Flipchart
8. Markers

Introduction

Budgeting is a very important issue since refugee women need to become familiar with how to handle money and control expenses, whether or not they are working. They need to learn that budgeting will help to prevent them from spending beyond their means/income.

Collect and summarize a variety of information about budgeting. Prepare a lesson and demonstrate the various points to the group by using a flip chart. Ask them for estimations of their basic expenses (as these are the most important) and use the answers to demonstrate how to do individual budgeting.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ Reasons for spending over budget.
- ❖ The best ways to avoid overspending.





Activities

One or both of the following two activities can be used in the budgeting section, depending on the needs of the participants and the resources that the trainer has access to. The first activity is quite simple and requires very little preparation time on the part of the trainer.

The second activity is more complex and requires substantial preparation time: pictures have to be collected and the classroom or meeting space needs to be carefully set up.

Time permitting, the first activity (drafting a simple budget) can be used as a preparation for the second activity (making informed decisions on what to buy and where, based on the budget of an individual/family.)

A. Planning Your Monthly Budget:

Time: 30 minutes

Objectives:

Participants will plan a monthly budget with the goal of spending less than they earn.

Procedure:

1. Divide participants in pairs and give each individual a budget sheet.
2. Ask everyone in the group to complete their budget sheets individually.
3. After everyone has completed their budget sheets, instruct participants to turn to their partners and compare budgets.

Debrief:

Ask the participants, will you be saving money with this budget? Or will you be in debt? What did you notice about your partner's budget? In what ways can you cut your expenses? How can you increase your family's income? How is budgeting for your life in the United States similar to or different from what you used to do in your country? What are the most challenging things about budgeting? Suggest ways of addressing those challenges.





Working Budget Sheet

Step 1. Add all the money you earn each month to get your total monthly income.

Income from Work:

+ Other Income:

**Total Monthly
Income:**

Step 2. List all of your needs and how much they cost each month. Add your own special needs to the list.

NEED	COST
Rent or House Payment	
Telephone	
Electricity	
Gas	
Food	
Transportation	
Insurance	
Medical Care	
IOM Loan	
Laundry	
New Clothes	
TOTAL NEEDS	





Step 3. *List things that you really want and how much they cost each month. Try not to spend money on too many wants.*

WANT	COST
Cost of Total Wants:	

Step 4. *Add your needs and wants to learn your total expenses.*

Total Needs:

+ Total Wants:

Total Expenses:

Step 5. *Subtract your total expenses from your total income.*

Total Income:

- Total Expenses:

Savings/Debts:

Note to Facilitators:

If participants are pre-literate or have limited literacy and numerical skills, use color-coded play-money (Explain, for example, that red is worth more than green.) or use pieces of paper in different colors to represent money. You can also use pictures: draw a house for "rent," a car/bus for "transportation," etc. Focus more on discussing the difference between needs and wants than on the concrete amounts in the budget.





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B. Shopping on a Budget:

Time: 45 minutes

Objectives:

Participants will learn how access to consumer goods can affect their budget. Through a structured activity, participants will practice reducing their expenditures on non-essential items.

Procedure:

1. Designate five areas in the classroom or meeting room as shopping areas and label the areas as follows:
 - ❖ Supermarket
 - ❖ Clothing store (non-chain)
 - ❖ Garage sale
 - ❖ Walmart or large chain store
 - ❖ Electronics store
2. Post pictures of consumer items and prices in the appropriate shopping areas. You will need photos of toiletries, clothing, food, furniture, electrical appliances, and luxury items.
3. Divide participants into groups and give each group an identical amount of money to spend.
4. Ask the people in each group to cruise each area and to shop by taking the photos off the wall and bringing them back to their group's table. Give them only a few minutes to do this.
5. Now give each group a budget sheet. Ask them to total the cost of the items and to decide which items are essential and which are not. Ask them to decide which of the items they will return in order to reduce their budget.
6. Ask each group to choose one luxury item and one necessity item from their purchases. They then come to the front of the class and show each item and state the cost. The other groups look at their purchases to see if they have the same items. They compare the costs of the items, where it was purchased and reduce their budget to reflect the costs of the cheaper items.





Debrief:

Focus on sharing the costs of items and how they reduced their budget. Discuss what they have learned about their shopping habits and the shopping "environment" in the United States. List ways in which they can reduce their expenditures.

Note to Facilitators:

If participants are pre-literate or have limited literacy and numerical skills, use color-coded play-money (Explain, for example, that red is worth more than green.) or use pieces of paper in different colors to represent money. You can also use pictures: draw a house for "rent," a car/bus for "transportation," etc. Focus more on discussing the difference between needs and wants than on the concrete amounts in the budget.





Shopping on a Budget Sheet

Amount of money available at the beginning of the month:

Item Purchased	Name of Store	Cost

TOTAL:

Amount remaining from budget:





Section 9: Transportation

Objective

Participants will learn about the basics of public transportation and how to use it.

Materials

1. Bus schedules
2. Subway map
3. City map
4. Flipchart
5. Markers

Introduction

This topic is of particular importance as many refugees may have no other means of transportation or even a driver's license. In addition, since refugee women are generally responsible for the children and shopping, they need some form of transportation in order to carry out their daily tasks. They may also need to commute to and from work.

Note to Facilitators:

This section can be completed either in a group session or individually.

Questions Raised by Refugee Women:

Refugee women generally ask questions about the following:

- ❖ How to find the correct bus number/subway for different routes.
- ❖ The cost of the bus/subway fare. Is it the same or different from one route to another or from one mode of transportation to another.
- ❖ How to pay the bus fare (i.e.: put it in the machine).
- ❖ How to signal the bus/bus driver to stop at the correct destination.

Explain the basics of bus/subway fares, numbers, and schedules. Point out that payment in exact change is usually required since, in most bus systems,





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the driver does not have access to money for change. Subways, on the other hand, often require the purchase of tickets or tokens.

Ensure that the participants understand that different bus numbers (and subways) have different routes, and demonstrate the use of a bus schedule (subway map) to determine which buses take which routes and their frequency. Also discuss the use of tokens, ride tickets, transfers and/or passes as alternative ways of saving money.

Field Trip

After the initial introduction, the best way to teach the participants (either individually or as a group) is to do a practical demonstration and take them on a bus/subway ride. Be sure to show them how to put the money in the machine and how to request that the bus stop at the chosen destination.





Section 10: Driver's Licenses

Objectives

Participants will—

1. Learn the process of obtaining a driver's license
2. Discuss the advantages and disadvantages of driving.

Materials

1. Driving Manual (specific as to state)
2. Flipchart
3. Markers

Introduction

For many refugee women, having a driver's license (and a car to drive!) provides a measure of independence and can save time in getting to work, going shopping, taking the children to school, etc. Being able to drive is also important during crisis situations, such as when someone needs to be taken to the hospital.

In order to obtain a license, the participants must first pass a driving test. In order to prepare for this test, they need to learn the driving rules and regulations listed in the driving manual (each state has its own driving laws).

Many refugees initially find it difficult to understand and follow the manual. Walk them through it step by step and explain the contents simply and clearly.

It is very important for them to have a good understanding of the material covered in the driver's manual, as the required written computer test can be a problem because of language difficulties.

Note to Facilitators:

Individual home visits are the best way to teach participants the information in the driver's manual.





Section 11: Housing

Objectives

Participants will—

1. Learn how to find a suitable apartment.
2. Become familiar with the rights of landlords and tenants.

Materials

1. Life Skills Evaluation Questionnaire
2. Local newspapers (Classifieds)
3. City map
4. Flipchart
5. Markers

Introduction

Good housing is very important for all refugee families. It is a major step towards greater stability and comfort. Since it is the responsibility of their relatives or the sponsoring agency to prepare it for them before their arrival, refugee families may not initially have difficulty finding housing; nevertheless, they need to learn how to find an apartment in a suitable and affordable location. They also need to be aware of landlord/tenant rights.

Finding an Apartment:

Some or most of these issues can be handled during the general orientation after their arrival (*see Section 1: General Orientation*).

First, refugee families should be informed that their initial housing issues (getting that first apartment) is the responsibility of either their relatives or the housing coordinator at the resettlement agency. Make sure they are aware of the advantages of keeping in touch with the housing coordinator.

Explain how they can find other apartments—either through friends and relatives who might know of an available apartment or through the classifieds in local newspapers. Walk them through the basic criteria that the apartment would have to meet, such as:





- ❖ Location (How close or far it is from children's schools, other family members, employment, shopping center, etc.).
- ❖ Size (Will it accommodate all the members in the family?)
- ❖ Safety (How safe is the area? Does the building have security?)
- ❖ Rent and other costs (Is the apartment affordable? Are utilities—water, electricity, and/or gas—included in the rent? If so, which ones? Is there a parking space and does it cost extra?)

Landlord/Tenants Rights:

It is very important for refugees to be aware of their rights as tenants and the rights their landlord. They should understand that the rights and responsibilities of both tenant and landlord should be stated clearly in their lease agreement.

Use any lease as an example. Read and explain to the participants the requirements of the lease in detail, and emphasize the fact that it is a legal document once both parties—landlord and tenant—sign it.

Activity

Time: 45 minutes

The following activity assists participants in establishing their housing priorities. The activity as detailed below is a sample to be adapted depending on local circumstances. The trainer can choose either to have the participants work with an imagined location in order to emphasize the issues or to use "real life" information from a particular location.

Objectives:

Given situation cards, a city map, and neighborhood descriptions, participants will be able to establish their housing priorities to the extent that they can choose the housing option that is the best for them.

Situation and Neighborhood cards (which the trainer will have to create) should be translated ahead of time. If participants are preliterate, have a literate volunteer (or a trainer) read the descriptions to the class.

Procedure:

1. Divide the class into groups according to their family situation—singles, couples, or families.





Journey of Hope

2. Give each group the situation card that most suits their situation and allow time for reading. Use the same situations initially; however, they may be adapted as appropriate.
3. Distribute the classified ads to each group. Again, they may be adapted as appropriate or real classified ads used.
4. Post copies of a city map around the room.
5. Beside each map, post descriptions of the neighborhood. Sample descriptions for Columbus follow; however, a trainer would have to write descriptions specific to the community for a "real life" example.
6. Ask participants to gather information from the maps, ads, and descriptions and to decide which housing option is the best for their situation.

Debrief:

Focus on sharing what factors they took into consideration when making their decision, whether choosing was difficult or easy, and why or why not. Determine if there are any priorities that are common to all the participants.

Note to Facilitators:

If there is time, write some abbreviations from the classified ads on the board or sheet of paper and ask them to state the English word and the equivalent of the word in their native language. If participants are preliterate, focus more on learning how to read the map and read family and neighborhood descriptions to the class.





The Neighborhoods

A. The East

The East is an area of quiet, tree-lined streets. Seventy-five percent of its residents own their own homes. The majority of the population of the East is made up of working professionals and comfortable retirees.

Crime: There is very little crime in this area. Police records show little more than occasional burglaries.

Shopping: There are very few stores in this residential area and their prices are moderate. The supermarket near Pixton Private School has the lowest food prices in town.

Schools: Thirty-five percent of residents' children attend schools in the East part of town. The remaining 65 percent of children in this area attend Pixton Private School, which offers high quality, but expensive elementary and high school instruction.

B. The Northeast

The Northeast is the oldest area in Columbus. This area was once considered the least desirable part of town to live in. In the early 1980's, however, the neighborhood began to change. Its buildings, many dating from the early 1800's, became attractive to middle class and upper class families who saw them as historic monuments. Poor families were evicted and houses were sold to families who restored them to their 19th century appearance. Most of the poor moved to the West. Scattered pockets of low-income families remain. Sixty percent of the families in the Northeast own their homes.

Crime: Burglaries are common in the Northeast while street crimes are uncommon. The only trouble spot in the Northeast is the area near Harlem Road, where there are bars, massage parlors, and two cinemas that show X-rated films. Robberies and street violence are problems in this small corner of the Northeast.

Shopping: Stores in the area are moderately priced. A K-mart discount store is at the corner of Westerville Road and Morse Road.

Schools: Washington High and Susan B. Anthony Elementary are located in the Northeast. These schools have less drug/violence problems than those in the West; about 20 percent of families in this area send their children to Pixton Private School.





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C. The Northwest

Crime: Burglaries are common in the Northwest. Robberies and street crime have been increasing in recent years.

Shopping: Stores in the area are moderately priced. K-mart, a discount store, is at the corner of Kenny and Tremont Roads.

Schools: Children in the area attend Jefferson High and Mayflower Elementary in the West. In the last 10 years, approximately 15 percent of families have sent their children to Pixton Private School because of crime in the public schools.

D. The West

The West is the section of town where much of the community's industry is located. Most of the factories are located near Betty Road. Few of this area's residents own their own homes. Forty percent of the population of the West is unemployed. A high percentage of those living in the West are receiving public assistance. Several government-subsidized housing projects have been built in this area over the last 20 years.

Crime: The West is a high crime area. Burglaries, muggings and other street crimes are common. Three large gangs of youths often battle for the drug trade in this area. Most town residents believe that it is unsafe to walk the streets of the West no matter the time of day.

Shopping: The stores, pharmacies, etc. in this area have very high prices. Merchants say that their costs are high because of theft or vandalism and that they must reflect these in the prices charged their customers.

Schools: Jefferson High and Mayflower Elementary are located in this part of town. Nearly all children in the area attend these schools.

"Citizens Crime Watch" headed by Shirley Nance, an African-American resident in her late 50's, has made some advances in reducing crime in recent years. "Citizens Crime Watch" organizes a community patrol by local citizens. These citizens report incidents/crimes to police.





Family Situation Cards

Family 1:

You are a family of five—husband, wife, and three kids (ages 6, 8, 11). You receive welfare of \$600/mo. plus \$175/mo. Food stamps.

Family 2:

You are a family of four—husband, wife, and two children (ages 3 and 5). The husband works full-time as a janitor and his income after taxes is \$800/mo. The wife works as a part-time cashier at a centrally located department store. After taxes, her income is \$350/month.

Family 3:

You are a family of 4 with two children ages 5 and 9. The husband works full-time as a computer technician. His income after taxes is \$1,700/month.

Family 4:

You are a divorced woman with two children (ages 9 and 14). You work part-time at a local market and your income after taxes is \$310/month. You receive \$249/month in child support from your former husband. You qualify for food stamps.

Family 5:

You are a family of five—husband, wife, two children (ages 4 and 14), and grandmother. The husband has an income after taxes of \$1,200/mo. He works as a machine operator in Johnstown.





The Housing Classifieds

For Rent:

Apt. 1 – Bedroom

1180 Williams Rd.

\$525—Utilities included. 1 bedroom w/kitchenette, bath, wall-to-wall carpeting, good neighborhood.

870 Galloway Rd.

\$355/mo., furnished, utilities included, 1 bedroom and garage. Near Jefferson HS and Needle Park.

2320 Harlem Rd.

\$315/mo. Utilities included, 1 bedroom, large kitchen, good neighborhood.

170 Clark Rd.

\$435/mo. Utilities included, 1 bdrm, large kitchen, good neighborhood.

Other Apts.

2601 Williams Rd.

\$675/mo. 2 bdrm, good neighborhood, near supermarket.

462 Galloway Rd.

\$520/mo., util. incl., 2 bdrm., near Needle Park, 1 bathroom, needs repair.

1500 Roberts Rd.

\$600/mo., 2 bdrm., 1 bath w/garage.

13 Clark Ave.

\$650/mo., 3 bdrm., near Susan B. Anthony Elementary School.





Evaluation

Explain to the participants that you would appreciate their feedback on the classes. Pass out the following evaluations and have the participants complete them.





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Life Skills Evaluation Questionnaire

1. What are the most useful things you learned during this training?

2. In what way will what you learned help you with your new life in the United States?

4. What field trips did you find the most useful and why?

6. What do you think about the trainer's knowledge of the material?

7. How do you feel about the way the material was presented to you?

9. Would you recommend this program to a friend?





SERIES A: PARENTING CHILDREN FROM BIRTH THROUGH 12

Section 1: Introductions & Getting Started

Objectives

Participants will—

1. Introduce themselves to the class and complete the "Getting to Know You" worksheet.
2. Discuss the purpose of parenting education classes.
3. Complete the Parenting Questionnaire to gain insight into their parenting styles, both past and present, and to provide this information to the Facilitator.

Materials

1. Parenting Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

Introduce yourself to the group by telling them who you are and what you do. Explain that the purpose of these classes is to not only help them become better parents, but also to help them understand the American system and become more familiar with the signs and symptoms of any behavioral/learning difficulties their children may be experiencing.

It is important to stress that they are the experts in parenting their children. These classes are simply a way to support and enhance the skills they already have, as well as to teach them new parenting techniques.

Discuss with the participants the outline of the topics that will be covered throughout these classes.





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Assessment

Explain to the participants that in order to introduce them to alternative parenting techniques, it is necessary to learn about their past and present styles of parenting. Pass out the Parenting Assessment Questionnaire to the participants. Depending on the number of participants, have them discuss it as one large group or in many small groups.

Note to Facilitators:

The answers given by the participants to this questionnaire provide the foundation for the information shared in these parenting classes. These answers indicate the particular parenting styles of the participants, thereby giving the facilitators prior knowledge of how the participants were parented themselves, how they parented in the past, and how their parenting has changed since coming to the United States. It is imperative that you use the information that comes out of this activity to make appropriate modifications in the subsequent sections to meet the needs of the participants.





Birth through 12 Assessment Questionnaire

1. What was parenting like in your home country?
 - a. How were you parented?

 - b. How did you parent your children?

 - c. If you lived elsewhere (for example, in a country of first asylum and/or a refugee camp) before coming to the United States, how were you able to parent your children?

2. Since coming to the United States, how has your parenting style changed?

3. What are your main worries about parenting in the United States?

4. What kind of support do you need in parenting?





Section 2: Child Development

Objectives

Participants will—

1. Become familiar with the developmental stages of a child from birth to age 12.
2. Learn to recognize how trauma may affect children and the behaviors that may appear as a result.

Materials

1. Developmental Assessment Questionnaire
2. Developmental Milestones Questionnaire
3. Flipchart
4. Markers

Introduction

Explain to the participants that before they can begin discussing parenting techniques they need to understand at what level of development their children are so that effective discipline to handle inappropriate behavior may be applied. Children of different ages need to be handled differently with regards to discipline. An older child has developed the ability to understand "right and wrong," and thus understands the nature of discipline, whereas a younger child has yet to develop this capacity and may not understand why they are being disciplined.

Assessment

Pass out the Developmental Assessment and the Developmental Milestones Questionnaires to the participants. Explain that the Developmental Assessment Questionnaire is to find out what they know about normal developmental behaviors of children through the age of 12 and the Developmental Milestones Questionnaire is to help determine their children's stage of development. Have the participants complete the questionnaire and handout; once finished, discuss their answers.





Note to Facilitators:

Some participants may be preliterate. If so, they will need to give their responses to the quiz verbally. As in Section One, the answers given by the participants to the quiz should help you decide what to emphasize in discussions about developmental milestones.





Child Development Assessment Questionnaire

Of the following, check off what you believe to be true.

1. ____ A three-month-old cries only because he/she is spoiled.
2. ____ An eight-month-old child is afraid of strangers.
3. ____ A two-year-old child is capable of making choices that the parent has limited for them. For example, "Would you like the red one or the blue one?"
4. ____ An infant should be given a bottle every time he/she cries because this is an indication that he/she is always hungry.
5. ____ Children aged 4-6 can use the toilet by themselves with no help.
6. ____ It is normal for children aged 4-6 to be aggressive occasionally.
7. ____ Children over three never wet the bed at all.
8. ____ Children aged 3-4 can manage their emotions and no longer throw tantrums over minor frustrations.
9. ____ Children aged 6-12 have unstable friendships or act unkindly to peers.
10. ____ Children aged 6-12 frequently suffer mood swings; their feelings are easily hurt and they have quick tempers.
11. ____ It is normal for children aged 6-12 to undergo puberty (hips widen, breasts develop, pubic hair appears, testes develop).
12. ____ The eating habits of children aged 6-12 fluctuate with changes in activity level.





Developmental Milestones Questionnaire

Of the following, check off the ones that apply to your child.

Age: 3 months

- Startles in reaction to a nearby, sudden loud noise (when not in a deep sleep).
- Moves each of his/her arms and legs as easily as the other.
- Can raise his/her head from a flat surface when on his/her stomach.
- Quiets if picked up when crying.
- Looks at you, watches your face.
- Follows a slowly moving object with eyes and head, when on his/her back.

Age: 6 months

- Holds his/her head upright and steady when held in a sitting position.
- When on his/her stomach, lifts his/her head and chest.
- Smiles and coos.
- Laughs and squeals.
- Searches for the source of sounds, such as a parent's voice or a squeaky toy, by turning his/her eyes and head.
- Plays with his/her hands by touching them together.
- Grasps a rattle when touched to the backs or tips of his/her fingers.
- Reaches for toys and other objects.
- Focuses eyes on small objects placed in front of him/her, such as a raisin or penny.

Age: 9 months

- Rolls over, stomach to back and back to stomach.
- Holds his/her neck stiffly when pulled to sitting position.
- Tries to stand on his/her feet and supports some of his/her weight when held upright.





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- ___ Picks up toys or small objects within reach.
- ___ Passes a small block or cookie from one hand to another.
- ___ Feeds himself/herself crackers or cookies.
- ___ Looks for, tries to locate an object he/she has been looking at that is dropped out of sight.

Age: 12 months

- ___ Sits alone (unsupported).
- ___ Stands, holding on.
- ___ Pulls self to stand.
- ___ Cruises around playpen or crib.
- ___ Can get self into a sitting position.
- ___ Responds to his/her name.
- ___ Says "ma-ma" or "da-da."
- ___ Imitates sounds and simple words.
- ___ Plays Peek-A-Boo.
- ___ Discriminates strangers from mother, father, and other familiar family members.
- ___ Can pick up a small object by squeezing it between his/her thumb and fingers.

Age: 18 months

- ___ Stands alone.
- ___ Rolls or throws a ball back to you.
- ___ Indicates wants by pointing, pulling, grunting.
- ___ Plays Pat-a-cake.
- ___ Drinks from cup.
- ___ Bangs two small blocks together.

Age: 24 months

- ___ Walks well.





- ___ Runs stiffly.
- ___ Can take five or more steps backwards.
- ___ Can bend over without holding on to someone/something to pick up a toy and stand up again.
- ___ Can walk up steps holding onto wall or rail.
- ___ Imitates household chores such as dusting or sweeping.
- ___ Says at least three words consistently other than "ma-ma" and "da-da."
- ___ Points to one or more parts of his/her body (hair, eyes, nose, etc.) when asked to.
- ___ Follows simple spoken directions such as "Give me your cup."
- ___ Feeds himself/herself with a spoon or fork, with some spilling.
- ___ Can put one or more small blocks on top of another.
- ___ Looks at and turns book pages.

Age: 2.5 years

- ___ Can kick a small ball forward.
- ___ Can take off clothes such as pajamas or pants.
- ___ Combines two words when speaking such as "play ball," "Daddy gone."
- ___ Asks the names of things.
- ___ Listens to stories and songs.
- ___ Points to familiar objects in pictures and in the room.
- ___ Scribbles on paper with pencil or crayon.
- ___ Can build a tower of four small blocks.

Age: 3 years

- ___ Jumps by lifting both feet.
- ___ Runs smoothly.
- ___ Walks upstairs and downstairs alone.
- ___ Throws small ball overhand.
- ___ Can put on clothing such as pants and socks.





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- ___ Knows his/her first name.
- ___ Refers to himself/herself by name.
- ___ Repeats common rhymes or TV jingles.
- ___ Understands simple stories told or read.
- ___ Copies/draws a straight line.

Age: 4 years

- ___ Pedals a tricycle.
- ___ Buttons and unbuttons large buttons.
- ___ Dresses with supervision.
- ___ Washes and dries hands.
- ___ Says first and last name.
- ___ Uses "I," "me," "you."
- ___ Matches two or three colors.
- ___ Understands meaning of words "on," "under," "behind."
- ___ Speaks in short sentences.
- ___ Copies a circle.
- ___ Builds a bridge using three blocks, when shown how.
- ___ Puts together puzzles of a few pieces.

Age: 5 years

- ___ Catches a large ball.
- ___ Balances on one foot.
- ___ Hops on one foot.
- ___ Alternates feet when going up stairs.
- ___ Buttons and zips clothing.
- ___ Cares for self at toilet.
- ___ Shares and takes turns.
- ___ Separates from mother easily.





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- ___ Plays group games such as hide-and seek and simple board and card games, following rules.
- ___ Knows major, visible parts of his/her body.
- ___ Tells his/her full name and address.
- ___ Matches and names three or more colors.
- ___ Can tell which of two sticks is longer, which of two pictured balls is larger.
- ___ Can answer questions such as "What do you do when you are sleepy, hungry?"
- ___ Copies a cross.

Age: 6-8 years

- ___ Can use scissors and small tools.
- ___ Can tie shoelaces.
- ___ Can print own name.
- ___ Can distinguish between left and right.
- ___ Understands time and the days of the week.
- ___ Can read and write with some mistakes such as reverse printed letters (b/d).
- ___ Develops permanent teeth.
- ___ Has a good sense of balance.
- ___ Enjoys copying designs and shapes, letters and numbers.

Age: 9-12

- ___ Improves coordination and reaction time.
- ___ Can be skillful in reading and writing.
- ___ Can focus attention and take time to search for needed information.
- ___ Can do routines (brushing teeth, tying shoes, bathing, etc.) by himself/herself.
- ___ Can prolong his/her interest.
- ___ Undergoes puberty (hips widen, breasts develop, pubic hair appears, testes develop).





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Outline/Lesson Plan

Developmental Stages

- *Birth through Age 5*
- *Ages 6-12*

How a Child Reacts to Trauma

- *Birth through 2 Years*
- *Ages 2-6*
- *Ages 6-10*
- *Ages 10-12: Preadolescence*

Activity

- *TIC-TAC-TOE Game*

Developmental Stages

From the time of their birth, children grow and develop; however, it is important to note that not all children develop at the same pace or in the same manner. The developmental process involves growing in four domains: physically, intellectually, socially, and emotionally. The developmental stages and the four domains interact with and build upon each other as a child grows. This module will not spend a lot of time on the different stages, but will briefly cover the milestones.

Notes to Facilitators:

A good technique for generating discussion at this point is to begin by asking participants to describe developmental milestones for various age groups and within each of the four domains. This teaching technique has several advantages:

- 1. Avoid "lecturing" them about the facts, which can be very boring!*
- 2. Acknowledge what they already know, thus empowering them as good and competent parents.*
- 3. Continue learning about the participant's view of children, their current base of knowledge, and where best to concentrate efforts in addressing misconceptions they may have about child development.*

Birth through Age 5:

Physical: During this developmental stage, children work very hard to master a wide range of physical and motor skills. A child begins to learn how to control and master their own body, then perfects balance, coordination, stability, and, as their gross and fine motor skills increase, the ability to manipulate objects. The child then develops mastery in





applying these skills to increasingly challenging and complex situations. An example of this is how children first learn to move themselves around, then to crawl, and then to walk.

Intellectual: During these ages, children are very interested in everything around them. They are very curious about themselves and their surroundings. An infant wants to taste, touch, and smell everything. They begin to manipulate objects in an effort to gain a simple understanding of such objects. Central to intellectual development is the emergence of symbolic thought, which results in the ability to understand and produce language. Toddlers seek the perfection of language skills and the use of language as a communication tool. As a result, language develops quite rapidly, and grammar and syntax are refined and their vocabulary increases.

Social: The most important developmental social task that occurs during a child's first year is the development of attachment to the primary caretaker. After the first year, a child then begins to develop trusting and affectionate relationships with other family members and adults outside the family. At this time, a child can engage in simple play with others—this involves playing along with their peers, but not directly interacting with them. After the third year, social relationships are expanded and the child develops more interactive play skills with their peers. They begin to explore, imitate, and practice social roles, while learning the concepts of right and wrong. At this time they also begin to understand the nature of rules.

Emotional: The cornerstone for emotional development is the emergence of trust. At this age, children are heavily dependent upon adults for their care and protection. How this dependency is responded to shapes a child's ability to trust. Next comes the development of autonomy, which involves self-mastery and control over one's environment. Then children become very curious—continually trying new things, taking charge, and actively trying to manipulate their environment—while becoming self-directed in many activities. The ability to understand right and wrong leads to self-assessment and affects the development of self-esteem.

Ages 6-12:

Physical: During this stage, gross and fine motor skills, as well as perceptual motor skills, are practiced, refined, and mastered.

Intellectual: Thinking becomes more logical and rational. The child begins to develop the ability to understand other people's perspectives.

Social: Relationships outside the family increase in importance, especially the development of friendships and participation in a peer group. A child imitates, learns, and adopts gender-specific social roles. The child develops a better understanding of rules, which they rely upon to dictate proper social behavior and govern social relationships and activities.





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Emotional: During these years, a child becomes more self-confident, self-directed, and purposeful in their behaviors. They develop a better sense of themselves as an individual with likes, dislikes, and special areas of skill. Self-worth is evaluated by their ability to perform, while self-esteem is largely derived from their perceived abilities.

As seen by these stages, much of a child's growth and development occurs during the first five years of life. Skills are perfected and social roles and relationships become more predominate as they enter adolescence.

How A Child Reacts To Trauma

While traumatic events can have serious impact on a child, the child's stage of development can influence the extent and type of impact. A child's reaction to trauma will not only involve what they saw, felt, heard, etc., but also the sense of crisis from their parents' reaction. Particularly influential to a child are the absence of parents and the terror of experiences that leave their parents frightened and unable to do anything to correct the situation.

Notes to Facilitators:

- 1. Many refugee parents are not aware that their children have problems as a result of trauma. Indeed, some parents assume that their children do not have any awareness of the loss and suffering experienced by their parents. This is a normal response; in order to recognize that their children have been traumatized, parents would first have to admit that they were unable to protect their children.*
- 2. A way of breaking through this denial is to get the parents to talk about the specific behaviors they see in their children that would indicate trauma.*
- 3. It is extremely important that you support parents through this process of recognizing that their children have experienced trauma. It is most important to tell them that they are not at fault.*
- 4. Should a participant seem particularly distressed, you should arrange for individual services from a trained mental health worker.*
- 5. As you talk to the participants about trauma reactions at different ages, periodically ask if anyone sees these behaviors in their children. While it is important to recognize these behaviors as possible responses to trauma, it is also critical that you acknowledge that these are normal reactions. At the same time, if these behaviors are a concern to the parent, then you should help them to receive individual guidance and assistance.*





Birth through 2 Years:

1. High anxiety levels can be seen in crying, biting, throwing objects, thumb sucking, and agitated behavior.
2. The child may not have a strong mental memory of the trauma, but may retain a physical memory of the event.

Ages 2-6:

1. Children do not have the same levels of denial as adults, so trauma affects them more quickly.
2. They may play out the traumatic event.
3. Children may become more attached to caregivers. Behaviors may include physically holding onto adults, not wanting to sleep alone, and wanting to be held.
4. They may withdraw and not talk.
5. They may experience repeated periods of sadness.
6. They may become physically dependent. He/she may refuse to dress, wash, and feed self; forget toilet training; and wet the bed.
7. They may not sleep well at night—nightmares are common.
8. The child may become angry or scared when faced with changes in his/her daily routine.
9. Children do not understand death and may think that the person will come back. They may react to death with anger and feelings of rejection.

Ages 6-10:

1. Children will express themselves most easily through play, such as art, dance, and music.
2. They may not be able to concentrate in school because of the sense of loss and injury.
3. Significant changes in behavior may be observed. A quiet child may become active, while an active child may become quiet.
4. The child may have fantasies about the trauma in which someone saves him/her from the outcome.
5. They may lose trust in adults.
6. The child may have a lingering dependence upon adults.





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7. They may complain about frequent headaches, stomachaches, and dizziness.
8. They may become more impulsive.
9. Their behaviors may regress to those typical of younger ages.

Ages 10-12: Preadolescence:

1. The child's attitude may become more childlike.
2. They may become angry and complain of the unfairness of the trauma.
3. They may be excited and happy about survival of trauma.
4. They may increase usage of symbolism to represent events before and after the trauma as omens and reasons for survival.
5. They may deny thoughts and feelings to avoid confronting the traumatic event.
6. The child may become judgmental of his/her own behaviors.
7. They may be unable to think about their future.
8. They may lose their sense of meaning and purpose of life.
9. They may complain of more physical ailments resulting from the psychological trauma.

As a parent of a child who has experienced significant trauma in their life, it is important for participants to be aware of any of these changes in their behavior. Ask them, since coming to the United States, has your child's behavior changed? Does the child act the same as when you were in your home country? If they have noticed any changes in behavior, emphasize that it is normal as they have been through the same traumatic experience as the parents. However, if the children's behavior becomes a problem or worries them, they should be encouraged to seek help from a professional.

Activity

TIC-TAC-TOE Game:

Time: 30-40 minutes

The Child Development Assessment Questionnaire and the Developmental Milestones Questionnaire (*from the beginning of this section*) can both be used as a source of questions for this game.





The trainer can pick a few true/false statements from each of the age categories. Prizes can be given to participants once the game is completed, such as small toys appropriate for their children's age or healthy snacks for the women/children.

Procedure:

1. Divide the class into two groups.
2. Assign one group to be the "X" group.
3. Assign the other to be the "O" group.
4. On the flipchart paper, draw a large TIC-TAC-TOE board.
5. Create question cards and place one question card (face down) in each square on the image. There should be a total of nine question cards in the image.
6. One group begins by choosing a square. The facilitator turns over the card in the chosen square and reads the question to whichever group chose the square. If the group can answer the question correctly, either an "X" or "O" is then drawn in the square (depending on whether the group answering the question is the "X" or the "O" group). If they answer the question incorrectly, the card is placed face down again and they are not awarded an "X" or an "O." The other team then chooses a square and attempts to answer the question. The game ends when one group is able to answer enough questions so that there is a vertical, diagonal, or horizontal row of "X"s or "O"s.
7. Encourage groups to choose the squares strategically so that they can maximize their opportunity to win while minimizing their opponent's opportunity to win.





Section 3: Child Abuse & Neglect

Objectives

Participants will—

1. Learn about the main types of abuse and neglect.
2. Become familiar with the reporting process for abuse and neglect.
3. Gain an understanding of why abuse and neglect occur.

Materials

1. Flipchart
2. Markers

Introduction

Inform the participants that this module will address child abuse and neglect. Child abuse and neglect are very serious issues that must be addressed. What one culture sees as discipline, may be seen as child abuse or neglect in the United States. Have the participants discuss parenting traditions from their own country. Write their answers on the flipchart. Once the list is completed, discuss how their traditions compare to American traditions.

Notes to Facilitators:

1. *While the definitions of child abuse and neglect are the same throughout the United States, the laws and procedures for each state differs. To provide participants with the correct information about mandated reporting and what happens after a report is made, you must talk to your local child welfare agency. Information provided here is based on the laws and procedures in Missouri, and may not be entirely applicable in your state.*
2. *A good follow up to this section is to invite child welfare workers to a discussion with the participants. This not only allows the participants the opportunity to ask questions of the child welfare workers, but also gives the workers an opportunity to learn about the various parenting styles of different cultures, which in return allows them to be more culturally sensitive when working with refugee families.*





Outline/Lesson Plan

Child Abuse

1. *Physical Abuse*
2. *Emotional Abuse*
3. *Sexual Abuse*

Child Neglect

1. *Physical Neglect*
2. *Educational Neglect*
3. *Emotional Neglect*
4. *Medical Neglect*
5. *Environmental Neglect*

Differences Between Abuse & Neglect

- *Reporting Child Abuse and Neglect*

Why Abuse & Neglect Occur

Activity

- *Case Scenario*

Child Abuse

Ask the participants for their definition of *child abuse*.

Definition: *Any physical, emotional, or sexual injury inflicted on a child, other than accidental, made by those responsible for the care and custody of the child.*

There are three main types of child abuse:

1. *Physical Abuse:*

Ask the participants for their definition of physical abuse.

Definition: *It includes any non-accidental injury caused to a child by a caretaker. It includes beating, shaking, biting, burning, punching, or other such physical acts, which may cause injury to a child. A parent or caretaker might not intentionally hurt a child, but it can happen as a result of punishment or excessive discipline.*

Some indicators of child abuse include:

- ❖ Bruises, welts, or other marks on the face, neck, or body.





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- ❖ Marks on the body that are reflective of the article used to punish: for example, an electrical cord, belt, shoe, or hand.
- ❖ Cigarette burns
- ❖ Broken bones
- ❖ Bite marks
- ❖ Lacerations or cuts

2. *Emotional Abuse:*

Ask the participants for their definition of *emotional abuse*.

Definition: *Includes rejecting, belittling, or blaming a child; constantly treating siblings unequally, and/or a persistent lack of concern by the caretaker for the child's welfare or well-being.*

3. *Sexual Abuse:*

Ask the participants for their definition of *sexual abuse*.

Definition: *Includes any inappropriate sexual contact between a child and an adult where the intention of the adult is sexual gratification.*

Child Neglect

Ask the participants for their definition of *child neglect*, as differs from *child abuse*.

Definition: *Failure to provide the basic necessities of life by those responsible for the care and custody of the child.*

1. *Physical Neglect:*

Ask the participants for their definition of *physical neglect*.

Definition: *Includes not providing adequate food, clothing, housing, or supervision.*

Note to Facilitators:

Because supervision is a major issue with parents from a different culture, it is important to spend a little time discussing how a child, depending on their age, cannot be left alone without appropriate supervision. You should know the state laws about when children may be left home alone.





2. *Educational Neglect:*

Ask the participants for their definition of *educational neglect*.

Definition: All children under the age of 16 must attend school. It is the parents' responsibility to ensure that their child enrolls in and attends school. This type of neglect also includes failure on the parents' part to address special education needs.

3. *Emotional Neglect:*

Ask the participants for their definition of *emotional neglect*.

Definition: Includes the lack of any emotional support or love on the part of a parent or caretaker.

4. *Medical Neglect:*

Ask the participants for their definition of *medical neglect*.

Definition: Includes not providing a child with appropriate and necessary medical care when needed.

Note to Facilitators:

Parents may raise issues about lack of access to health care services. You should be prepared to let them know of services available in the community for low-income, uninsured families.

5. *Environmental Neglect:*

Ask the participants for their definition of *environmental neglect*.

Definition: Includes not providing a child with a safe and healthy environment in which to live.

A child who experiences abuse and/or neglect may suffer greatly in their development. It is also important to remember that one of the greatest roles a parent plays is that of teacher. If a parent shows their child that the best way to handle anger is to hit, or does not show a child how to love and express emotion, the child will grow up and continue to do things the way that their parents taught them.

Differences Between Abuse & Neglect

1. Abuse is the act of causing harm to a child while neglect is the failure to act in the proper way to prevent the causing of harm to a child.





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2. Abuse has an episodic manner, it happens in bursts and not always continually. Neglect, on the other hand, has a chronic manner and happens constantly.
3. Indicators of abuse will occur shortly after the act has occurred, while the indicators of neglect take longer to appear.

Reporting Child Abuse & Neglect?

When abuse or neglect is thought to be occurring, people call a hotline to report it. Most reports come from professionals, including teachers, the police, hospital workers, social service providers, and child care providers. It is important to know that these people are mandated reporters—which means that if they suspect that abuse or neglect are occurring, they must call and report it to the officials. Other sources or reports come from family members and neighbors.

What Happens When Abuse or Neglect Is Reported?

Once a report is made, an investigation into the report will be conducted. Every report made to the child abuse hotline must be investigated. A Child Protection Worker completes this investigation. For incidents of abuse, the worker will visit the child to check for marks and bruises, which may indicate whether abuse has occurred. The worker will talk with the child, parents, teachers, and other people involved who may be able to help substantiate the claim. What the worker is looking for is how the injury occurred and does it seem as though this type of injury is likely to have occurred as was told. After the investigation, the worker will decide whether the reported is indicated or not; in other words, is there enough indication that abuse or neglect has occurred. If there is not enough evidence to support the report, then the case is closed. It is important to note that a worker from the Department of Family Services (DFS) will investigate calls during normal working hours. From 5:00 p.m. to 12:00 a.m. an off-duty police officer will respond. They will carry an identification card stating they are an employee of DFS. After midnight, a regular police officer will respond. If someone comes to your home, please remember to ask for identification.

If abuse or neglect is indicated, then the worker must decide whether the child is able to remain in the home or not. This decision is based on the severity of the abuse or neglect and how safe a child will be if they remain in the home. If it is decided to remove the child, DFS must petition Family Court to remove a child. If the child is removed, the child will be placed in foster care where they will remain until the parents take the necessary steps to have their child returned to them. This may include attending parenting classes, receiving drug/alcohol treatment, anger management classes, etc. It is important to note that workers do not wish to remove children from their home; so, if the risk is moderate the family may be able to receive intensive services at home, including therapy and frequent visits from workers.





Why Abuse & Neglect Occur

Many people will tell you that there should be no reason why a parent should ever injure a child or fail to care for their child; however, it does happen and quite frequently. Some explanations as to why abuse or neglect include:

- ❖ Inability to parent, due to a lack of experience.
- ❖ Alcohol or drug abuse, domestic violence.
- ❖ Too high expectations placed on the children.
- ❖ High levels of stress: unemployment, not making enough money, single parenting, low social support.
- ❖ Parents were abused or neglected themselves.
- ❖ Poor anger management or problem-solving skills.

See if parents can identify any other explanations or stresses that may lead to abuse or neglect.

Inform the participants that, as refugees, they are faced with stress that comes not only from being forced to leave their home country, but also from having to resettle in a totally different country with a new language, new culture, and new laws. The important thing for them to remember is that there are people out there to help them. They need to recognize their stress and seek help to relieve it.

Note to Facilitators:

This section may raise a lot of concerns, emotions, and identification of individual family needs. It is very important that you not only offer support, encouragement, and hope to participants, but that you also stand ready to help families with personal needs. Follow-up to personal concerns is critical at this time.





Journey of Hope

Activity

Case Scenario

Time: 45-90 minutes

Procedure:

1. Divide participants into two groups. Instruct group one to create a case scenario involving a neglected child.
2. Ask group two to create a case scenario involving an abused child. The participants do not need to act out a situation, just imagine one.
3. After both groups have created their scenarios (15-30 minutes) ask each group in turn to present their scenarios to the class without offering any solutions. A group member can read the scenario out aloud and either the facilitator or a volunteer can write the basic information on the flip chart. Follow each presentation with a discussion built around the following questions:
 - ❖ What happens in the scenario?
 - ❖ How can we tell that the child is being neglected/abused?
 - ❖ What suggestions could we offer for addressing this problem?
4. Depending on the comfort level within the group, the facilitator can choose to take the discussion one step further and ask:
 - ❖ Have you witnessed/experienced similar situations in your lives?
 - ❖ How did you react/intervene?
 - ❖ Was this reaction/intervention successful in addressing/solving the problem?
 - ❖ Why or why not?

Note to Facilitators:

It is recommended for the trainer to prepare a few sample case scenarios as examples if participants should have difficulties coming up with their own scenarios.





Section 4: Guidance vs. Discipline

Objectives

Participants will—

1. Learn about different discipline styles, including their own.
2. Distinguish the difference between discipline and punishment.

Materials

1. Discipline Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

Explain to the participants that this module will address discipline and punishment with regard to their children's misbehavior.

Assessment

Pass out the Discipline Assessment Questionnaire to the participants. Have them answer the questions with regard to how they have and how they now discipline their children. Depending on the number of participants, this activity can be completed either as one large group or in separate smaller groups.

Notes to Facilitators:

1. *If any of your participants are preliterate, you will need to conduct this activity orally.*
2. *The answers given for these questions should be the foundation of how you present the following information to the participants. If the answers reflect a positive style, enforce this while discouraging "punishment." The information presented is a guideline, and the trainer must adapt it to the participants needs.*
3. *It is important to present the information in a manner that does not imply criticism of the participants' parenting.*





Journey of Hope

4. *When presenting the material, ask the women questions about the material. This should make them more actively involved in the discussion of discipline vs. punishment.*





Discipline Assessment Questionnaire

1. When in your home country, how did you handle your child's misbehavior?
2. Since coming to the United States, how has this changed?
3. What types of behaviors do you expect from your children? What types of behaviors do you not want your children to have?
4. What are the main types of problems that you have with your children?





Outline/Lesson Plan

Discipline vs. Punishment

1. *Discipline*
2. *Punishment*

Why Not Spank?

Activity

Discipline vs. Punishment

1. *Discipline:*

Ask the participants to define *discipline*.

Definition: *Discipline is the rules, guidelines, and standards for acceptable behavior that parents establish for their children. Discipline forms boundaries within which children learn to behave and act in an acceptable manner.*

2. *Punishment:*

Ask the participants to define *punishment*.

Definition: *Punishment is a penalty administered by a parent to a child when the child has chosen to break a rule, guideline, or standards that have been set by the parents. Punishment is not an abusive act. Appropriate types of punishment include time out, the loss of privilege, or having to replace a broken object.*

Discipline means guidance, not punishment. Discipline is a part of positive child guidance. Guidance means helping a child learn how to behave towards people and things. Punishment is how a parent responds to a child's misbehavior.

The following guidelines can be converted into a handout (*see the Activity section at the end of this section*).

Suggestions for Teaching & Guiding Children:

- ❖ Be firm, but calm. This will cause your child to cooperate more often than using harsh and angry words.
- ❖ Set a good example. This will allow your child to learn what is right and wrong by your own actions and attitudes.





- ❖ Give your child a choice. This allows them to make their own decisions as long as the choices you give them are acceptable to you. Then accept the child's decision. For example, rather than arguing over what your child will wear to school, tell your child that they can wear the red shirt or the blue shirt.
- ❖ Give notice to your child before you interrupt their activity. For example, "You have ten minutes before you need to wash your hands before dinner."
- ❖ Focus on the "Dos," not the "Don'ts." Telling a child what not to do does not prepare him/her for what to do. Instead, show them a more acceptable way to act.

	Discouraging	Encouraging
Examples:	"Do not throw the ball."	"Roll the ball on the floor."
	"Stop hitting."	"Talk to him, tell him what you want."
	"Do not touch."	"Just look."

- ❖ Give your child attention for the good and positive things they do. Do not always focus on the negative. Many children will learn that the best way they can get their parents attention is to misbehave because parents are always there when they are bad, but never say anything when they are good.
- ❖ Build feelings of confidence in your children; belittling a child destroys self-confidence. It is important for a child to develop a feeling that they are able to accomplish things, that they are a capable and worthwhile person. Examples:

Situation	Belittling	Constructive
Your daughter spills the garbage on the floor while taking it out.	"Give me that, you can't even take out the garbage without spilling it."	"That's a hard job, carry it this way and you will not spill it."
Your son cries in frustration as he does his math homework.	"I told you it would not work that way."	"I know you are frustrated. Let's do this first and then see if it works."

It takes time to learn how to take more positive steps and approaches to the discipline of children. Parents usually react to their child's misbehavior





Journey of Hope

without thinking first, which often results in parents acting out of anger. If a parent finds that they are getting angry with their child's behavior, they need to give themselves time to cool down before they decide what the appropriate discipline will be. A parent should never act out of anger, as this can lead to the harming of a child.

Why Not Spank?

Most people believe that spanking a child is not punishment or child abuse. This is an unknown area. But, once again, what would spanking a child accomplish, besides hurting the child, that a more positive approach could not accomplish while teaching the child what is more appropriate? More times than not, a parent will spank a child when they are angry. This is when the situation can become more serious and abuse can occur.

Ask the parents if they have ever had to correct a child more than once for the same behavior. Have they ever had to spank more than once to correct the misbehavior? Usually, having to say or do something more than once means that a lesson was not learned the first time. This is where the concept of discipline as a guidance tool comes into play.

Hitting a child teaches them more than just how to obey rules. Hitting also teaches children fear, poor self-esteem, revenge, and permission to hit others, especially those you love.

- ❖ **Fear:** Hitting, or even the threat of hitting, often teaches children fear. Children who fear their parents may also learn to fear other adults.
- ❖ **Poor Self-Esteem:** Self-esteem develops in the manner in which children are treated in their environment. Children who are hit, or threatened with being hit, feel as though they are not loved or valued. Nobody ever feels good after being hit.
- ❖ **Revenge:** Children who are repeatedly hit often want to seek revenge. Young children who cannot hit will find other ways to seek revenge. For example, breaking something, writing on the walls, or stealing.
- ❖ **Permission to Hit:** Parents who hit their children are teaching them that hitting is okay. This type of behavior is passed on from parents to children.

Explain to the participants that the next section will address appropriate ways to punish children for violating the rules and expectations of behavior that parents have set to guide their children's behavior.





Activity

As an alternative to simply presenting examples of discouraging/encouraging phrasing by parents (*see the Suggestions for Teaching & Guiding Children subsection earlier in this section*) offer one example and ask the participant to suggest other examples from their own experience. Then invite the group to offer feedback on the examples. In the same fashion, instead of presenting situations along with "belittling" and "constructive" ways of responding to it, draw on the participants' experience for situations and solutions in order to make the material more relevant to their needs.





Section 5: Time Out

Objectives

Participants will learn the discipline technique of "Time Out."

Materials

1. "Time Out" Handout
2. Timers
3. Flipchart
4. Markers

Introduction

Briefly explain that the topic of today's discussion is the discipline technique of "timing" a child out. "Time Out" is the interruption of a child's unacceptable behavior by removing them from the "scene of the action." By removing them, you will not only stop the behavior, but also take them away from whatever reinforcing events are encouraging or strengthening the behavior.

Outline/Lesson Plan

Time Out

- How to Do It Right

Testing & Manipulating

- Six Types of Testing

- How to Handle Testing

Activity

Time Out

Whenever a child breaks a serious rule or ignores a command to stop doing something, Time Out is a technique to teach them better behavior. Use Time Out for stopping inappropriate behavior before it becomes either physical or a serious violation of family rules. For instance, use Time Out for swearing, hitting, kicking, silliness, temper-tantrums, etc. Because the parent is attempting to teach their child a better behavior, they are disciplining them,





not punishing them. Time Out is effective because it denies a child access to people and to the environment in which they were misbehaving.

Time Out is a simple training procedure that requires little talking on the part of parents, but does require some effort in the beginning. Once a parent sees their child engaging in an inappropriate behavior, the steps involved are:

1. Calmly give a warning that is both verbal and physical. Hold up one finger and say, "That's one."
2. If they stop, fine. If they do not stop, give a second verbal and physical warning. Hold up two fingers and say, "That's two."
3. If they stop, great. If they do not stop, hold up three fingers and say, "That's three, now it is time for Time Out."

It is appropriate to have a child sit quietly for one minute for each year of their age. Time Out usually works better with children who are two-years-old and older, as they have already begun to develop a sense of what is right and wrong.

Before parents can begin to use this technique, they must carefully explain to their child what Time Out is. Many children may already know because it is used within the school system as a way of correcting misbehavior. The parent should tell the child that each time he/she breaks certain rules or refuses to stop doing certain kinds of things, he/she will be told to take a Time Out. Parents should explain to the child that this means that they will have to go to a quiet place somewhere else in the house and stay there quietly while doing nothing until they are allowed to return.

Until a child understands what "Time Out" means, parents will have to walk them through the procedure—the way they are expected to take a time out. Parents need to give explicit directions as to where to go and what to do.

How to Do It Right:

The best way to ensure that this technique works is to be consistent. It will not work magically right away, and it will take a child some time to adjust to this technique if they have never experienced it before. Reasons why this technique fails is that the parent

1. talked too much while doing it;
2. got too upset while doing it;
3. did not keep up with doing it (no consistency); and
4. was sidetracked by the child's testing and manipulation, which will be discussed further.





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An example of how to use Time Out:

Situation: Your child wants to eat a snack before dinner.

"Can I have a snack before dinner?"

"No, it is too close to dinner."

"Why not?"

"That's 1"

"I want a snack, I am hungry."

"That's 2."

"You never let me have anything I want."

"That's 3, take X amount of minutes."

What do you notice about this example? The parent gives only one explanation, and does not repeat it. After the first warning is given, the parent does not do any more talking in response to the child's complaints. The parent only gives a warning up to three. It is important to notice in this example that the parent does not get upset. All of these tactics combined show the child that the parent's authority is unquestionable. The discipline technique is short and to the point. If the child were to continue again after the Time Out then the parent would start all over again. After some time, most children will respond to usually after the count of one or two.

Explain to participants that children will rarely ever thank them for disciplining them. They also won't take disciplining easily; instead, they will do things that parents will not like and that, if not handled properly, can drive parents crazy. These are what we call testing and manipulating.

Testing & Manipulating

Testing serves a very meaningful purpose. Testing occurs when a child is frustrated. Since the child is frustrated by not getting what he/she wants, the first goal of testing is TO GET THE PARENT TO GIVE HIM/HER WHAT HE/SHE WANTS. If this does not work, they will then PUNISH THE PARENT FOR NOT GIVING THEM WHAT THEY WANT. It is important to remember that children are selfish and they want what they want when they want it. If they fail to get it, they will become angry and express this anger in some way. Just remember that this is perfectly normal, but you have to know how to handle such testing appropriately.





Six Types of Testing:

1. *Bothering:* This involves the child repeating questions such as "Why," "Why can't I," "How come," "Why not now," etc. They will continue until the parent gives in. It can also involve a series of complaints and gripes.
2. *Intimidation:* The child gets angry or has a temper tantrum. This involves yelling, slamming doors, or throwing things. In its extreme form it can include breaking things or damaging property.
3. *Threats:* This involves your child giving you consequences until you give in to their wants this minute.
4. *Torment:* This involves crying, pouting, looking sad or depressed, sitting alone, and/or not talking. This tactic is designed to induce feelings of guilt. It is quite effective with some parents.
5. *Sweetness and Light:* This is when the child suddenly becomes sweet and affectionate, giving hugs, telling the parent how much he/she loves them, etc.
6. *Physical:* This is the most drastic form of testing and usually the least frequent. It includes physical attack or running away.

With the exception of number five, they all share a common theme. The parent is frustrating the child with rules or discipline. The child, in turn, frustrates the parent through testing. If the parent gives in to such testing, they will relinquish all control to the child.

How to Handle Testing:

All six types of testing are basically handled the same way. They are either ignored or are dealt with using Time Out. It is hard to determine how long the period of testing will last, but in order for the parents to remain in control, they must not give in. Parents are the adults who set the rules; if parents give into their children's testing and manipulation by giving the children what they want, then there might as well not be any rules.

The important thing for parents to remember is to not give in. The use of the Time Out procedure must be consistent. Trying it once or twice will not be successful. Parents need to continue using it until their child realizes that this will be the technique used for certain behaviors, behaviors that will not be tolerated.

Encourage the participants to begin using this procedure with their children. Make sure that they remember to explain to their children that this is what will be happening to them when they misbehave. Give the participants the timers as a way to time their children out. Remind them to time one minute for each year of age.





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Activity

Start the class with a case study based on participant responses to the last question (i.e.: What are the main types of problems that you have with your children?) on the Discipline Assessment Questionnaire which they filled out at the beginning of the previous section. Pick one or more problems that could be addressed through the discipline technique of "Time Out." This can be a fun way of engaging the participants in the topic from the very start of the lesson.





Section 6: Behavior Management

Objectives

Participants will—

1. Learn how to manage their child's behavior in a more active manner, thus fostering appropriate behavior.
2. Discuss the importance of making rules.
3. Learn about natural and logical consequences as a means of teaching desirable behavior.

Materials

1. Family Rules Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

Begin today's section by getting feedback on whether the participants have tried using the Time Out technique taught in the previous section. Ask them about whether it has been successful or whether they have had any problems. Encourage those who have not begun to use it to try it.

Explain to the participants that this class will highlight active parenting techniques that are designed to encourage good behavior while appropriately addressing inappropriate behaviors in a manner that teaches children an acceptable alternative behavior.

Assessment

Have the participants complete the Family Rules Assessment Questionnaire. Once completed, have the participants share their answers (*see the Activity subsection*).

Note to Facilitators:

Use the participants' answers as the basis for presenting this section's information.





Family Rules Assessment Questionnaire

List four or five rules in your home that you have set for your children. List the punishment that occurs for breaking each rule.

1. Rule:

Punishment:

2. Rule:

Punishment:

3. Rule:

Punishment:

4. Rule:

Punishment:





Outline/Lesson Plan

Behavior Management

Rules

Discipline

Choices & Consequences

- *Choices*

- *Consequences*

How to Teach through Choices & Consequences

Activity

Behavior Management

One of the most important responsibilities of a parent is managing their child's behavior. Children need to learn right from wrong, which behaviors are acceptable, and which behaviors are not. Some of the ways in which a parent tries to manage their child's behaviors are not appropriate; many of these ways were discussed in the Discipline vs. Punishment section of this module. Behavior management is a general term used to describe techniques used by parents to help their child learn appropriate and desired behaviors. Such techniques include those used to reduce inappropriate behavior and establish guidelines for behaviors.

Rules

In order to successfully manage a child's behavior, parents must establish clear and consistent rules. Parents expect their child to behave in an acceptable manner; however, in order for children to behave properly, parents first need to define what is acceptable and what is not acceptable—in other words, the rules.

Besides defining what the rules are, it is equally important that these rules be applied consistently. If rules keep changing or disappearing, the result will be confusion and anger on the part of the child.

Established rules must be fair. The intent of rules is to let children know what they can and cannot do; rules are not intended to inhibit the positive growth of the child. Rules that are too strict prevent children from learning independence, autonomy, and responsibility. If children feel that the rules their parents have established are too strict, they should be allowed the opportunity to discuss their reasons.





Journey of Hope

Discipline

After the rules have been established, any violation of such rules must be dealt with in an immediate, consistent, and non-abusive manner. There are three key factors that must be taken into consideration to make discipline effective:

1. Discipline must occur immediately after the inappropriate behavior. A short time span helps children understand the relationship between the inappropriate behavior and the discipline. If too much time goes by, children may not remember what they did that was wrong.
2. Consistency in enforcing the rules will help decrease the number of times children misbehave. Consistency is the key ingredient to the overall success of helping children learn what is and is not acceptable.
3. The discipline technique used to address the misbehavior must be applied in a fair and non-abusive manner. A parent must create a home environment with clear and consistent consequences for inappropriate behavior. If such an atmosphere is created, when rules are violated the consequence to the behavior can be viewed as fair by all. Abusive behaviors teach children that they are no good rather than their behavior is unacceptable.

Choices & Consequences

Choices and consequences is a technique used by parents to help their child learn self-control, make good decisions, modify their behavior, and develop independent thinking.

Choices and consequences allow children capable of knowing right from wrong the ability to take responsibility for their own behavior. Children learn to act in a certain way based on the expected consequences of their behavior. The consequences of their behavior strongly influence whether the behavior will occur or not.

Choices:

As adults we have to make choices all day long—and so do children. The kinds of choices we make usually depend upon the outcomes or consequences that we can expect. In other words, we learn from our choices. Children also make choices to act good or bad based on the consequences they can expect from their behavior.





Consequences:

There are two types of consequences (each of which can be either pleasant or unpleasant) that result from all behaviors: natural consequences and logical consequences.

1. *Natural Consequences:* This type of consequence happens in the natural course of events. For example, a child plays with matches and burns his/her fingers, or a child who walks on hot pavement with no shoes burns his/her feet. These consequences happen naturally, no one has to plan them.
2. *Logical Consequences:* These are planned or arranged consequences, which are established by parents as a way of helping their child learn appropriate and desirable behaviors. The three most commonly used logical consequences are:
 - a. **Loss of Privileges:** This may be used when children have broken a rule, refused to obey a request, or when they have misused things. This technique involves taking away a privilege for a certain period of time; for example, not being able to play with a certain toy, watch television, or being able to go to a friend's house.
 - b. **Time Out:** This technique has already been described.
 - c. **Restitution:** This requires children to "make good" for an act they committed. For example, if a child breaks something, they must "pay for" the broken object. This could be in the form of money or they could do extra chores. This technique is very effective with middle- and high-school-aged children.

The above examples of consequences are an attempt to correct misbehavior. Consequences, however, are not always unpleasant. Rewards are also logical consequences for appropriate behavior. Examples would be when a child studies for a test and they get a good grade, or when a child is allowed to stay up later on a weekend night because they went to bed on time every night for a week.

How to Teach through Choices & Consequences

Choices and consequences is a very powerful tool for parents to use in helping their child learn desirable behaviors. This is especially true of logical consequences because parents have a lot of control over them. Once a child learns that a particular behavior will result in a particular consequence, they will learn to make a choice based on the expected consequence to that behavior.





Journey of Hope

To help children manage their behavior, expected consequences have to appear after the behavior has occurred. If not, the child will become confused and will not know what to expect. For example, if you promise a child an ice cream cone after they have cleaned their room, you need to follow through or else they will be less likely to believe you the next time you promise them anything.

If a child breaks a rule, such as swearing, and the consequence is a Time Out, the rule would have no meaning to them if the consequence were not enforced. The consequence of a behavior must occur each time the behavior does.

When choosing a consequence for a behavior, parents must remember that the consequence must be related to a specific behavior; otherwise, the logical consequence can be seen as unfair. An inappropriate consequence of breaking a toy would be not allowing the child to have dinner that evening. An appropriate consequence would be not allowing the child to play with his/her toys for two days.

Choices and consequences only work when children are capable of knowing right from wrong, can perform the desirable behavior, and have the ability to make knowledgeable choices.

Activity

Facilitators can use the Family Rules Questionnaire as a discussion tool by not only asking the participants to list rules they set for their children and the respective punishments for breaking them, but also by asking participants to share what rules/punishments work in their households and which do not.





Section 7: Behavior Management (*continued*)

Objectives

Participants will—

1. Learn the behavior management technique of "ignoring."
2. Practice using verbal and physical redirection.
3. Review the material by completing the class evaluation.

Materials

1. Behavior Management Evaluation Questionnaire
2. Flipchart
3. Markers

Introduction

Explain to the participants that they will be learning about two more behavioral management techniques to handle inappropriate behavior—ignoring and redirection. Also inform them that this is the last class in this series.

Outline/Lesson Plan

Ignoring

- *When to Ignore & When Not to Ignore*
- *Before Using Ignoring Parents Should...*

Redirection

- *Verbal Redirection*
- *Physical Redirection*
- *How to Use Verbal & Physical Redirection*

Evaluation

Ignoring

Ignoring is a form of behavior management that can be used to eliminate or reduce behaviors that parents find irritating and annoying. Ignoring allows





Journey of Hope

parents to communicate to their child their disapproval of certain behaviors by deliberately not paying attention in either words or actions to undesirable behaviors, whenever they occur. Not paying attention means absolutely no acknowledgment, in any manner, of the behavior's presence.

Ignoring is not threatening, hitting, or criticizing children because of the undesirable behavior. To criticize a behavior, parents have to be paying attention to the behavior. To some children, any kind of attention, even negative attention, is reinforcing. When a parent pays attention to an undesirable behavior, they are actually encouraging the child to continue the behavior.

When to Ignore & When Not to Ignore:

There are some behaviors that a parent should not ignore. These include:

1. *When there is a degree of potential harm to a child.* Examples include, playing with matches or inserting objects into an electrical outlet. These types of behavior could place the child at risk of harm if ignored.
2. *Damage to property.* Behaviors that could damage or destroy property should not be ignored. For example, writing on the walls with permanent markers, stepping on plants, or breaking objects are behaviors that require immediate action.
3. *Irritating behaviors for attention.* Some behaviors displayed by children are done solely for the purpose of getting attention. Most parents find these behaviors to be irritating. These include whining, temper tantrums, interrupting, and quarreling. Temper tantrums are not likely to happen if no one is watching them. Paying attention to these behaviors only tends to reinforce their continued use, so these behaviors should be ignored.

There are some irritating behaviors, however, that should not be ignored; for example, crying because a child is frightened or hurt. This type of crying will most likely stop if the child is held and reassured.

Before Using Ignoring Parents Should...

1. Decide what behavior they want to see.
2. Be sure they can tolerate the undesired behavior without eventually giving in or punishing the child.
3. Decide whether they can tolerate the behavior without having to remove the child from the area.





4. Ignore the behavior 100 percent of the time, no matter how long it lasts.

Redirection

Redirection is a technique designed especially for younger children that encourages more desirable behaviors. Redirection is used to:

1. Prevent physical injury.
2. Promote desirable behavior.
3. Reduce punishing interactions.
4. Promote learning and exploration.

Verbal Redirection:

This is a means for parents to manage their child's behavior by verbally expressing a command or request. It is a way to redirect the behavior of the child by talking to him/her. It involves a parent initially telling a child that the behavior they are engaged in is not acceptable. Some examples are: "Chairs are for sitting. No standing, please." "No standing in the bathtub. Please sit still." "Oh, what a nice toy. Please put it back on the shelf."

Inappropriate examples of redirection include: "No standing on the chair. You'll fall and break your neck." "Quit standing in the tub. Do you want to fall and hurt yourself?" "Yes I see the toy. Now just don't leave it on the floor."

As you can see from the examples, the parent is stating what they expect. The inappropriate examples do not show the child what you expect from them. Verbal redirection also includes directing the child's attention and behavior to more appropriate activities and avoiding unnecessary confrontations. This type of redirection works best for children under the age of three.

Physical Redirection:

Physical redirection is similar to verbal redirection except that it involves actual physical redirection of the child from the behavior. This technique allows parents to use a nurturing touch to redirect the child to performing more appropriate behavior. Examples include: physically redirecting a child away from an electrical socket to a safe toy to play with; escorting a child from the bathroom to the living room and engaging the child in play; or taking a dangerous object away from a child and giving them a safer one to play with.





Journey of Hope

Inappropriate examples include physically jerking a child away from an electrical socket; spanking a child for entering the bathroom unassisted; or slapping a child's hand for touching a dangerous object. These examples involve the use of a harsh or abrasive touch.

The ideal way to redirect a child's behavior is through the combined use of verbal and physical redirection. Used together, the child quickly learns that a particular behavior is unacceptable.

How To Use Verbal & Physical Redirection:

1. In a firm voice, the parent should let the child know he/she is engaging in or about to engage in an unacceptable behavior. The firm voice indicates this is not a game, and the no indicates he/she is to stop the behavior immediately.
2. Tell the child his/her behavior is unacceptable.
3. Attempt to let the child re-establish the original setting. This means that if he/she has taken something, physically and verbally redirect him to return the object to where it belongs.
4. Physically and verbally redirect the child. Engage the child in play.
5. Praise the child for cooperating.
6. If the child repeats the behavior, repeat steps 1-6.

Explain to the participants that this completes the parenting education classes for children under the age of 12. Ask them if they have any questions regarding the material covered.

Evaluation

Explain to the participants that you would appreciate their feedback on the classes. Pass out the evaluations (*see Section 13: Building Strong Relationships*) and have the participants complete them.





SERIES B: PARENTING ADOLESCENTS

Section 8: Introductions & Getting Started

Objectives

Participants will—

1. Introduce themselves to the class.
2. Discuss and become familiar with the purpose of parenting education classes
3. Complete the Parenting Adolescents Assessment Questionnaire to gain insight into the parenting styles of participants

Materials

1. Parenting Adolescents Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

Introduce yourself to the group by telling them who you are and what you do. Explain that the purpose of these classes is to not only help them become better parents, but also to help them understand the American system and become more familiar with the signs and symptoms of any behavioral/learning difficulties their children may be experiencing.

It is important to stress that they are the experts in parenting their children. These classes are simply a way to support and enhance the skills they already have, as well as to teach them new parenting techniques.

Discuss with the participants the outline of the topics that will be covered throughout these classes.

Assessment

Explain to the participants that in order to introduce them to alternative parenting techniques, it is necessary to learn about their past and present styles of parenting. Pass out the Parenting Adolescents Assessment





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Questionnaire to the participants. Depending on the number of participants, have them discuss it as one large group or in many small groups.

Notes to Facilitators:

1. *The answers given by the participants in this activity will help you understand the concerns these parents have.*
2. *An alternative to this activity can be found in Section 1 of the first series in this module. If you do not have parents in this class who attended the other class, you may want to use the other questionnaire. The answers will give you knowledge of how the participants where parented themselves, how they parented in the past, and how it has changed since coming to the United States.*





Parenting Adolescents Assessment Questionnaire

Please tell us something about yourself and your family.

1. Name:
2. Ethnicity:
3. How long have you been in the United States?
4. Your children's Names and ages:

Name: *Age:*

Name: *Age:*

Name: *Age:*

Name: *Age:*

5. Do you work? Y N If yes, what do you do?

6. List several problems with your adolescent(s) that you would like help in addressing.





Section 9: Child Development

Objectives

Participants will—

1. Become familiar with the developmental characteristics of children in the adolescent stage.
2. Learn to recognize how trauma may affect adolescents and the behaviors that might result.

Material

1. Flipchart
2. Markers

Introduction

Adolescence is often described as the "storming" age of a child. This is due to the many physical and emotional changes that children in this age group experience—changes that cause children great anxiety. This is especially true in early adolescence when external peer pressures easily affect a child's emotions and behaviors. During middle and late adolescence, children tend to establish their own identities and develop a sense of self, which may separate them from either their family or peer group. In order for parents to help their children during adolescence, it is important that they understand this crucial stage of development. This understanding will also help make their children's adolescence easier for the parents.

Outline/Lesson Plan

Developmental Stages

How Adolescents React to Trauma

- Signs of Trauma

Developmental Stages

Note to Facilitators:

Ask participants to describe adolescents' behaviors and changes in the four areas (physical, intellectual, social, and emotional). Affirm their understanding of this stage of development and build on that understanding by discussing the following information.





1. *Physical:* At this developmental stage, children experience a lot of physical changes. These changes, which occur as a result of puberty, include rapid growth, the maturation of sexual organs, and the development of secondary sex characteristics. The elevated hormone levels that trigger puberty also cause mood swings. Adolescents must become accustomed to these changes in order to adapt their behavior accordingly.
2. *Intellectual:* During early adolescence, the beginning stages of operant thinking appear. Children develop the ability, although limited, to think hypothetically and to take different perspectives into account. During middle and late adolescence, formal operational thinking becomes more developed and the majority of adolescents begin to actively use it.
3. *Social:* In early adolescence, relationships center around a peer group: behavior is guided by group values and self-esteem is based on acceptance by others. At this stage, most relationships remain same-sex and social roles are still defined by external sources. Gradually, young adolescents become interested in relationships with members of the opposite sex; however, this is done mostly in peer groups.

During middle and late adolescence, children begin to develop a more individualized and internalized value system. This comes after careful consideration and independent thought. At this stage, they select friends based on personal characteristics and mutual interests—the importance of a peer group declines and individual friendships are strengthened. Youth in this stage also experiment with social roles and explore options for a future career.

4. *Emotional:* Early adolescents identify strongly with their peer group. They depend upon their peers for emotional stability and support, as well as to help mold their emerging identity. As such, their confidence is greatly effected by the acceptance of their peers and they are quite vulnerable to emotional stress.

During middle and late adolescence, identity becomes more individualized as a sense of self emerges. This sense of self is often separate from either family or peer group. Self-esteem is influenced by their ability to live up to their own internalized standard for behavior. Self-appraisal and introspection are quite common.

How Adolescents React to Trauma

For all children, adolescence is an extremely difficult time, which can be greatly affected by the experience of a traumatic event. The following are behaviors that an adolescent might evince as a result of experiencing trauma:

- ❖ Adolescents show the same symptoms of Post Traumatic Stress Disorder (PTSD) that adults do.





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- ❖ They may feel anger, shame, and betrayal, and may act out their frustration through rebellious acts in school.
- ❖ They may opt to move into the adult world as soon as possible to get away from the sense of disaster (resulting from living in chaos and fear due to PTSD) and to establish control over their environment.
- ❖ They may be judgmental about their own behaviors and the behaviors of others.
- ❖ Their sense of survival may contribute to their sense of immortality.
- ❖ They are often suspicious and guarded in their reactions to others.
- ❖ Eating and sleeping disorders are common.
- ❖ They may lose control of their impulses and become a threat to themselves and other family members.
- ❖ Alcohol and drug abuse may become a problem as a result of the perceived meaninglessness of the world.
- ❖ They may fear that they will experience trauma again, which will add to their sense of a limited future.
- ❖ They may experience psychosomatic illness as a way a coping with the traumatic event.

Signs of Trauma:

The following list is intended to show certain behaviors which parents should use as indicators that their adolescent is experiencing a reaction to the trauma they have gone through.

- ❖ Running away
- ❖ Sexual aggression
- ❖ Sexual promiscuity
- ❖ Sleep disturbances
- ❖ Delinquency
- ❖ Anxiety or nervousness
- ❖ Rage
- ❖ Shame
- ❖ Feelings of betrayal
- ❖ Rebellion





- ❖ Loss of concentration
- ❖ Suicidal thoughts or attempts
- ❖ Depression

Parents need to remember that their adolescents experienced the same trauma they did. While an adolescent's ability to recall traumatic events is greater than that of a younger child, it may still not make that much sense to them. The only way an adolescent can react to trauma is through their behavior. Parents need to look for the signs and, if necessary, seek professional treatment to assist their adolescent in coping with the trauma they experienced.





Section 10: Parenting a Bicultural Teenager

Objective

Participants will understand how culture, both their own and American, has a significant influence on their adolescents' sense of identity.

Materials

1. The "Trees" Exercise
2. Flipchart
3. Markers

Introduction

Explain to the participants that this section involves identifying how to raise an adolescent in a bicultural society. This is an important aspect to discuss because of the significant influence peers have on adolescents. Being immersed in a completely different culture is quite frightening to an adolescent. This stage of life requires them to seek out their own individual identity, which becomes even more confusing when they are faced with retaining their own culture or assimilating into a new one. This can also be a significant strain on the child/parent relationship.

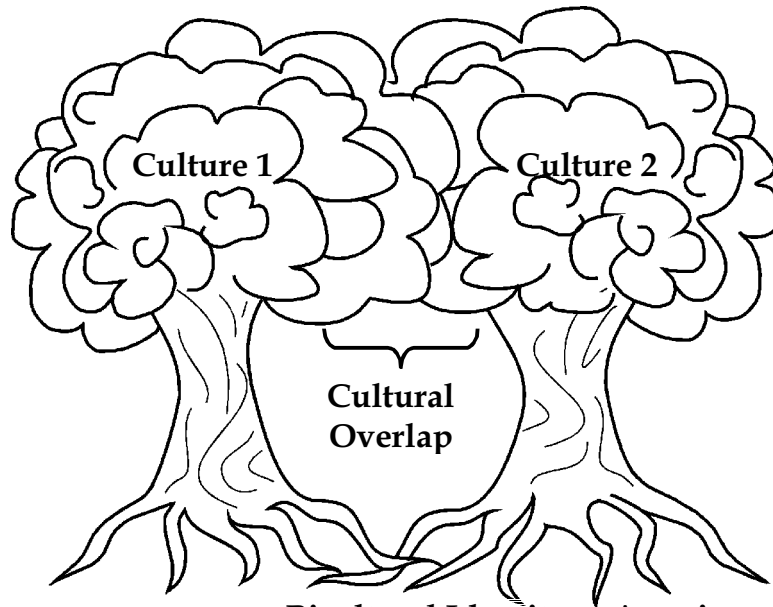
Assessment

Pass out the "Trees" exercise to each participant (*see Diagram 1 for an example*). Depending on the number of participants, this exercise can be done with one large group or with separate smaller groups. Explain to the groups that the two trees represent the two different cultures, their own and American. State that the leaves and trunk, which are fully visible, represent the behaviors displayed by both cultures. Next state that the roots, which are hidden, represent the beliefs and values which make up the different cultures.

Ask the participants to identify the behaviors of their culture, write what they state on the leaves section. Next ask them to identify the beliefs and values which make up their culture. Do the same for the other tree representing American culture.

Once the two trees are completed, talk to the participants about being bicultural. Ask them if they can see ways in which their adolescents are accepting some American behaviors and/or beliefs. Write their answers on the bottom of the sheet.





Somali

- Qu'ran & "Normal" school (8-12 years) with some university
- Extended family/kinship
- Respect for elders
- Dictatorship
- Listen to parents & teachers
- Wife must get permission from husband
- Lots of children (6+)
- Value sons more than daughters
- Man can choose divorce without wife's permission
- Woman's name follows Father-Grandfather, not husband.
- Circumcise girls & boys
- Polygamy
- Towns: long dresses, cover heads
- Privacy
- Marriage at 13-14

Bicultural Identity

- Somali:* religion, respect, sexual values, marry Muslims
- American:* education, health, small families, democracy, equality, leave out tribal conflicts, no circumcision, good professions for daughters

American

- Women & children have more freedom
- Different religions, including some Atheists
- Small families
- Children talk back to parents & teachers
- Democracy
- Elderly in nursing homes
- Children move out at 18
- Everyone very frank
- Monogamy
- Equality for men & women
- Sexual freedom

Diagram 1: The above "Trees Exercise" example is derived from a session held with refugee adolescent girls in a Parent Education Training held in Houston, Texas, 1999.





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Next, have the participants discuss the problems they are having, if any, with their adolescents adopting American adolescent behavior and/or beliefs.

Questions to facilitate discussion include:

- ❖ Do you want your child to retain their own culture, adapt to American culture, or is it okay for them to be bicultural?
- ❖ If your adolescents choose to become "American" how will you handle this?
- ❖ Is there anything you do to help your adolescent decide?
- ❖ What are the strengths to being bicultural? What are the weaknesses?
- ❖ How do your adolescents feel about being immersed in two different cultures?
- ❖ Does your adolescent ever talk about "American" kids? If so, what do they say? Is it negative or positive?
- ❖ If you want your adolescent to retain their culture how will you encourage this?





Section 11: Parenting Adolescents

Objective

Participants will identify the parenting method they use with their adolescent(s) by completing the Parenting Approach Questionnaire.

Materials

1. Parenting Approach Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

Explain to the participants that today's section involves identifying their parenting style when it comes to their adolescent. One of the problems with parenting is that while parents have the job of parenting an adolescent, they do not have the right tools. If all a parent has to use are worn out punishments (the tools) when confronted with a misbehaving teenager, effective parenting is like trying to build a big home with only a rusty saw and small hammer. The goal of the rest of this module's sections is to give parents the proper tools, or to build on already existing skills, to effectively parent their adolescents.

Assessment

Have the participants complete the Parenting Approach Assessment Questionnaire. Once completed, have them share their answers with the rest of the group.

Note to Facilitators:

When the participants share their answers, see if you can find any similarities among the conflicts experienced by the participants and their adolescents. Use their answers to facilitate a discussion about the similarities of these conflicts and how they handled them. This is a good tool to share their parenting strengths, and to show how parents deal with the same type of conflicts with adolescents. For questions regarding what mistake they made, get feedback from the other participants as to how the situation could have been better handled.





Parenting Approach Assessment Questionnaire

1. Describe the last conflict you had with your adolescent, including what happened, what you said, and what your adolescent did.

2. How did you feel during the conflict (irritated, angry, hurt)?

3. How did your adolescent respond to your discipline?

4. What was one mistake that you made?





Section 12: Handling Problems

Objectives

Participants will—

1. Learn how to develop responsibility in adolescents.
2. Address the importance of giving their adolescents freedom, within certain limits, as a method of developing responsibility while decreasing problems.
3. Differentiate between natural and logical consequences as a means of teaching adolescents responsibility for their behavior.

Materials

1. Flipchart
2. Markers

Introduction

Explain to the participants that the main theme for today's section is developing responsibility in adolescents. When responsibility is developed, parents have the ability to decrease their own stress by allowing their adolescents to be "responsible" for their own actions. A big mistake made by parents is for them to assume all of the responsibility for their adolescent's misbehavior. This can cause more anger and frustration on the side of the parent than there need be.

Outline/Lesson Plan

Responsibility

Freedom & the Limits to Freedom

Consequences

1. *Natural Consequences*
2. *Logical Consequences*





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Responsibility

Ask the participants to give you the definition of *responsibility*.

Definition: *Responsibility is the process of making choices and then accepting the consequences of those choices.*

The first step, as parents, in helping adolescents prepare for responsibility is to resist the temptation to blame and punish them for their mistakes and misbehavior. When disciplining teenagers, parents must use methods that will teach responsibility while helping them to handle everyday problems.

As adults, we have learned that our choices are usually guided by the consequences that follow. If a particular choice brought about a positive consequence, we are most likely to make that choice again. If the consequence was negative, then we know how to avoid the same negative consequence the next time. This holds true with adolescents and is a way for them to grow and learn.

Freedom & the Limits to Freedom

Before an adolescent can begin to make responsible choices, they must be given some freedom to do so; yet there needs to be limits to the freedom given to them. Many parents make decisions for their children because they believe they know what is best for their child. While it is true that a parent does know best, a choice can only be made when there is freedom to choose, otherwise a choice is no choice at all. If parents constantly dictate their children's behavior, then they will not have the opportunity to learn responsibility.

Giving freedom within limits means setting limits that are in line with the child's age and level of responsibility. Limits that are too restrictive lead to rebellion, and those that are too loose lead to selfish and destructive behavior. Be aware of what the adolescent can and cannot do when setting limits.

Consequences

Consequences occur as a result of the choices one makes (see *Section 6: Behavior Management*). There are two types of consequences, natural and logical, that can help an adolescent to be responsible for his/her own choices.





1. *Natural Consequences:*

These consequences are the natural result of what adolescents choose to or not to do. They do not require parental intervention. For example:

- ❖ The consequence of not studying for a test is getting a bad grade.
- ❖ The consequence of sleeping late on a school day is being late for school.
- ❖ The consequence of not putting your bike away is it getting rusty or stolen.

Natural consequences do not require parental discipline, which takes the responsibility off the parent's shoulders. In order for natural consequences to be effective as a teaching/learning aid, however, parents must not interfere, either in terms of a rescue or to say, "I told you so."

There are several situations in which natural consequences should not be a parent's method of discipline, they are:

- ❖ When the natural consequence poses a threat to the adolescent; for example, experimentation with drugs or alcohol.
- ❖ When the natural consequence is too far in the future for the adolescent to understand the connection; for example, not doing their schoolwork may lead to their failure to graduate or to get into college.
- ❖ When the consequence of an adolescent's behavior affects others; for example, they borrow the car and forget to put gas in it, and the parent runs out of gas. Parents have to take action as necessary.

2. *Logical Consequences:*

These are the consequences that a parent deliberately chooses to show an adolescent what logically follows when they choose an unacceptable behavior.

How to Use Logical Consequences:

- ❖ *Give the adolescent a choice.* Use such statements as "Either you may _____ or you may _____. You decide." Or phrase the choice as "When you have _____, then you may _____"
- ❖ *Involve the adolescent in a discussion to set the consequences.* By allowing them to be involved in the decision-making process, they are less likely to rebel against the consequence. They are more likely to cooperate with the parent's authority instead. An





Journey of Hope

example would be saying to the child, "I have a problem with you leaving your things all over the house. What do you think we can do to solve it?"

- ❖ *Make sure that the consequence is logically connected to the misbehavior.* For example if they are constantly on the phone, say "Either limit your phone calls to 15 minutes or give up a of night using the phone each time you go over 15 minutes." An illogical consequence would be "Either limit your phone calls to 15 minutes or you are not going out Saturday."
- ❖ *Only give choices you can live with.* If you give a consequence that you cannot accept, then you are more likely not to follow through with the consequence and no lesson will be learned.
- ❖ *Keep the tone firm and calm.* If parents use a tone that reflects anger and frustration, their adolescent has a greater chance of beginning a fight. A tone that is firm and calm lets them know that the parent has the authority.
- ❖ *Give the choice one time and then act.* For a logical consequence to teach a lesson, it must be enforced. Adolescents always choose; although they may not always respond verbally, it will be clear from their behavior that a choice has been made. Parents should not provide a second chance without putting the consequences into effect.
- ❖ *Expect testing.* When parents attempt to redirect an adolescent's misbehavior from negative choices towards positive ones, they should expect the adolescent to continue to misbehave for awhile. The adolescent will test whether the parent is really going to do what they say they will. If parents consistently follow through on consequences, the adolescent will soon see that testing does not work and change.
- ❖ *Allow the adolescent to try again after experiencing the consequences.* Once an adolescent has experienced the consequence of making a poor choice, allow them the opportunity to try again. The goal is for them to learn from the consequence.





Section 13: Building Strong Relationships

Objectives

Participants will—

1. Learn techniques to effectively communicate with their teen in an effort to build a strong, rather than antagonistic, relationship with their adolescent.
2. Learn what adolescents need in order to grow into flourishing adults.

Materials

1. Parenting Evaluation Questionnaire
2. Flipchart
3. Markers

Introduction

Inform the participants that this is the last section. In order to bring these classes to a close, this section suggests several ideas/tips to building a strong relationship with an adolescent. Rather than having an antagonistic relationship, it is better to have one that is filled with trust and love. It should be the goal of all parents to create a home environment that allows for honesty and open communication rather than one marked by misbehavior and anger and arguments.

Outline/Lesson Plan

How to Communicate with Adolescents

- What an Adolescent Needs

Activity

Evaluation

How to Communicate with Adolescents

- ❖ When talking with an adolescent, or with any child, parents should always give them their undivided attention. This shows the adolescent that their parents really do care about what they have to say. Adolescents should feel free to talk whenever they have a problem. If they feel that their parents are not interested in what they have to say, they will eventually learn not to come to their parents with problems.





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- ❖ Parents should always remain calm when discussing important issues. Try to see things from the adolescent's point of view while remembering that it is up to you as the parent to set guidelines for appropriate behavior.
- ❖ Be polite. How parents communicate with their children will determine how the children will communicate with the parents. Remember that much of what a child learns about relationships and communication is learned from their parents. Because of a parent's role in their lives, parents are the greatest teachers for what they take with them to adulthood.
- ❖ Parents should avoid being overly critical of their adolescent. Adolescents will not confide in their parents if they feel that their parents are constantly judging their behavior or find it to be lacking. This is very challenging for parents to do. They need to remain firm on such issues such as no drug use while showing flexibility with such things as clothing or hairstyles.
- ❖ Parents need to reassure their children that they can talk to them about anything. This involves using many of the steps listed above. Parents should seek help from other sources if they need assistance or find a subject uncomfortable.
- ❖ Parents should allow adolescents the opportunity to express their feelings and opinions even if they are different from those of the parents. Parents need to present their own viewpoint calmly and honestly.
- ❖ Parents need to help adolescents build self-confidence by encouraging (but not forcing) participation in activities.
- ❖ Parents should focus on all the things that their adolescents do well, reward appropriate behavior, and praise them for a job well done.
- ❖ Parents need to remember when they were adolescents; remember how they felt and use this as a guide in parenting.

What an Adolescent Needs:

- ❖ Clear limits. Determine what is acceptable and what is not acceptable. What are the consequences for their actions?
- ❖ Fair and consistent discipline. Discipline carries over to every aspect of their lives.
- ❖ Parents to be positive role models.
- ❖ Permission to fail—not necessarily acceptance of their behavior, but accepting them.
- ❖ Opportunities to laugh and to be happy.
- ❖ Opportunities to be successful whether in school or at home.
- ❖ Consistency.





- ❖ Encouragement to be responsible.
- ❖ Support and trust.
- ❖ To be loved.
- ❖ To be respected.

Activity

Role Playing:

Time: 45 minutes - 1 hour

As a wrap-up to the parenting module, refer the participants back to the Parenting Approach Questionnaire (see *Section 11: Parenting Adolescents*) in which they described a conflict between the parent and an adolescent.

In preparation for this activity, the trainer needs to review the participant responses on the questionnaire and select some situations to use in the activity. For example, if the group consists of 20 members, 10 situations need to be selected. Write one sentence describing each situation/conflict on an index card, without giving any details on how the parent/adolescent behaved. For example: "You have asked your adolescent to be home by 9 p.m. on school nights and they came home after 10 p.m. on two consecutive nights."

Procedure:

1. Divide the group in pairs in which one participant will be the parent and the other one the adolescent.
2. Hand each pair an index card describing a conflict and ask them to act it out in their pairs, assuming the role assigned to them. If you wish, you can also assign an "observer" from the group to each pair, whose task is to observe the interaction of the pair. Instruct observers to pay attention to both verbal and non-verbal (body language) communication between the parent and the adolescent. Comfort level within the group permitting, you can also ask a few pairs to role-play their conflict for the whole group.
3. Discuss the activity by role (parent/adolescent/observer.) You can use the following questions:
 - ❖ What parenting techniques did you employ?
 - ❖ When in the course of your interaction did you feel effective and when did you feel your adolescent was effective?





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For parents role-playing adolescents:

- ❖ How did it feel to be in the shoes of an adolescent? What insights did you gain from the experience?
- ❖ What felt uncomfortable?
- ❖ What would you like to do better the next time?

Then have the group offer their suggestions on how the conflict could have been handled.

This closing activity can be used as an evaluation tool by both the group and the trainer with the goal of determining to what extent the participants are employing parenting techniques discussed throughout this module.

Note to Facilitators:

Keep linguistic barriers in mind when planning this activity. In order for the interaction to succeed, you either need to have good interpreters in class or participants have to speak the same language.

Evaluation

Explain to the participants that you would appreciate their feedback on the classes. Pass out the following evaluations (the same evaluations are used in Section 7: Behavior Management [continued]) and have the participants complete them.





Parenting Evaluation Questionnaire

1. How helpful was the information on parenting techniques? *(Circle one of the following.)*

Very Helpful Somewhat Helpful Not Very Helpful Not much Not at all

2. Do you plan to use the ideas that we talked about? *(Circle one of the following.)*

Yes No

3. How did you like the activities that we did? *(Circle one of the following)*

A lot Somewhat Not much Not at all

4. What do you think about the facilitator's knowledge of the material? *(Circle one of the following.)*

Excellent Good Fair Poor

5. How do you feel about the way that the material was presented to you? *(Circle one of the following.)*

Excellent Good Fair Poor

5. How has your relationship with your children improved because of these classes? *(Circle one of the following.)*

A lot Somewhat Not much Not at all

7. How frequently have you used the skills you learned in the classes with your children? *(Circle one of the following.)*

A lot Somewhat Not much Not at all

8. Do you feel better able to parent your child in American society as a result of these classes? *(Circle one of the following.)*

A lot Somewhat Not much Not at all

9. Would you be interested in learning more about parenting in the future? *(Circle one of the following.)*

Yes No

10. Would you recommend this program to a friend? *(Circle one of the following.)*

Yes No





MODULE III: CHILD CARE

Objectives

Participants will—

1. Determine whether or not they need child care.
2. Address the advantages and disadvantages, with regards to both the needs of the parent and the child, of different types of available child care options.
3. Learn how to cope with the process of sending a child off to child care.

Overview

In developing this curriculum, we found that it appeals and applies most to women or parents with young children (infant to five years). Work-readiness is also important. Women who are work-ready, especially those currently seeking employment, are generally much more eager to attend sessions and field trips regarding child care.

- Section 1:** Questionnaire & Child Care Settings
- Section 2:** The Needs of Children & the Cost of Care
- Section 3:** Licensed Child Care
- Section 4:** Visiting Child Care
- Section 5:** Getting Ready to Go

While each section's curriculum is fairly complete, trainers must adapt the curriculum to reflect the following:

1. The cultural norms, values, beliefs, and experiences of the ethnic group(s) represented by the participants.
2. The specific needs of the participants.
3. The particular community environment.

Towards that end, it is recommended that the following steps be taken to maximize effectiveness in the use of this curriculum:

1. Only individuals who have background and experience in child care should deliver this curriculum. While every attempt has been made to design a complete and thorough curriculum, the trainer(s) should have some experience in this subject matter prior to offering the training.





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2. The first section is critical to the development of future sections in the module. The series of questions posed in these beginning sections are not designed to be just an ice breaker activity, but rather to help the trainer(s) understand the child care practices of the participants and the particular issues they may be facing. Trainers should consider this section as an opportunity for the participants to educate the trainer(s). The answers to these questions should be used to inform future sections of the curriculum. Trainers should expect to make modifications in the curriculum based on the outcomes of this first section, as well as knowledge of community issues prior to commencing the program.
3. Modifications should be made in the curriculum to reflect the specific cultural norms, values, beliefs, and experiences of trainees. While some references are made to cultural norms, values, beliefs, and experiences of parents from Somalia and Sudan, these are offered for illustrative purposes only. Even these references are, by necessity, generalizations and therefore should be used cautiously. Nuances related to the specific cultures of trainees should be incorporated where appropriate. Answers to the questions posed in Section 1 should provide some insight to such cultural norms, values, beliefs, and experiences as they relate to parenting. Community leaders and literature should also be consulted as well.
5. The curriculum is written in a style of English suitable for trainers, but which will need to be simplified for clients for whom English is not their first language. Finding simple ways to communicate some of these concepts is important to gaining participants' understanding.

While it is beyond the scope of this manual to address serving the needs of individual families, trainers should be aware that delivery of this program to groups of families could help to identify specific families who could benefit from more individualized services.





Section 1: Questionnaire & Child Care Settings

Objectives

Participants will—

1. Assess their interest in and knowledge of child care.
2. Learn about the various types of child care settings.
3. Preview some child care settings.

Materials

1. Child Care Assessment Questionnaire
2. Videos
3. Flipchart
4. Markers

Introduction

Child care is a necessary commodity in the United States, as households where both mother and father work are predominant. Mothers of young children are stepping into the working world earlier and earlier. Refugee women in their home countries are, for the most part, accustomed to being the primary caregiver in the home, but financial necessity often requires the woman to work while living in the United States. This transition may be a difficult one for the woman, but additionally for the children who are used to having constant care in their home.

There are two types of child care settings available for parents to choose from: in-home child care and licensed facility child care. Each has their own advantages, and parents may be more comfortable with having a member of the community care for her children in her home. The focus of this orientation is to make the participants knowledgeable regarding the different types of child care, and the advantages and disadvantages of each. Additionally, the needs of children at different age ranges are discussed. This is pertinent to the topic, as some participants may consider their children old enough to take care of themselves at home when they reach a given age.





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Licensed child care facilities are usually something that many refugee women have not previously encountered. Many kinds of child care facilities exist, and many offer different activities. Henceforth, a thorough assessment of several child care facilities should be made before choosing a particular one. This section will give examples of questions that a mother investigating outside facilities should pose. Also techniques for facilitating a smooth transition into child care for both mother and child are discussed.

Differences to Consider

Participants may react differently when discussing/weighing the advantages and disadvantages of different types of child care. In a previous seminar, many Somali women felt that the advantage of a caregiver from their own community outweighed education and license factors. A Sudanese woman in the group, however, was adamant that licensing was a more important advantage than a caregiver from her own community.

Such differing opinions have a direct influence on the kinds of child care settings different women are interested in visiting. In the previous example, the Sudanese participant was very eager to tour child care centers, while many of the Somalis expressed interest in in-home or family care tours.

Assessment

The following questionnaire can be completed either individually or as a group. It is designed to be an icebreaker to allow for cultural exchange and to provide general information about the participants needs and concerns regarding child care.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as your participants' needs indicate.





Child Care Assessment Questionnaire

1. Why should we learn about child care? Why are you interested in child care?

2. Do you need child care?

3. Have you tried to find child care? What was your experience? What obstacles, if any, did you encounter?

4. Have you used child care in the United States? What was your experience?

5. Did you or families you know use child care in your home country? What was that child care like?





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Outline/Lesson Plan

Child Care Settings

- *In-Home Child Care*
- *Family Child Care*
- *Center Child Care*

Activity

- *Video*

Child Care Settings

Explain to the participants that there are different types of child care settings. Ask the participants to think of some advantages and disadvantages of each type of child care and discuss them together. Suggest other pros and cons that have not been brought up by the group.

Note to Facilitators:

The following tables may be adapted into translated handouts.





In-Home Child Care:

One type of child care setting is the parent's own home. The child care provider takes care of the children in the environment of their own home.

Advantages	Disadvantages
The child does not need to travel.	The caregiver may not be licensed.
The child maintains his/her own schedule.	The child may be isolated from other children.
Children of different ages may be taken care of by the same caregiver.	The caregiver may not have knowledge of child development.
There will be coverage for school vacations and holidays.	If your child is not speaking, you may not know how the time is spent.
The caregiver may accommodate a parent's unusual work schedule.	The care may be very expensive.
When the child is sick, the caregiver may still provide care.	
The caregiver may speak the child's first language.	
It may be possible for parents to find a caregiver from their community.	





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Family Child Care:

Another type of child care setting is the caregiver's home. In this instance, the child would go to the provider's home for care.

Advantages	Disadvantages
Parents may prefer a home setting to a center.	If the caregiver is sick, they may not provide care.
The child will probably have playmates.	If a child is sick, the caregiver may not provide care.
The caregiver may provide more flexible hours.	The caregiver may change hours.
The caregiver may be licensed.	The caregiver may not be licensed.
The caregiver may be able to pick up older children after school.	The child may not get enough attention if the caregiver accepts too many children.
The care may be inexpensive.	The caregiver may not offer age-appropriate activities.
The caregiver may accept a mildly ill child.	If the caregiver does not have a yard, the children may not be able to go outside.
It may be possible for parents to find a caregiver from their community.	
The caregiver may speak the child's first language.	





Center Child Care:

A center is another type of child care setting. It is a facility that exists to provide child care and is similar to a small school.

Advantages	Disadvantages
A center is almost always regulated and inspected for minimum standards.	A center will have specific hours that may not suit everyone.
A center usually has some staff who have studied child development.	Children must conform to the center's schedule (i.e. napping, eating).
The child will be with other children.	When sick, the child would not be allowed to go to the center.
A center will provide care even when the teacher is absent.	The child-to-staff ratio may be high (i.e. too many kids for staff to handle).
Many materials and activities are available.	The center may close for holidays and vacations.
Most centers provide outdoor play.	The care may be expensive, especially for infants and toddlers
A center probably will not close without advance notice.	The staff probably will not speak the child's first language.
There would be a chain of command through which to address complaints.	
Many centers provide a record of the children's activities.	
A center will provide exposure to English.	





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Activity

Video:

Show the participants some video examples of the different types of child care settings. It is not necessary to show an entire video, as the purpose is simply to provide a visual aid so that they can better envision the different types of settings. Participants will be able to see what may go on in the different settings, and will be able to make some initial comparisons. Have the participants talk about the situations and settings they respond to during the video.

Suggested videos:

1. *The Creative Curriculum for Early Childhood*, Diane Trister Dodge, 1988.
2. *Caring and Learning: The Creative Curriculum Family Child Care*, Laura J. Colker, Diane Trister Dodge, 1991.
3. *Keys to Quality in School-Age Child Care*, Montgomery County Public Schools Television Foundation, Inc., 1993.





Section 2: The Needs of Children & the Cost of Care

Objectives

Participants will—

1. Learn about various needs of children at different ages.
2. Discuss child care costs and tuition assistance options.

Materials

1. Flipchart
2. Markers

Introduction

Explain that the purpose of this session is to talk about the different needs of children. Emphasize the importance of being aware of those needs when searching for child care, as various child care settings and care takers will address these needs in different ways and with variable success.

Explain that child care not only differs by setting, but also with the age of the child in question. While many caregivers will accept children of different ages, there is almost always a cost difference, as well as a difference in children's needs at different developmental stages.

Note to Facilitators:

Acknowledge to the participants that you know they possess a lot of knowledge about the needs of children at different ages. Try to develop this session as a discussion, not a lecture.

Differences to Consider

Often centers with a religious affiliation are able to offer tuition assistance to families; however, it is important to provide options for different religious groups. For example, if there is a mosque-affiliated (as opposed to church) or Muslim child care center in the area, consider a tour.

In the seminar example used in the previous section, the Sudanese Christian participant in the group was very interested in touring a church-affiliated child





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care facility. The Somali Muslim participants, however, were not as interested in the visit, even though the Methodist facility had Muslim caregivers and welcomed children of various religious backgrounds.

Outline/Lesson Plan

Needs of Different Age Groups

- *Infant Needs*
- *Toddler Needs*
- *Early Childhood Needs*
- *School-Age Children's Needs*

Cost

- *Tuition Assistance*
- *Free Programs*

Needs of Different Age Groups

As parents, the participants already know that children of different ages have different needs. In the world of child care, children are usually categorized as infant, toddler, early childhood, or school-aged.

Infants: children 0-12 months old.

Toddlers: children 12-36 months old.

Early childhood: children 3-4 years old.

School-aged: children 5 years old and older.

Ask participants to think of the different needs of children at these four given stages of development. Encourage them to be specific. Keep a list on a flipchart and add any needs the participants have not considered. They may consider many that are not included below.

Note to Facilitators:

The following tables may be translated and used as handouts.





Infant Needs:

Consistency	Infants need to know their caregivers will respond. The responses a caregiver gives should be consistent.	<i>Example:</i> When an infant is upset, a caregiver he/she knows should respond.
Physical Care	Infants need caregivers that handle babies' bodies with ease, and understand feeding and the importance of cleanliness.	<i>Example:</i> A caregiver should easily change diapers, wash a baby's body, and know how to serve the appropriate food.
Emotional Support	Infant caregivers should learn an infant's moods and signals. Caregivers should comfort, play with, and talk to infants.	<i>Example:</i> If an infant rubs his/her face when he/she is tired, a caregiver should learn that signal. If an infant is usually cranky in the morning, a caregiver should know this habit and provide comfort.
Mobility	Infant caregivers need to help babies use different positions throughout the day, and to encourage physical play. Time out-of-doors is also good for infants.	<i>Example:</i> An infant should not spend all day seated in a swing. The caregiver should help the baby to play lying down, sitting up, and standing or crawling as is appropriate. A caregiver should help an infant learn motions like waving and clapping. A walk outside is a good way for babies to explore their world.





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Toddler Needs:

Atmosphere	Toddlers need an atmosphere that encourages exploration while providing safety.	<i>Example:</i> A caregiver should provide plenty of opportunities for a toddler to explore, perhaps with manipulatives like blocks or creative dough. A caregiver must also set limits since toddlers are just learning about their world. For instance, a caregiver would stop a child from throwing blocks.
Mobility	Toddlers need to explore their physical capabilities. They also need quiet play time.	<i>Example:</i> A caregiver should help a toddler to crawl, walk, slide, and run. A caregiver should also help a toddler concentrate during quieter times.
Language Development	Toddlers are ready to learn a lot of language!	<i>Example:</i> A caregiver should talk and sing with a child. They should also read books and name objects for a toddler.
Emotional Support	Toddlers require patience, routines, and encouragement to try to do things themselves.	<i>Examples:</i> A caregiver needs to be patient with a toddler's desire for repetition, such as singing the same song multiple times. They should follow a daily routine that the child can grow to understand (i.e. time to eat, time to nap). A caregiver should encourage a child to try things like putting on his/her own clothes, offering assistance only as necessary.
New Skills Mastery	Toddlers can learn new skills, from working with their hands to getting along with others.	<i>Example:</i> A caregiver should provide opportunities for a toddler to color, mold, and create things. Toddlers should also learn to interact appropriately with other children.
Physical Care	Caregivers need to keep dangerous things out of the reach of toddlers. Caregivers also need to pay attention to a toddler's toilet and nursing needs.	<i>Example:</i> A caregiver should store cleaning agents out of the reach of children. They should discuss weaning and toilet training with parents.





Early Childhood Needs:

Three-, four-, and five-year-old children have many of the same needs as babies and toddlers. Caregivers still need to provide a safe environment where dangerous materials are out of reach. They also often need to assist children in using the bathroom and in keeping clean. Children continue to need consistent, caring response from caregivers.

Other needs include:

More Structured Materials	Caregivers need to provide more complex materials for children to work with. This helps children prepare for future school skills, like math and writing.	<i>Example:</i> Early childhood students should have access to items like puzzles, paper, crayons, and scissors to allow them to make and create.
Assistance with Peer Relationships	At this stage, children are learning how to make and maintain friendships. Caregivers need to help them in this process.	<i>Example:</i> A caregiver needs to help children learn to take turns and not to try to solve difficulties with friends through hitting.
Consolation and Comfort	Early childhood learners still need their caregivers to comfort them in disagreements and disappointments. Children this age are still learning about the world and are not too big to cry.	<i>Example:</i> A caregiver needs to hold and comfort a child who skins his knee, not respond that the scratch is too small to cry over.





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School-Age Children's Needs:

After-school caregivers need to provide a good end to the school day, incorporating choices for the children.

Time to Relax	An after-school program should provide a quiet space in which a tired child can relax and be quiet.
A Snack	Children need a nutritious snack to satisfy their hunger after school.
Time to Play	Children need opportunities for active play (such as a game of basketball) and quiet play (such as putting together a puzzle).
Assistance with Friendships	An after-school caregiver should help a child learn how to make and maintain friendships; encouraging children to solve their disagreements peacefully and mutually.
Help with Homework	An after-school program may provide homework help. This is a big help to refugee children whose first language is not English.





Cost

List "Infant," "Toddler," "Early Childhood," and "School-Aged" on a flip chart. Ask the participants to identify which type of care would be most expensive, least expensive, etc. Almost always, infant care is the most expensive and the cost of care drops as a child's age increases.

Infant care (0-12 months)	\$\$\$\$
Toddler care (12-36 months)	\$\$\$
Early Childhood (3-4 years)	\$\$
School-Aged Children (5 years and up)	\$

Compile a listing of local child care options that represents the full price spectrum. The following are for the southwest side of Houston, Texas.

Note: Prices are for full-time, five days-per-week care.

	Child Care Facility #1:	Child Care Facility #2:
Infant	\$110	\$126
Toddler	\$110	\$108
3 years and up	\$90	\$95

Tuition Assistance:

Inform participants that some child care facilities are able to offer a sliding scale or other tuition assistance. A sliding scale means that parents pay according to their income: parents who earn a low salary pay less than parents who earn more.

Some facilities, usually with a church or other religious affiliation, offer tuition assistance to certain families. Ask the director of a center how to apply.

Free Programs:

If a family receives Temporary Assistance for Needy Families (TANF), they should ask their human services caseworker for a child care referral (see *Module VI: Public Benefits & Community Service*). In some cases, child care will be free for a prescribed length of time.





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If a child is 3-4 years old, he/she may be enrolled in Headstart, a federal early childhood program. Families qualify for this program by income, but space is limited.

Note to Facilitators:

Have information on Headstart locations in your area and consider taking the class on a tour.





Section 3: Licensed Child Care

Objectives

Participants will—

1. Address the concept of licensed child care.
2. Identify some of the benefits of licensed child care.

Materials

1. Flipchart
2. Markers

Introduction

Explain to the participants that this session will cover licensed child care.

Ask them if anyone knows or has a good idea of what licensed child care means. After discussing their answers, explain that licensed child care means that the care facility or home is visited and inspected by a state agency—probably the Department of Protective and Regulatory Services. The agency checks to ensure that the care facility meets the state's minimum child care standards. Minimum standards are just that—minimum; any facility not able to meet these standards is not providing the minimum deemed necessary for acceptable child care.

Explain that many child care facilities meet minimum standards and then exceed them. For example, a facility may provide more staff than is deemed necessary or the staff may have more education than is required.

Outline/Lesson Plan

Minimum Standards

1. *Governing Body Responsibilities & Notifications*
2. *Administration & Communication*
3. *Personnel*
4. *Facility Operation & Physical Environment*
5. *Activities at the Facility & Child/Staff Ratios*
6. *Activities Away from the Facility & Child/Staff Ratios*





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7. *Safety, Sanitation, & Fire*
8. *Physical Health & Well-Being*
9. *Nutrition*

Benefits of Licensed Care

Minimum Standards

Note to Facilitators:

The following information is garnered from "Day-Care Center Minimum Standards and Guidelines" from the Texas Department of Protective and Regulatory Services. Please request minimum standards information from your state and revise the following as appropriate.

Inform the participants that the following information is only partially complete—there being many more specific requirements for licensed child care. This information, however, will give them a basic understanding of licensed care.

1. *Governing Body Responsibilities & Notifications:*

This provision makes the governing body of the child care facility responsible for things such as:

- ❖ Complying with minimum standards.
- ❖ Not discriminating against children for reasons of race, color, national origin, sex, or religion.
- ❖ Maintaining insurance in case of the injury of a child in care.
- ❖ Notifying the state regarding changes at the facility.
- ❖ Notifying the state of certain illnesses in children or staff, of injury to a child, and any official complaints of crime made against staff members.

2. *Administration & Communication:*

This provision makes the facility responsible for things such as:

- ❖ Posting its license, its emergency evacuation plan, and notice of any field trips.
- ❖ Posting near its phone appropriate emergency phone numbers like the police and the poison control center.
- ❖ Keeping enrollment records with information like parents' work phone numbers and designated emergency contacts.





- ❖ Keeping health and immunization records for the children in care.
- ❖ Reporting the outbreak of illnesses or other risks to parents.
- ❖ Allowing parents to visit the facility at any time.

3. *Personnel:*

This provision makes the facility responsible for having responsible and qualified staff. Some requirements include:

- ❖ Having as director a person who is at least 21-years-old with the required level and type of education.
- ❖ Providing training for new employees prior to assigning them to work with children.
- ❖ Maintaining records about staff members, including such things as any convictions and documented information about their orientation and training.
- ❖ Requiring all staff to attend certain training hours yearly.

4. *Facility Operation & Physical Environment:*

This provision regulates space, furniture, and equipment in a child care facility. Some requirements include:

- ❖ Providing enough indoor and outdoor space for the number of children in a facility.
- ❖ Providing enough play equipment for children.
- ❖ Having a working telephone number.
- ❖ Providing comfortable seating for children.
- ❖ Providing individual beds, mats, or cots to sleep on as is age-appropriate.
- ❖ Providing a specified number of toilets in the restrooms.

5. *Activities at the Facility & Child/Staff Ratios:*

This provision regulates things such as discipline, activities, and child/staff ratios. Some requirements include:

- ❖ Using positive discipline methods that nurture self-esteem, self-control, and self-direction.





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- ❖ Not using corporal punishment and not subjecting children to yelling or profane language.
- ❖ Providing age-appropriate activities.
- ❖ Providing opportunities to play out-of-doors.
- ❖ Complying with child/staff ratios. For example, one caregiver may not be responsible for more than four infants or for more than seventeen three-year-olds.
- ❖ Keeping staff members awake at all times if night care is being provided.
- ❖ Allowing small children to leave their cribs to play and explore with staff.
- ❖ Making sure feeding bottles are clearly marked with each child's name.

6. *Activities Away from Facility & Child/Staff Ratios:*

This provision governs field trips, water activities, and the transportation of children. It includes such things as:

- ❖ Informing parents of field trips.
- ❖ Carrying first-aid supplies on field trips.
- ❖ Providing constant supervision of wading and swimming pools.
- ❖ Providing a certified lifeguard if the children are swimming, not wading.
- ❖ Using age-appropriate infant/child seats or seatbelts when children are being transported.
- ❖ Loading and unloading children at the curbside.
- ❖ Not allowing children to cross a street unsupervised.

7. *Safety, Sanitation, & Fire:*

This provision makes requirements such as the following:

- ❖ Covering electrical outlets with covers.
- ❖ Providing railings for stairways.
- ❖ Barring firearms from non-residential facilities.
- ❖ Installing correctly heavy equipment to prevent tipping.





- ❖ Providing toys for children two-years and younger that cannot be swallowed.
- ❖ Providing a guide to first-aid that is easily accessible to staff.
- ❖ Controlling the temperature of water available to children.
- ❖ Having an annual sanitation inspection performed by a local or state official.
- ❖ Providing proper light and ventilation.
- ❖ Washing linens before use and after soiling.
- ❖ Managing garbage inside and outside the facility.
- ❖ Keeping the facility insect- and rodent-free.
- ❖ Washing of staffs' hands with soap and hot water.
- ❖ Sanitizing of children's beds and small children's toys.
- ❖ Washing and sanitizing food service equipment.
- ❖ Having an annual fire inspection performed by a local or state fire marshal.
- ❖ Moving children to a designated, supervised safe area in the case of emergency.
- ❖ Evacuating all staff and children in three minutes in case of an emergency.
- ❖ Equipping the facility with smoke detectors.

8. *Physical Health & Well-Being:*

This provision governs illness, injury, medication, animals, and smoking.

- ❖ Attending appropriately to sick children until a parent arrives for pick-up.
- ❖ Not admitting sick children for care.
- ❖ Calling a child's physician in the case of serious illness.
- ❖ Providing first-aid and Cardiopulmonary Resuscitation (CPR) as necessary.
- ❖ Keeping records documenting medications given to children.
- ❖ Accepting medications from parents only in their original bottles.





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- ❖ Ensuring that any animals at the facility are properly vaccinated.
- ❖ Advising parents of any animals at the facility.
- ❖ Keeping stray animals away from the facility and the children.
- ❖ Refraining from smoking at the facility.

9. Nutrition:

This provision governs nutrition. Some requirements include:

- ❖ Serving nutritious food to children according to state food guidelines.
- ❖ Serving regular meals and morning and afternoon snacks.
- ❖ Not forcing children to eat.
- ❖ Discussing a child's eating problems with the parents.

Benefits of Licensed Care

Ask the participants to consider what they have learned and to think of some of the benefits of using a licensed child care facility. Keep a list of their responses on a flip chart.

The following is a list of benefits if the discussion needs help:

- ❖ Complaints can be made to the state licensing agency, which will be listed on the posted license.
- ❖ The child care facility knows how to respond in an emergency.
- ❖ The director and staff have some education and/or training regarding working with children.
- ❖ The staff may not use corporal punishment.
- ❖ There is enough play equipment for children.
- ❖ The staff will not be responsible for more children than is manageable.
- ❖ Parents are informed of field trips.
- ❖ Wading and swimming pools are supervised at all times.
- ❖ The facility has been inspected for fire safety and sanitation.
- ❖ The staff can provide first aid.





- ❖ Sick children will not be admitted for care.
- ❖ Meals and snacks will be provided according to nutrition guidelines.





Section 4: Visiting Child Care

Objectives

Participants will—

1. Develop a list of questions to ask staff on visits to child care centers and homes.
2. Compile a list of questions to ask themselves regarding sites they have visited.

Materials

1. Lists of Suggested Questions
2. Flipchart
3. Markers

Introduction

Inform the participants that this session is to prepare for visits to child care facilities. The more information parents have about a facility and/or caregiver, the better the choice they will make; therefore, it is important to emphasize that parents should not only observe during the visits, but should also ask questions. Asking questions up front is a good way to avoid concerns and problems. By gaining a lot of information now, there will not be so many surprises or letdowns when their children start care.

Outline/Lesson Plan

Activity

- *Questions to Ask the Caregivers/Director*
- *Questions to Ask about the Food*
- *Questions to Ask about Play*
- *Questions to Ask about Rest*
- *Questions to Ask about Cleanliness*
- *Questions to Ask about Cost*
- *Questions to Ask about Hours*
- *Questions to Ask about the License*





- *Questions to Ask about Illness & Injury*
- *Questions to Ask Yourself*

Activity

Help the participants develop questions under the following headings. Keep a list on a flip chart. Let the women start with their ideas and fill in as needed.

The following questions can also be developed as a handout for the participants to use during child care visits.





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Questions to Ask the Caregivers/Director

1. What do you do with the children on a typical day?

2. What do you do when an infant is crying?

3. What do you do when a child is upset?

4. How do you discipline children?

5. What would you do in a medical emergency?

6. How long have you worked in child care?

7. How long have you worked at this facility or as an in-home provider?

8. What is your education and training?

9. How do you feel about talking with parents?





10. What do you like about children?

11. How many infants does one caregiver handle? How many toddlers? How many 3-5 year olds? How many school-aged kids?

12. Do you read books to the children?

13. Do you sing to and with the children?

14. How do you feel about a child whose home language is not English?





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Questions to Ask about the Food

1. When do the infants and/or children eat?
2. How many times do they eat?
3. What do they eat?
4. Is the food prepared here or do I bring it from home?
5. What do you do if a child does not want to eat?





Questions to Ask about Play

1. What kinds of toys do you provide?
2. What do babies play with here?
3. What do toddlers play with here?
4. What do early childhood learners play with here?
5. What do school-aged children play with here?
6. Do all the children go outside during the day?
7. Is there a yard for play?
8. Are there strollers to walk infants and toddlers?





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Questions to Ask about Rest

1. When do the children sleep?
2. How long do they sleep?
3. Where do they sleep?
4. Do I need to bring a mat from home?
5. What do you do if a child has trouble napping?





Questions to Ask about Cleanliness

1. How often are the floors cleaned?
2. How often are the restrooms cleaned?
3. When do the children wash their hands?
4. Do I need to bring diaper wipes for my infant?





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Questions to Ask about Cost

1. How much does one week of care cost for infants?
2. How much does one week of care cost for toddlers?
3. How much does one week of care for early childhood children cost?
4. How much does one week of after-school care cost?
5. Are there any extra costs? For example, if the class goes on a field trip.
6. Is there a sliding scale for tuition?
7. Is there tuition assistance available? How can a family apply?





Questions to Ask about Hours

1. When can I drop my child off?
2. When must I pick up my child?
3. What will happen if I am late?
4. What days is care not available?





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Questions to Ask about the License

1. Are you, or is the facility, licensed by the state?
2. May I see the license?
3. When was your last inspection?
4. Can I visit at any time?





Questions to Ask about Illness & Injury

1. Can my child come if he/she is sick?
2. What happens if my child becomes sick at the center?
3. Will you be able to give my child his/her medications?
4. What will happen if my child is injured at child care?
5. Does the home or center have insurance?





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Questions to Ask Yourself

1. Does the child care facility feel welcoming?
2. Is the facility clean and bright?
3. Are the children helped to stay clean and/or diapered?
4. Do the children seem relaxed and happy?
5. Are the caregivers pleasant? Do they smile?
6. Do you hear the noise of happy children?
7. Can you imagine your child being happy here?





Section 5: Getting Ready to Go

Objectives

Participants will—

1. Assess and discuss how they feel as they get ready to use child care.
2. Learn methods that may ease the transition for them and their children.

Materials

1. Child Care Preparation Questionnaire
2. Child Care Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Once a decision has been made regarding a child care provider, the child and family need to start getting prepared for the change in routine. While some children are very excited by the possibility of spending time away from home with other people and activities, others may have some fears about the new situation. Being adequately prepared for the new routine will help both the parents and child make better adjustments.

Assessment

Have the participants complete the Child Care Preparation Questionnaire (can be done individually, in small groups, or as one large group). Once completed, have them share their answers with the rest of the group.





Child Care Preparation Questionnaire

1. How do you think you will feel about your child's first day at child care?

2. How do you think your child will feel about his/her first day at child care?

3. What might you be excited about? What might your child be excited about?

4. What might you feel uneasy about? What might your child feel uneasy about?





Outline/Lesson Plan

Getting Ready

Field Trips

Speakers

Evaluation

Getting Ready

Note to Facilitators:

The following list may be translated and used as a handout for participants to keep.

The following are ideas for the participants to consider as they and their children prepare for child care.

- ❖ Try not to make other major changes in your child's life. For example, don't start toilet training at this time. Going to child care will be a big change for your child. Let him/her feel settled and happy at child care before asking them to take on another challenge.
- ❖ If your child is old enough to understand, even partially, explain ahead of time that there will be a change in your family's routine because you will be going to work and he/she will be attending child care.
- ❖ Keep a positive attitude about child care! Your child will be guided, in large part, by the way you respond to the new situation. If you are sad, your child may feel sad, too. If you are excited, your child may feel some excitement as well. For example, don't say, "I'm sorry I have to go back to work and you to Betty's house for child care." Say instead, "All of the kids at Betty's have a lot of fun. She has a sandbox in her back yard to play in. And I like Betty very much!"
- ❖ If your child is an older toddler or of early childhood age, you may want to visit the child care place before your child officially starts. Let your child see what goes on at child care. Don't stand back! Talk with the other children or help the teacher pass out the snack. If you seem genuinely excited, your child will notice.
- ❖ Celebrate the transition to child care in a special way. Perhaps you can bake a special cake the night before your child's first day. Let your child and your family know it is to celebrate the first day of child care!
- ❖ Pack a favorite toy of your child's for his/her first day. Your child will probably be happy to have something familiar with them in a new place.
- ❖ Plan to stay a little while at child care on the first day. Don't spend the time only with your own child, but help the caregivers and be involved





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with other children. When your child appears settled in, tell him/her that you are going and that you will be back at pick-up time. Leave without making a fuss.

- ❖ If it is possible, come for pick-up a little early on the first day. Encourage your child to play longer and ask the caretaker how the first day went.
- ❖ Ask your child casual questions about child care, like, "What did you eat for lunch today? Did you play in the beautiful playhouse? Did you read a special book?" Also tell your child a little about your day at work. Avoid asking your child questions like, "Did you like child care? Did you miss me while I was at work?"
- ❖ Most children take between two to three weeks to settle into child care. Each child, however, is different. A very outgoing child may be excited about the new situation and adjust more quickly than you expect, while another child may have a harder time.
- ❖ Infants and small children sometimes need to be held by or kept near the provider constantly for the first few days.
- ❖ For older children having difficulties adjusting, find out from the provider which children he/she enjoys playing with. Try to meet the parents of your child's playmates. Invite a playmate to your home for a few hours on a weekend. Your child will feel more comfortable at child care as he/she gets to know others.

Field Trips

1. Young Men's Christian Association/Young Women's Christian Association (YMCA/YWCA) child care and after-school care facilities.
2. Private child care centers such as Kindercare.
3. Religious-affiliated child care centers.
4. Family child care provided by a caregiver outside the participants' community.
5. Family child care provided by a caregiver within the participants' community.
6. An after-school program at an elementary school.

Speakers

1. An employee of the school district's early childhood division.
2. A nanny or in-home caregiver.
3. A refugee woman who is currently using a child care provider.





Evaluation

Explain to the participants that you would appreciate their feedback on the classes. Pass out the following evaluations and have the participants complete them.





Child Care Evaluation Questionnaire

1. How helpful to you was the information about child care?
Very helpful Somewhat helpful Not very helpful Not at all helpful
2. Will what you learned help you find and choose child care?
Yes No
3. How did you like the activities that we did?
Very much Somewhat Not much Not at all
4. Did you like the field trips that we took?
Excellent Good Fair Poor
5. Were the field trips helpful to you?
Yes No
6. What do you think about the facilitator's knowledge of the material?
Excellent Good Fair Poor
7. How do you feel about the way the material was presented to you?
Excellent Good Fair Poor
8. Would you be interested in learning more about child care?
Yes No
9. Would you recommend this program to a friend?
Yes No





MODULE IV: HEALTH & WELLNESS

Disclosure: Most of the information presented in this section is based on publications from the Institute of Medicine (IOM), the U.S. Preventive Task Force (USPTF), the Department of Navy Virtual Medicine website, the National Heart Lung and Blood Institute (NHLBI) website, and information from the American Cancer Society (ACS), the American College of OB/GYN, and the American College of Preventive Medicine (ACPM). The information has been adapted to aid refugee populations as they adjust to a new life in the United States. When recommendations from the different associations conflicted, all the views were presented in order to allow each individual to make up his/her own mind about the issue. (Akintoye Adelakun, MD. March 24, 1999).

Overview

This module consists of a number of sections covering a variety of health and wellness topics/issues.

- Section 1:** Nutrition
- Section 2:** Preventative Healthcare
- Section 3:** Substance Abuse (*Cigarettes, Alcohol & Drugs*)
- Section 4:** Counseling to Promote Physical Activity
- Section 5:** Counseling to Prevent Low Back Pain
- Section 6:** Hypertension (*High Blood Pressure*)
- Section 7:** Diabetes
- Section 8:** Gynecological Care
- Section 9:** Medications

While each section's curriculum is fairly complete, trainers must adapt the curriculum to reflect the following:

1. The cultural norms, values, beliefs, and experiences of the ethnic group(s) represented by the participants.
2. The specific needs of the participants and their families.
3. The particular community environment.

Towards that end, it is recommended that the following steps be taken to maximize effectiveness in the use of this curriculum:

1. Only individuals who have background and experience in health should deliver this curriculum. While every attempt has been made to design a complete and thorough curriculum, the trainer(s) should have some experience in this subject matter prior to offering the training.





Journey of Hope

2. The assessment at the beginning of each section is critical to the further development of the section. The series of questions posed are not designed to be just an ice breaker activity, but rather to help the trainer(s) understand the health problems and practices of the participants and the particular issues they may be facing. Trainers should consider this section as an opportunity for the participants to educate the trainer(s). Trainers should expect to make modifications in the curriculum based on the outcomes of this first section, as well as knowledge of community issues, prior to commencing the program.
3. Modifications should be made in the curriculum to reflect the specific cultural norms, values, beliefs, and experiences of trainees. While there are some references made to cultural norms, values, beliefs, and experiences of individuals from different countries, these are offered for illustrative purposes only; these references are, by necessity, generalizations and therefore should be used cautiously. Nuances related to the specific cultures of participants should be incorporated where appropriate. Answers to the assessment questions should provide some insight to such cultural norms, values, beliefs, and experiences as they relate to health. Community leaders and literature should also be consulted as well.
4. The curriculum is written in a style of English suitable for trainers (specifically those with health experience), but which will need to be simplified for clients for whom English is not their first language. Finding simple ways to communicate some of these concepts is important to gaining participants' understanding.

While it is beyond the scope of this manual to address serving the needs of individual families, trainers should be aware that delivery of this program to groups of families could help to identify specific families who could benefit from more individualized services.





Section 1: Nutrition

Objectives

Participants will—

1. Discuss the importance of nutritional need counseling and healthcare prior to conception.
2. Learn how to improve their family's overall nutritional status, before conception, during conception, and after conception, by introducing healthful dietary practices.
3. Learn about behavioral changes before conception that will contribute to a successful pregnancy.

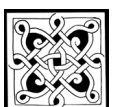
Materials

1. Cultural Nutrition Assessment Questionnaires (for adults, children, and the elderly)
2. Cultural Nutrition Evaluation Questionnaire
3. Pictures of foods from all food groups
4. Large sheets of unlined paper
5. Flipchart
6. Scotch tape
7. Markers

Introduction

Nutrition plays a major role in promoting maternal and infant health. The goal of this section is to help women's health trainers to understand the rationale for nutrition services and to incorporate appropriate nutrition education into their class sessions. This manual promotes an individualized approach to nutrition services for refugee women's health.

Refugees have complicated nutrition requirements because of their previous socioeconomic circumstances. Many refugees have had to do with just getting enough to eat, rather than getting a balanced diet. Depending on their country of origin, and their prior circumstances (War vs. Politics), the nutritional picture can be very diverse. For example, infant nutrition within former Soviet Union countries has been compromised because mothers have not been encouraged to breastfeed and imported formulas are in short





Journey of Hope

supply; as a result, iron deficiency anemia is rampant (>25 percent) and goiters are common. Among Somali refugees, there are iron and vitamin deficiencies (such as scurvy); meanwhile, Ethiopians have significant protein malnutrition. The nutritional picture can be further complicated by parasitic infections that make correction of the refugee's nutritional deficiencies more difficult. Among Cubans, poor economic conditions have resulted in micronutrient deficiencies, which in turn have been responsible for epidemics of vision problems (optic neuropathy), hearing deficits, and problems of the nervous system (neuropathies).

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

1. Participants who are single or without children.
2. Participants with religious dietary restrictions.
3. The physical state/life stage of the woman, i.e. adolescence, pregnancy, old age, or breastfeeding.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about nutrition and to be an introduction to cultural biases regarding nutrition.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.

Note to Facilitators:

Remember that children with special nutritional needs are to be referred; therefore, only appropriate nutrition behavior and strict compliance with physician's recommendations need to be stressed.

Special children's conditions include diabetes, cystic fibrosis, phenylketonuria (PKU), oral facial abnormalities, Down's syndrome, or children with gastrointestinal diseases requiring specialized feedings and formula.





Journey of Hope

9. What do you know about diabetes, beriberi, and anemia?

10. What are your worries or concerns about food in United States?

11. Are you on a special diet at home based on cultural or religious reasons?

12. Do you have any food-related allergies and/or medical problems?

13. Do you know where (stores) to find the kinds of foods that you like to eat?

14. What kind of support do you need in feeding yourself and your children?

15. What is your cultural attitude about breastfeeding?

16. Are you familiar with the kinds of food that are good for your children?

17. What kinds of dietary traditions would you like to continue in the United States?

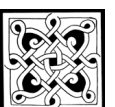




18. How do you prepare your food at home?

19. Do you let your plates air-dry after washing?

20. Who eats first in your family and why?





10. When was the last time your child saw a physician?

11. Are all his/her immunization shots up to date?

12. Do you feed your child specialized formulas?

13. Do you know how to make homemade children's food? If not, would you like to know?





Journey of Hope

Cultural Nutrition Assessment for the Elderly

1. How are your elderly dependents eating?

2. Does he/she need a special diet?

3. Do you have concerns about the way they are eating?

4. Do they have any other medical problems, such as dental problems, etc.?

5. Do they have any food-related allergies and/or medical problems?





Outline/Lesson Plan

General Nutritional Recommendations

Women's Nutritional Needs

- *Special Considerations for Pregnant Women*

Infants & Children

Food Safety

Fast Facts

Intervention Strategies

Activities

- *The Food Pyramid Game*
- *TIC-TAC-TOE*
- *Creating Nutrition Plans*
- *"How-To" Seminars*

Field Trips

Speakers

Evaluation

General Nutritional Recommendations

1. Adults and children over age two should limit their total fat intake to <30 percent of total calories and dietary cholesterol <300 mg/day. Saturated fat consumption should be reduced to less than 10 percent of total calories. To achieve these goals, patients should be encouraged to eat fish, poultry prepared without skin, lean meats, and low-fat dairy products. They should be encouraged to eat a variety of foods, especially whole grain products and cereals, legumes (beans, peas), vegetables, and fruits.
2. The U.S. Department of Health and Human Services (DHHS) currently recommends at least five servings of fruits and vegetables and at least six servings of breads, cereals, or legumes each day.
3. Increase dietary intake of iron, beta-carotene, or other antioxidants.
4. People with high blood pressure (hypertension) should reduce their sodium intake.
5. Emphasize that intake of refined sugars and sticky starches may affect dental health.
6. Explain that diseases associated with dietary excess and imbalance rank among the leading causes of illness and death in the United States.





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Women's Nutritional Needs

1. Women should consume the recommended quantities of calcium for their condition (pregnant, nursing) or age: adolescents and young adults (1,200-1,500 mg/day); adults aged 25-50 (1,000 mg/day); postmenopausal women (1,000-1,500 mg/day); and pregnant and nursing women (1,200-1,500 mg/day).
2. Provide pregnant women with specific nutritional guidelines to enhance fetal and maternal health.
3. Explain the role of iron during pregnancy and in the diets of newborns and young children.
4. Explain the use of folic acid by women of childbearing age to prevent neural defects.

Special Considerations for Pregnant Women:

The following table lists conditions that put a woman at higher nutritional risk. These women need more specialized attention, and require one-to-one counseling sessions and interventions. Subsequently, it may be necessary to separate these women from the rest of the group so as not to confuse the situation.

Note to Facilitators:

The following table can be converted into a handout if necessary.

Special Condition	Medical Problem	Counseling Needed/Intervention
Diabetes (Mother has Type 1 or Type 2)	Is caused by too much sugar in the blood, either because the pancreas is not producing adequate amount of insulin, or the insulin that the body produces is not doing the job of controlling sugar. Diabetes, if not controlled properly, can lead to blindness, amputations, pregnancy problems, and organ failures.	<ul style="list-style-type: none"> ❖ Complications are preventable. ❖ Regular exercise, adherence to medications, diet, and good vigilance should be emphasized. ❖ Pregnant women need special care from a physician.
Gestational diabetes	Diabetes that occurs only during pregnancy. It usually goes away after the baby is born.	<ul style="list-style-type: none"> ❖ Observe a specialized diet during pregnancy.





Special Condition	Medical Problem	Counseling Needed/Intervention
Phenylketonuria (PKU)	Inherited condition consisting of an inability to metabolize the amino acid (phenylalanine). A person with this problem may develop mental retardation either from eating foods high in phenylalanine as a young adult or if their mother ate foods high in phenylalanine while pregnant.	❖ Mother (and children until they reach adolescence) should observe a phenylalanine-restricted (avoiding meat, dairy, and other foods high in protein) diet before and during pregnancy.
Obesity	Has been associated with many pregnancy complications.	❖ Special care when pregnant. ❖ Counsel to reduce weight, then stabilize before getting pregnant.
Hypertension (either before or during pregnancy)	Can cause pregnancy complications requiring a special diet. Can cause organ damage, including brain stroke and seizures/convulsions.	❖ Reinforce physician's warnings, and assist person to understand their disease, follow their programs, and take their medications.
History of caesarian or operative birth	Increased risk for many problems, including another caesarian section. Adhesions from previous surgery can cause abdominal problems and affect eating habits.	❖ Refer to a nutritionist and a doctor.
Pregnant, but not gaining weight	The baby may not be growing properly, or the mother is not eating well, or both.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
History of premature birth	Possibly low nutrient intake, but could have many other causes.	❖ Provide guidance, support, counsel, and emphasize physician warnings and recommendations. ❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
Renal (kidney) disease	Can be caused by other diseases. Can lead to organ damage and need for transplant.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
History of hemorrhage (bleeding) after birth	Has many causes.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.



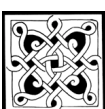


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Special Condition	Medical Problem	Counseling Needed/Intervention
Multiple pregnancy	Mother's resources are shared by more than one baby; therefore, there are problems relating to how to sustain the pregnancy. There is increased risk of low birth weight.	❖ May need a vitamin supplement along with balanced daily diet.
History of poor pregnancy outcomes	Has many causes.	❖ Discuss possible causes and address any identified nutrition problems. Refer to a physician.
<i>Use of Drugs/Medications</i>		
Cigarettes & other tobacco Products	Cigarette smoking causes many problems, from hypertension to organ failure.	❖ Encourage them to stop smoking completely.
Alcohol	Can cause fetal-alcohol syndrome (FAS) in babies.	❖ Refer to Alcoholics Anonymous, and encourage CAGE screening.
Retinol (is sold in some pharmacies as a supplement)	Is often prescribed for skin diseases. Too much of it during pregnancy can cause problems for the baby.	❖ Avoid retinoin products during pregnancy.
Isoretinoin	It is a vitamin A analogue; as such, it is toxic in high amounts.	❖ Avoid during pregnancy.
Dihydrophenylhyd antoin (Dilantin) for seizures	Interferes with folic acid metabolic pathway.	❖ People who have to take this drug need special care during pregnancy.

Infants & Children

1. Infants require breast milk or appropriate alternatives (e.g., infant formulas) to provide adequate nutrition. Parents should be encouraged to breastfeed.
2. Current studies suggest that infant consumption of breast milk for at least 6 months may reduce the child's risk of ear infection, lower respiratory tract illness, meningitis, allergies, diarrhea, and abnormal mental development.
3. Infants may also benefit from iron-fortified formula and foods to replace depleted iron stores, as iron deficiency anemia during infancy may be associated with impaired mental and nervous system development.





4. Proper nutrition throughout childhood is important to facilitate normal growth and development.

Food Safety

The following are methods to prevent food poisoning.

1. Keep food in refrigerator at 40°F or 4°C.
2. Refrigerate all cooked food within two hours of being cooked.
3. Sanitize kitchen dishcloths with one tablespoon of bleach in one quart of water.
4. Wash hands carefully after handling raw meat.
5. Wash meat boards periodically with bleach.
6. Date all leftovers, and eat within two days.
7. Cook ground beef, meat products, and poultry until they are no longer red in the middle (160°F or 72°C).
8. Do not eat raw or lightly cooked eggs.
9. Defrost meat, poultry, and fish products in refrigerator, microwave, or cold water (this must be changed every 30 minutes).
- 10 Allow dishes and utensils to air dry to prevent recontamination, and wash dishes within two hours of use.

Fast Facts

1. Because foods high in complex carbohydrates and fiber and low in fat content are also lower in calories, they are ideal for helping maintain a healthy body weight.
2. The replacement of foods high in simple carbohydrates (e.g., table sugar, honey, corn sweeteners) with those containing starch and fiber improves caloric balance and may lower the risk of developing cavities.
3. Increased intake of dietary fiber improves bowel function.
4. The consumption of foods containing large amounts of soluble fiber (e.g., dried beans, oat products) appears to lower levels of LDL cholesterol (whether or not they have replaced foods high in saturated fat and cholesterol).
5. Observational studies suggest an association between eating vegetables and fruits and a lower risk of cancer.



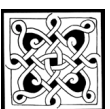


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6. Cross-cultural studies have shown a correlation between the sodium intake of different populations and the incidence of hypertension (high blood pressure).
7. The following are the recommended amounts of dietary calcium for individuals: men (1,000 mg/day); adolescents and young adults (1,200-1,500 mg/day); women 25-50 years old (1,000 mg/day); postmenopausal women (1,000-1,500 mg/day); pregnant and nursing women (1,200-1,500 mg/day).
8. Adequate dietary iron intake is important for menstruating and pregnant women and for young children to maintain iron stores and prevent iron deficiency anemia.
9. Women of childbearing age who take folic acid supplements may be less likely to give birth to children with neural tube defects.
10. While women who give birth prematurely have breast milk high in protein, the protein is still not enough to sustain the baby (thus the baby would need protein supplements).
11. Nutritional status is especially important during pregnancy.
12. Studies have shown that low birth weight and neonatal (newborn to one month) mortality are more common in pregnant women with very poor nutritional status and in those who fail to gain adequate weight during pregnancy.
13. Pregnancy brings increased requirements for energy and specific nutrients, such as protein, calcium, folic acid, and iron.
14. The elderly can also have special nutritional requirements. Depending on the patient's nutritional status, underlying medical disorders, functional status, teeth, and therapeutic drug regimens, it is be important to modify recommended daily intake levels of calories, sodium, calcium, water, dietary fat, fiber, protein, and other nutrients to reduce the risk of complications.

Intervention Strategies

1. Develop strategies for increasing participants' healthy nutrition behavior and knowledge about nutrition.
2. Develop lesson plans on different foods and different categories of foods.
3. Continuously monitor participants' progress and adjust the lesson plan.
4. Become familiar with the community where the participants reside and facilitate their use of the community's resources.





5. Educate participants about the benefits of breastfeeding unless there is a potential problem, e.g. the mother is on medications or the baby has a medical condition.
6. Identify barriers to breastfeeding.
7. Encourage the use of a food diary and monthly health diary (weight, height, and baby's weight, height, and growth pattern).
8. Develop a more intensive intervention program, consisting of the following, for participants in need:
 - ❖ Home visits.
 - ❖ Periodic telephone calls.
 - ❖ Permission to talk to patient's physician regarding your concerns, and interventions thus far.
9. Incorporate new knowledge and be culturally sensitive.

Activities

Depending on the needs of the participants and available resources, one or more of the following activities can be used for this section.

The Food Pyramid Game:

Time: 20 minutes

Objective:

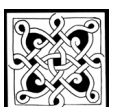
Given a set of pictures representing different food groups, participants will be able to create a food pyramid.

Procedure:

1. Divide participants into groups of not more than four members.
2. Give each group a pile of pictures of foods and ask them to create a food pyramid.
3. Invite each group in turn to present their pyramid to the class, explaining why they decided to place the pictures as they did.

Note to Facilitators:

In the absence of pictures, the trainer can ask participants to draw different foods in the pyramid. Also, the activity can be conducted as a competition—the fastest group gets a prize (a healthy snack) and other groups get consolation prizes or they are





Journey of Hope

asked to prepare a healthy meal for the class. Another possible variation is to have the class choose a panel of "judges" who will pick the "best" food pyramid and award a prize.

TIC-TAC-TOE:

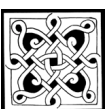
The Nutrition Evaluation Questionnaire can also be used as questions in a TIC-TAC-TOE game.

Procedure:

1. Divide the class into two groups.
2. Assign one group to be the "X" group.
3. Assign the other to be the "O" group.
4. On the flipchart, draw a TIC-TAC-TOE Board.
5. Place one question card (face down) in each square on the image. There should be a total of nine question cards in the image.
6. One group begins by choosing a square. The facilitator turns over the card in the chosen square and reads the question to whichever group chose the square. If the group can answer the question correctly, either an "X" or "O" is then drawn in the square (depending on whether the group answering the question is the "X" or the "O" group). If they answer the question incorrectly, the card is placed face down again and they are not awarded an "X" or an "O." The other team then chooses a square and attempts to answer the question. The game ends when one group is able to answer enough questions so that there is a vertical diagonal or horizontal row of "X"s or "O"s.
7. Encourage groups to choose the squares strategically so that they can maximize their opportunity to win while minimizing their opponent's opportunity to do so.

Creating Nutrition Plans:

1. Nutrition diary: breakfast, lunch, and dinner.
2. Baby's nutritional diary: breakfast, lunch, and dinner.
3. Health diary: weight, height, significant health events, etc.
4. Baby's health diary: weight, height, growth pattern, doctor's visits, immunization shots, etc.





"How-To" Seminars:

1. How to make homemade baby food.
2. How to breastfeed.
3. How to lose weight.
4. How to reduce stress at home.
5. Ways to prevent food poisoning.

Field Trips

1. Trips to the neighborhood supermarket, international market, and/or Food Cooperatives.
 - ❖ Exercise on picking the right vegetables.
2. Trips to farms or farmer's markets, including organically grown vegetable farms.
3. Trips to Sam's Cluts or Costco for information on bulk purchasing.

Speakers

1. Dieticians with the same cultural background as the participants.
2. Guest lectures on cooking for people with diabetes, high blood pressure, etc.
3. Presenter from local Women, Infants and Children program (WIC) office to present on healthy nutrition for mothers and babies and how the WIC program can benefit the participants.





Journey of Hope

Evaluation

Part 1: To determine whether the objectives have been met and how much information the participants have retained, have the class complete the following questionnaire (either individually as a handout or orally as a group).

Part 2: This is an opportunity for students to ask the trainer questions. Encourage students to ask questions about the different topics covered (Presenter should feel free to use own initiative/experience and if necessary use the "fast fact" section for elaboration).

Part 3: Feedback about lectures and presentations. Review with participants what worked, what didn't, and give participants the opportunity to make suggestions for improvement.

Part 4: Reflections from the presenter's perspective—Have I learned anything? What would I do differently?





Cultural Nutrition Evaluation Questionnaire

1. What are the different states/stages of womanhood and the nutritional requirements that they impose?
2. How many servings of fruits and vegetables are recommended per day?
3. How many servings of breads, cereals, or legumes are recommended per day?
4. How much calcium per day does a pregnant woman need?
5. What three elements are very important in pregnancy?
6. What are the possible consequences of eating too much?
7. How should meat be defrosted?
8. Name two uses of bleach in the kitchen.





Section 2: Preventive Healthcare

Objectives

Participants will—

1. Become familiar with preventive health resources in the United States and the importance of utilizing preventive services.
2. Discuss their approach to preventive health care as gained from their culture(s).
3. Identify potential obstacles that may prevent women from getting necessary care.
4. Learn about particular health risks so that they can change unhealthy lifestyle behaviors.

Materials

1. Preventative Healthcare Assessment Questionnaire (for adults, children, and the elderly)
2. Preventative Healthcare Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

This section aims to alert women to the important role prevention and preventive clinical services play in reducing women's risk for illness, injury, chronic disease, disability, and early death. Personal behaviors such as smoking, exercise, dietary habits, use of alcohol, and safe sexual practices impact health and reduce or enhance a woman's risk of illness and disability. For example, tobacco use is estimated to have caused 400,000 deaths in 1990; poor diet and lack of regular physical activity, another 300,000 deaths; and alcohol use, an additional 100,000 deaths. Education and outreach programs are important avenues for identifying and changing health-damaging behaviors that enable women to lead healthier lives.

Effective interventions and educational programs that encourage women to adopt healthful behaviors and avoid harmful ones must address personal and environmental factors that influence women's behaviors. In addition to social norms that encourage particular behaviors as a form of group solidarity or identification, knowledge and attitudes about the effects of health damaging





behaviors and social support from family and friends are also important factors.

A comprehensive approach to preventive health education must include information about the effects of health-related behaviors and strategies to change these behaviors, as well as information about the importance of preventive clinical services. These clinical services include clinical breast exams, blood pressure screening and bone density tests that reduce the risk of serious illness and premature death through early detection of problems within treatable stages of illness and disease. Some factors that impact women's ability to utilize clinical services include lack of transportation and time constraints, in addition to health care arrangements that fail to include coverage for preventive services. For instance, there is considerable variation among plans in the coverage of preventive services, and poor women and minority women in particular continue to face financial barriers to receiving preventive services.

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

Participants may have different perceptions, expectations, and cultural understandings regarding prevention, including the techniques and methods used. They may lack access to health care services (i.e., time constraints, transportation, etc.), or be restricted due to a lack of coverage for preventative screening. Additional differences that affect the type of and need for preventative health care are:

1. People who are single or without children vs. families with children.
2. Religious and/or cultural dietary concerns.
3. The age/state of the woman—whether adolescent, menopausal, pregnant, or breastfeeding.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about and be an introduction to cultural biases regarding preventative healthcare.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





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Preventative Healthcare Assessment Questionnaire

1. What kinds of health services are available in your country?

2. When do people go to see a doctor in your country?

3. When people are sick, whom do they go to see in your country?

4. Are women required to see doctors even when they are not sick?

5. In your country, what are the recommendations about doctor's visits for women, men, children, and the elderly?

6. Do you know how often you are supposed to see your healthcare provider or a doctor here in United States and why?

7. Do you know how often men, the elderly, and children are supposed to visit doctors in United States and why?

8. What does risk or risk factors mean to you? Give examples of risks.

9. What do you know about cancer and its causes? Who gets what?





10. How is cancer prevented in your country of origin?

11. How is cancer prevented in the United States?

12. What is high blood pressure?

13. In your country, what do you do for people with high blood pressure?

14. If high blood pressure is not treated, what do you think happens?

15. What do you know about diabetes?

16. How do you treat or prevent diabetes in your country?

17. If diabetes is not controlled properly, what do you think happens?

18. What do people do for dental problems in your country?

19. How often do you think you should see a dentist here in United States?





Preventive Healthcare for Children & the Elderly Assessment Questionnaire

1. How often should your child see a doctor?

2. What are immunization schedules?

3. What are the advantages of immunization?

4. Do you know where to go for immunization in your area?

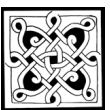
5. Do you know that many of your child's immunizations are free?

6. When was the last time your child saw a physician?

7. Does your child have any health conditions?

8. How often do the elderly members of your family see a doctor? When was the last time they did?

9. Do you know what medication your family's elderly members should be taking to prevent disease?





10. Do you know which vaccinations your family's elderly members should be getting and how often?

11. Do your family's elderly members have any medical problems?





Outline/Lesson Plan

General Preventative Healthcare

- *General*
- *Female Specific*
- *Male Specific*

The Basics of Dental & Oral Health

Intervention Strategies

Evaluation

General Preventative Healthcare

General physical exams should occur every 5 years, until age 50, after which they should occur each year. The routine physical exam should be tailored to a patient's individual risk factors, and they should receive counseling on health behaviors and referral for appropriate preventive services.

Controversy and contradiction among major authorities (regarding recommendations for screening services) continue. The following tables, however, list the recently released recommendations from the U.S. Preventive Services Task Force (USPSTF).

General:

Skin cancer	A skin examination should be performed annually for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or evidence of precursor lesions. Starting at age 40, all individuals should also be examined every year.
Thyroid cancer	Adults whose upper body has been exposed to radiation should be checked regularly for thyroid nodules.
Hypertension screening	In general, individuals should have their blood pressure taken regularly. Individuals with the following risk factors, however, should have yearly blood pressure measurements: <ul style="list-style-type: none"> ❖ An initial diastolic pressure of 85-89. ❖ African-American males. ❖ Family history of hypertension in a first degree relative. ❖ Obesity. ❖ Diabetes.





Vision screening	Comprehensive eye examinations should be performed every 3 to 5 years in African Americans aged 20-39 years, and regardless of race, every 2 to 4 years for individuals aged 40-64 years.
Cholesterol screening	Beginning at age 18, blood cholesterol should be tested at least every 5 years. The USPSTF states that routine cholesterol screening should be performed on all men aged 35-65 and all women aged 45-65.
HIV	Counseling concerning high-risk behaviors and the use of condoms is extremely important.
Counseling service	Participants may require counseling on the following: dietary assessment and nutrition; physical activity and exercise; cancer surveillance; safe sex practices; tobacco, alcohol, and substance abuse; accident and injury prevention; dental health; domestic violence; stress; bereavement; and suicide.
Tuberculosis	Because refugees are considered high-risk individuals, tuberculin skin testing should be included as part of a health screening within the first 30 days after a refugee arrives in the United States.
Immunization	<ul style="list-style-type: none"> ❖ Tetanus/Diphtheria: Primary series followed by a booster every 10 years or single booster at age 50. ❖ Hepatitis B: People with high-risk behaviors (IV drug use, multiple partners) should be immunized. ❖ Influenza: This vaccination should occur annually for the elderly and those with chronic illness. May be of benefit for healthy adults as well.

Female Specific:

Breast cancer	For women 40 and older, an annual clinical exam should be performed. In women older than 40, physicians may elect to perform a clinical breast examination for those who are at high risk. Most authorities recommend a baseline mammogram at age 40, then every 2 years for the ages of 40-50, and annually for age 50 and over. For high-risk women, mammograms may start at age 35 years, then annually. USPSTF advises routine mammography to be performed alone or with a clinical breast exam (CBE) every 1 to 2 years in women aged 50-69 years. They further state that there is insufficient evidence to recommend for or against routine mammography or CBE for women aged 40-49 or aged 70 or older. (See Section 8: Gynecological Care.)
Cervical Cancer	Pelvic examination with a Pap smear should be performed annually on women 18 years and over, until 3 consecutive satisfactory examinations. Frequency may then be less often at the physician's discretion, but should be at least every 3 years. (See Section 8: Gynecological Care.)
Osteoporosis	All women should be counseled on proper intake of calcium and regular exercise, especially in young adulthood.





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Pregnancy	It is important to counsel young women on contraception.
Abuse	Women are at high risk for both physical and mental abuse. It is estimated that up to 1 in 4 emergency room visits by females may be the result of abuse. All female participants must be asked about abuse!

Male Specific:

Testicular Cancer	A testicular exam should be performed annually for males age 13-39 years, especially those with a previous history of testicular problems.
Prostate Cancer	A rectal examination should be part of the periodic health examination of males 40 years and older, and annually for men 50 years and older. Is often combined with a colorectal examination.
Colorectal Cancer	A rectal examination should be included in the periodic health examination of individuals 40 years of age and over. For those over 50 years of age, their stool should be tested annually for the presence of blood, with a sigmoidoscopy performed every 3-5 years. The USPSTF states that there is insufficient evidence to recommend for or against routine screening by barium enema or colonoscopy.

The Basics of Dental & Oral Health

The American College of Obstetricians and Gynecologists (ACOG) recommends that dental hygiene should be included in counseling as part of periodic evaluation visits, which should occur yearly or as appropriate. The American Dental Association (ADA) recommends that adults should be seen annually for routine dental care and preventive services, including oral cancer screening and oral hygiene counseling. This recommendation applies to patients with full dentures as well as patients "with teeth."

1. Encourage all participants (including older adults and the toothless) to see a dentist regularly for preventive care.
2. Encourage all participants to brush their teeth with fluoride-containing toothpaste and to use dental floss daily.
3. Encourage individuals who have a history of frequent cavities to reduce their intake of foods containing refined sugars and to avoid sugary/starchy between-meal snacks. A fluoride-containing mouthwash might also be beneficial.
4. Counsel participants not to use tobacco in any form, and to limit alcohol consumption.





5. Encourage individuals who are out in the sun to protect their lips and skin from the harmful effects of ultraviolet rays by using sunscreens and lip balms of SPF 15 or more, to wear protective clothing such as hats, and to avoid direct sun exposure between the hours of 10:00 a.m. and 3:00 p.m.
6. Encourage individuals who engage in sports that have the potential for oral and dental trauma (such as football, hockey, boxing, etc.) to use appropriate protective equipment, including headgear and mouth guards. Urge participants to wear safety belts while in motor vehicles and helmets while riding bicycles and motorcycles.
7. Encourage individuals, especially those who use tobacco or alcohol, to see a dentist or physician if they have any mouth problems (such as color changes, cracks, ulcers, bleeding; or swelling or thickening in the lips, cheeks, gums, tongue, or roof of the mouth) that last longer than 2 weeks.
8. Encourage participants to obtain counseling about the effects and complications of any medications they are taking.

Intervention Strategies

1. Develop strategies for emphasizing the importance of primary prevention and healthy behavior to the participants.
2. Develop lesson plans around different health problems (cancer) and preventive recommendations.
3. Continuously monitor progress and adjust the lesson plan.
4. Facilitate participants' use of their community's primary prevention resources (free breast exams, free blood pressure (BP) check, etc).
5. Encourage activities that increase knowledge about prevention (prevention games).
6. Identify barriers that may be preventing the participants from seeking preventive medical services and educate them about the barriers.
7. Encourage the use of a monthly health diary (weight, height, BP, doctor's visit, and medications).
8. Develop a more intensive intervention program for at-risk participants which includes:
 - ❖ Home visits
 - ❖ Periodic telephone calls
 - ❖ Family education (women, husbands, and children)
 - ❖ Permission to talk to person's physician regarding concerns and interventions thus far.





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9. Incorporate new knowledge, communicate it to the participants, and be culturally sensitive.

Evaluation:

Part 1: To determine whether the objectives have been met and how much information the participants have retained, have the class complete the following questionnaire (either individually as a handout or orally as a group).

Part 2: This is an opportunity for students to ask the trainer questions. Encourage students to ask questions about the different topics covered (Trainer should feel free to use own initiative and experience, and if necessary use the "fast fact" section for elaboration).

Part 3: Feedback about lectures, and presentations. Review of what works, what didn't, what needs work, and suggestions.

Part 4: Reflections from the presenter's perspective—Have I learned anything? What would I do differently?





Preventative Healthcare Evaluation Questionnaire

1. How often should a person have a general physical exam? After age 50, how often?

2. What are the advantages of immunization? What are immunization schedules?

3. What does "risk factor" mean?

4. What is high blood pressure and what does it put you at risk for?

5. What is a baseline mammogram and when is it recommended that you have one?

6. What is the purpose of preventative healthcare?

7. What are vaccinations?





Section 3: Substance Abuse

(Cigarettes, Alcohol, & Drugs)

Objectives

Participants will—

1. Learn about the nature and problems of substance abuse.
2. Discuss the special circumstances and the methods of addressing substance abuse in the refugee population.

Materials

1. General & Cultural Substance Abuse Assessment Questionnaire
2. Substance Abuse Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

During resettlement in host countries, refugee women often face problems that are worse than those faced by voluntary migrants. While these problems are often related to previous traumatic experiences, there are many refugee women who may not have personally experienced torture or trauma, but who, nonetheless, perceive themselves as being marginalized from mainstream society. These feelings of marginalization can lead to isolation and depression, risk factors that may result in the abuse of alcohol, cigarettes, and other drugs. Besides the usual street drugs like heroin, cannabis, cocaine, etc., refugees may have other addictions—such as amphetamines and khat (Also known as Qat or Miraa. Consists of the fresh young leaves of the *Catha edulis* plant, which contain a psychoactive substance, and has been associated with many health problems).

Before resettlement, all refugees are screened for drug abuse and those who fail are considered excludable to the U.S. resettlement program until rehabilitation has occurred and the refugee has completed a clean drug test. However, not all drugs are tested for or excludable, and once resettled, some refugees may once again begin using drugs because of old habits or as a way to deal with the increased socioeconomic pressures following resettlement. The most commonly abused substance is tobacco (in the form of cigarettes), followed by alcohol, cannabis, amphetamines, and khat.





Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

1. Cultural attitudes towards drugs—some may find it offensive/accusatory.
2. Views on khat as a drug.
3. Views on cigarettes and alcohol as drugs.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about drugs and to be an introduction to cultural biases regarding drugs and drug abuse.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.

Note to Facilitators:

For specific substance abuse assessments, which are used when substance abuse is suspected, see Appendix A: Health & Wellness—Section 3: Substance Abuse for the standard questionnaires.





General & Cultural Substance Abuse Assessment Questionnaire

1. What do you know about drug use?
2. What kinds of drug use do you have in your home country?
3. What are people's attitudes about drugs in your home country?
4. Are there laws in your country against drugs? If so, what kinds of drugs?
5. Which drugs do you consider to be potentially abusable?
6. Are cigarettes and alcohol drugs?
7. Are drugs indigent to your country available in the United States?
8. What do you think Americans consider are potentially abusable drugs?
9. Are you familiar with American laws regarding drugs?





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10. Are you familiar with available programs regarding drug abuse prevention?

11. Does your work place have an Employee Assistant Program (EAP)?

12. What is an EAP?

13. Does your work place have a drug policy?





Outline/Lesson Plan

Tobacco

Alcohol

Drugs

Special Circumstances: Pregnancy, Adolescents, & Children

- Pregnancy

- Adolescents & Young Adults

Fast Facts

Intervention Strategies

Activities

- List Game

- Diaries

- How-To Seminars

Field Trips

Speakers

Evaluation

Tobacco

Many refugees are not aware (due to the lack of public health education in their home country) that tobacco is a drug or of the debates regarding cigarettes in the United States. In the United States, most tobacco users have at least a vague idea that the habit is harmful, but may be unaware of the specifics or the magnitude of the risk.

To put it in perspective, smoking kills more Americans every 6 weeks than died in the entire Vietnam War and also kills more Americans every 2 months than died of AIDS during the 1980's. The figures for the leading causes of preventable death in the United States are: 434,000 yearly from smoking (data for chewing tobacco is unavailable), 100,000 from alcohol abuse (including accidents), 53,000 from passive smoking (that is, 1 death from environmental tobacco smoke for every 8 from active smoking), followed by only 6,000 per year from drug abuse. Knowing the health burden of cigarette smoking in United States, one can only imagine the health effects of cigarettes among the refugee population. Furthermore, the health effects of smoking have not been properly personalized; for example, a young adult nonsmoker has a 15 percent chance of dying before 65, but a smoker has a 40 percent chance—triple the nonsmoker's risk of early and premature death.





The notion that it is too late to stop or that "the damage is already done" is also unfounded; a 50-year-old lifelong smoker who quits doubles his/her chance of living to 65. Forty million Americans are now successful ex-smokers.

Unfortunately younger smokers, especially adolescents, are less amenable to persuasion not to start smoking or to quit because of future harm to their health; as a result, the following points also need to be emphasized with them.

- ❖ Smoking is very expensive. A two-pack-a-day smoker would have \$180,000 at the end of 30 years if he/she simply invested the cigarette money at standard interest rates.
- ❖ Smoking damages physical fitness.

Alcohol

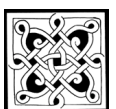
The American Psychiatric Association's diagnosis guidelines (DSM-IV) recognizes two distinct primary disorders of alcohol use: Alcohol Abuse and Alcohol Dependence. Together, their lifetime prevalence in the general population is 13.6 percent. Alcohol use disorders are many times more common in males than in females (4:1 in the United States), and their onset is usually between the ages 16 and 30; both genetic and environmental factors contribute to this. It is crucial to be able to distinguish recreational alcohol use from Alcohol Abuse and Alcohol Dependence.

Alcohol Abuse: Is a maladaptive pattern of alcohol use leading to clinically significant impairment or distress (evident in recurrent failures to fulfill obligations at work, school, or home, or in recurrent health or legal problems due to alcohol use). Typically, individuals with alcohol abuse continue to use alcohol despite these adverse consequences.

Alcohol Dependence: Is alcohol abuse with the additional feature of physiological and psychosocial evidence of addiction. The symptoms of Alcohol Dependence include:

- ❖ Tolerance (needing increasing amounts to obtain desired effect.)
- ❖ Withdrawal (irritability, insomnia, malaise, increased heart rate, tremors, nausea, vomiting, and/or tactile hallucinations beginning 24-48 hours after the last drink.)
- ❖ Unsuccessful attempts to cut down or stop.
- ❖ Devoting more time (obsession) to activities necessary for obtaining alcohol and giving up other activities because of alcohol.

The social consequences of problem drinking are often as damaging as the direct medical consequences. Nearly 20 percent of drinkers report problems





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with friends, family, work, or police due to drinking. People who abuse alcohol have a higher risk of divorce, depression, suicide, domestic violence, unemployment, and poverty. Intoxication may lead to unsafe sexual behavior—increasing the risk of STDs, including HIV. Finally, an estimated 27 million American children are at risk for abnormal psychosocial development due to the their parent's abuse of alcohol.

Moderate alcohol consumption, however, has favorable effects on the risk of coronary heart disease (CHD). CHD incidence and mortality rates are 20-40 percent lower in men and women who drink 1-2 drinks/day than in nondrinkers. The exact mechanism for the protective effect of alcohol is not known.

Drugs

The abuse of both illicit and legal drugs remains an important medical problem in the United States. Although casual (i.e., occasional) use of illicit drugs declined steadily from 1979 to 1992 in the general population, drug use has apparently been increasing since then, especially among teenagers and young adults. Occasional use of marijuana accounts for a large proportion of reported drug use, but many drug users use other illicit drugs (cocaine, heroin, phencyclidine, methaqualone, hallucinogens, etc.), legal drugs not prescribed by a physician (e.g., amphetamines, benzodiazepines, barbiturates, and anabolic steroids), or inhalants (amyl and butyl nitrite, gasoline, nitrous oxide, glue, and other solvents). An estimated 5 million Americans smoke marijuana regularly (at least once a week), almost 500,000 use cocaine weekly, and over 500,000 used heroin or other injectable drugs in the past year.

Drug use is more common among men, the unemployed, adults who have not completed high school, and urban residents. The overall prevalence of drug use does not differ greatly among Caucasian, African American, and Hispanic populations, but patterns of drug use may. Drug use statistics, however, may be different for refugees; for example, many refugees from the Horn of Africa are addicted to khat—the leaves of which contain many different psychoactive compounds. Adverse effects of khat include reproductive toxicity (infertility due, in men, to decreased testosterone and decreased sperm count and motility), central nervous system stimulatory effects, insomnia, restlessness, and anxiety (from pseudoephedrine effect), a strong association with oral cancer (independent of smoking), and drug interaction with some antibiotics. It is also secreted in breast milk and can, therefore, cause problems in breastfed infants. Published information regarding khat and refugees in London and Liverpool, England highlighted a significant problem that must be addressed.

The adverse effects of other drugs include acute cardiovascular complications (e.g., arrhythmias, myocardial infarction, cerebral hemorrhage, and seizures); nasal and sinus disease and respiratory problems (when





smoked); and diminished motivation, irregular sleep patterns and other symptoms of depression. "Crack," a popular and cheap smokeable form of cocaine, is also highly addictive.

Drugs that are injected intravenously result in a high death rate due to overdose, suicide, violence, and medical complications from injecting contaminated materials (e.g., HIV infection, hepatitis, bacterial endocarditis [bacteria infection of the lining of the heart], kidney infections and blood clots in the lungs); in some cities, up to 40 percent of intravenous drug users (IDUs) are infected with HIV.

Although the extent of adverse effects of marijuana use is controversial, chronic use may be associated with respiratory complications or lack of motivation. There are other indirect medical and social consequences of drug use that are equally important: criminal activities related to illegal drugs take a tremendous toll in many communities, intravenous drug use and crack are major factors in the spread of HIV infection, and drugs play a role in many homicides, suicides, and motor vehicle injuries. Nearly half of all users of cocaine or marijuana reported having driven a car shortly after using drugs.

Special Circumstances: Pregnancy, Adolescents, & Children

Pregnancy:

Alcohol Use: The proportion of pregnant women who report drinking has declined steadily in the United States. Recent surveys indicate 12-14 percent of pregnant women continue to consume some alcohol, with most reporting only occasional, light drinking (median: 4 drinks per month). Binge drinking or daily risk drinking (usually defined as 2 drinks per day or greater) is reported by 1-2 percent of pregnant women, but higher rates (4-6 percent) have been reported in some screening studies.

Pregnant women should be advised to limit or cease drinking during pregnancy. Excessive use of alcohol during pregnancy can cause Fetal Alcohol Syndrome (FAS), a mixture of growth retardation, facial deformities, and central nervous system dysfunction (microcephaly, mental retardation, or behavioral abnormalities). Even infants who do not have full FAS, often display growth retardation or neurologic problems. FAS, has been estimated to affect approximately 1 in 3,000 births in the United States (1,200 children annually), making it a leading treatable cause of birth defects and mental retardation.

The level of alcohol consumption that poses a risk during pregnancy remains controversial. FAS has only been described in infants born to alcoholic mothers, but the variable incidence of FAS among alcoholic women (from 3-40 percent) suggests that other factors (e.g., genetic, nutritional, metabolic, or temporal) may influence the expression of FAS.





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The timing of exposure and pattern of drinking may be important, with greater effects proposed for exposure early in pregnancy and for frequent binge drinking.

Drug Use: While associated with a variety of adverse outcomes, the problems associated with drug use (e.g., use of alcohol or cigarettes, poverty, poor nutrition, and inadequate prenatal care) may be more important than the direct effects of the drugs. Regular use of cocaine and opiates is associated with poor weight gain among pregnant women, impaired fetal growth, and increased risk of premature birth; cocaine appears to increase the risk of premature detachment of the placenta. The effects of the social use of cocaine in the first trimester are uncertain. Cocaine has been blamed for some congenital (present at birth) defects, but their full extent have not been definitively established. Infants exposed to drugs in the uterus may exhibit withdrawal symptoms, due to opiates, or increased tremors, hyperexcitability, and hypertonicity (excessive tone of the skeletal muscles resulting in inflexibility) due to cocaine.

Adolescents & Young Adults:

The leading causes of adolescent and young adult death in the United States are motor vehicle accidents and other unintentional injuries, homicides, and suicides; of these, about half of the cases are associated with alcohol or other drug intoxication. Driving under the influence of alcohol is more than twice as common in adolescents than in adults. Binge drinking is especially prevalent among college students: half of all men and roughly one third of all women report heavy drinking within the previous two weeks. Most frequent binge drinkers report numerous alcohol-related problems, including problems with schoolwork, unplanned or unsafe sex, and trouble with police.

Drug use and abuse remain important problems among adolescents. The use of illicit drugs may interfere with school, increase the risk of injuries, contribute to unsafe sex, and progress to more harmful drug use. Abuse of anabolic steroids in adolescent boys and young men can cause psychiatric symptoms and has been associated with liver, hormonal, and cardiovascular problems.

Alcohol interventions in adolescents have focused on primary prevention of alcohol use. Recent reviews of school-based programs found that most effects were inconsistent, small, and short-lived; programs that sought to develop social skills to resist drug use seem to be more effective than programs that emphasize factual knowledge.

Fast Facts

1. The symptoms and signs of Alcoholism include the presence of an alcohol odor on the breath, ataxia (lack of coordination), red nose or palms, jaundice, poor dental care, abdominal tenderness, signs of portal





hypertension (increased blood flow/pressure in the veins of the liver), or loss of peripheral sensation or motor power. Heavy drinkers may underestimate the amount they drink because of denial, forgetfulness, or fear of the consequences of being diagnosed with a drinking problem. One result is that doctors are frequently unaware of problem drinking by their patients.

2. Persons who are dangerously intoxicated, with a history of serious withdrawal symptoms in the past, with unstable medical complications, or who are suicidal need immediate medical assistance.
3. Levels of intervention range from brief educational classes (Level 1) to home rehabilitation (Level 3). Abstinence from alcohol use and attendance at Alcoholics Anonymous (AA) meetings is recommended. Alcohol use disorders are chronic and recovery is a long and difficult road. Refusal to participate in treatment for an alcohol use disorder is grounds for separation.

Intervention Strategies

1. Adopt the National Cancer Institute "Fours A's" in smoking cessation, and adapt it for alcohol, drugs, and cigarettes.
 - ❖ **Ask** about smoking, drugs, and alcohol regularly.
 - ❖ **Advise** all smokers, drug users, and alcohol users to quit; personalize the message and risk as discussed in the subsection on tobacco.
 - ❖ **Assist** the participant in stopping by setting a quitting date, providing self-help materials, etc.
 - ❖ **Arrange** appropriate follow-up counseling (it takes time, effort, and usually several attempts to be successful).
2. Develop an effective screening tool to detect problem drinking, smoking, and drug use for adults and adolescents.
3. Develop a standard method of interviewing refugees about substance abuse that is clear, concise, and culturally sensitive. It should include
 - ❖ Careful history of substance abuse.
 - ❖ Use of standardized screening questionnaires.
 - ❖ Participants should be asked to describe quantity, frequency, and tolerance effects. One drink is defined as 12 ounces of beer, a 5-ounce glass of wine, or 1.5 fluid ounces (one jigger) of distilled spirits.





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- ❖ Responses suggestive of problems with substance abuse usage should be confirmed with more extensive discussions with the participant (and family members where indicated) about patterns of use and problems related to use.
- 4. Discussions with adolescents should be approached with discretion in order to establish a trusting relationship and to respect the participant's concerns about the confidentiality of disclosed information.
- 5. Discuss U.S. employment and drug policy.
- 6. All pregnant women should be screened for evidence of substance abuse.
- 7. Personalize discussions about substance abuse and pregnancy as previously described in this section. Women who smoke should be advised that the risk of low birth weight is greatest for mothers who both smoke and drink.
- 8. If necessary, assist the participant to obtain advice and counseling. Counseling should involve feedback of the evidence of a substance abuse use, direct advice to reduce abuse, and plans for regular follow-up.
- 9. People with physical symptoms, behavioral or mood problems, or difficulties at work and home should be monitored to determine whether further interventions are needed.
- 10. Develop plans for accessing the community mental health resources.
- 11. Develop plans for lost cause and difficult cases.

Activities

List Game:

1. List five substances that can be abused.
2. List five adverse effects of substance abuse of your choice.
3. List five social and medical problems associated with alcohol.
4. List five problems associated with khat.

Diaries:

1. Smoking "holidays" and quitting schedule.
2. Diet diary.





How-To Seminars:

1. Videotaped educational materials.
2. How to quit smoking seminars.
3. How to stop drugs coming into your home.

Field Trips

Trips to substance abuse intervention centers in the neighborhood.

- ❖ Exercise on drug prevention, emphasizing the four A's.

Speakers

1. Substance abuse professionals (SAPs), ideally with the same cultural background as the women.
2. Guest lectures on drug abuse prevention.
3. Guest lectures on the use of the Employee Assistant Program (EAP) at work.

Evaluation

Part 1: Use the following questionnaire to determine whether this section's objectives have been met and how much information the participants have retained.

Part 2: This is an opportunity for participants to ask the trainer questions to (trainer should feel free to rely on own initiative and/or experience in dealing with this section. Fast facts, however, are available for reference). Encourage students to ask questions about the different topics covered.

Part 3: Feedback about lectures and presentations—what works, what doesn't, what needs work, and suggestions.

Part 4: The presenter's own reflections—Have I learned anything? What would I do differently?





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Substance Abuse Evaluation Questionnaire

1. What are the different drugs discussed?
2. What are the side effects of drugs—social, medical, and psychological?
3. What are the prevention recommendations regarding pregnancy and adolescents?
4. Where are the substance abuse intervention centers in the community?
5. How might you and your family deal with drug abuse?





Section 4: Counseling

To Promote Physical Activity

Objectives

Participants will—

1. Learn how to improve the health of their families through healthy living and regular physical exercise.
2. Discuss the available exercise resources and programs in the United States.

Materials

1. Physical Activity Assessment Questionnaire
2. Physical Activity Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Regular physical activity is recommended to prevent coronary heart disease (CHD), hypertension, obesity, and diabetes.

In 1985, national survey data revealed that 56 percent of men and 61 percent of women in the United States either never engaged in physical activity or did so on an irregular basis. The 1991 surveillance data suggests that the prevalence of a sedentary lifestyle (58 percent overall) has not changed. For example, CHD, the predominant risk associated with a sedentary lifestyle, is the leading cause of death in the United States. It is estimated that the incidence of CHD could be reduced by 35 percent if people became more physically active. Furthermore, there is evidence that physical activity and fitness reduce the incidence of at least five other chronic conditions: hypertension, obesity, diabetes, osteoporosis, and mental health disorders. Moderate physical activity comprises activities that can be comfortably sustained for at least 60 minutes (e.g., walking, slow biking, etc.). Vigorous activity describes those of an intensity sufficient to result in fatigue within 20 minutes.

It is important to mention that there are presently no good studies on exercise and the refugee population; however, given the situation in the United States





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regarding sedentary living, the topic of exercise with emphasis on its health benefits needs to be addressed.

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

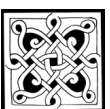
Differences to Consider

1. Cultural and religious attitudes towards exercise.
2. Emphasize exercise programs that are family focused.
3. Emphasize caution when pregnant and exercising.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange and be an introduction to cultural biases regarding physical exercise.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





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10. Do you know how to initiate regular exercises?

11. Do you know about nutrition and wellness?

12. Would you like to participate in a regular exercise program?

13. What do you know about exercise and children?

14. Do you know the recommended duration and frequency of good exercise?

15. What is your opinion about the American attitude about exercise?





Outline/Lesson Plan

Fast Facts

Intervention Strategies

Activities

- *List Game*
- *Diaries*
- *How-To Seminars*

Field Trips

Speakers

Evaluation

Fast Facts

1. Studies suggest that physically inactive people have a 35-52 percent greater risk of developing hypertension than those who exercise. Studies have shown that increased physical activity leads to lowered blood pressure.
2. Among men, moderately vigorous sports activity has been associated with a 41 percent lower risk of death from CHD (the risk reduction from stopping smoking was 44 percent).
3. The age-adjusted risk of Non-Insulin Dependent Diabetes Mellitus (NIDDM) is significantly reduced with consistent exercise. The protective effect of physical activity is more pronounced in persons at highest risk for NIDDM (i.e., those with positive family history, obesity, or hypertension.) These preventive effects are most probably due to decreased insulin resistance. (See *Section 7: Diabetes.*)
4. Physical activity assists with weight maintenance and increases the chances of success for initial and long-term weight loss. This results from increased total energy output, the preservation and creation of lean body mass (muscle versus fat), and an increased metabolic rate. It also helps provide positive mental reinforcement.
5. Postmenopausal women can slow down bone loss through physical activity. For example, studies examining exercise history and fitness level reveal greater bone mass in the more active and fit. Physical activity can also reduce the rate of bone loss in premenopausal women.
6. Direct evidence that physical activity reduces the incidence of hip fractures includes a recent large case-control study. This study found a reduction in the risk of hip fracture in women who were active in the past, as well as in those with recent moderate exercise history.





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7. Most exercise-induced injuries are preventable. They often occur as a result of excessive levels of physical activity, sudden dramatic increases in activity level (especially in persons with poor baseline fitness), and improper exercise techniques or equipment. Intense exercise training can also result in the interruption of menstrual function, bone loss (partly reversible), and an increased fracture risk.

Intervention Strategies

1. Counseling to promote regular physical activity is recommended for all children and adults.
2. Develop a method of presenting an exercise-counseling program that is culturally sensitive.
3. In counseling about exercise, emphasize the proven efficacy of regular physical activity in reducing the risk for CHD, hypertension, obesity, and diabetes.
4. In preparing for the counseling, ascertain the individual's activity level and any barriers, and provide information on the role of physical activity in disease prevention.
5. Emphasize the family approach when appropriate (families that exercise together, live well together).
6. Assist in selecting appropriate types of physical activity. Factor in medical limitations, disabilities, and activity characteristics that both improve health (e.g., increased caloric expenditure, enhanced cardiovascular fitness, and low potential adverse effects) and enhance compliance (e.g., low perceived exertion, minimal cost, and convenience).
7. Emphasize regular, moderate-intensity physical activity rather than vigorous exercise. This emphasis encourages a variety of self-directed, moderate-level physical activities (e.g., walking or cycling to work, taking the stairs, raking leaves, cycling for pleasure, swimming, racket sports, etc.) that can be more easily incorporated into an individual's daily routine.
8. Develop appropriate short-term and long-term goals. Over a period of several months, progression to a level of activity that achieves cardiovascular fitness (e.g., 30 minutes of brisk walking most days of the week) would be ideal. Development and maintenance of muscular strength and joint flexibility is also desirable. Sporadic exercise, especially if extremely vigorous in an otherwise sedentary individual, should be discouraged in favor of moderate-level activities performed consistently.
9. Develop an agreed-upon method of evaluation based on the individual's goals.





10. Yoga, Tai Chi, and Step Aerobic exercises can be performed and taught on-site. Progress would then be measured over an agreed upon time period. Experience in IRSA's refugee women's training program has shown that most women were receptive to a variety of group exercise activities if the activities were conducted exclusively with women in a secluded area, if the program moved gradually from easier activities to more strenuous, if women could wear culturally appropriate attire, and if the trainer used humor and camaraderie to encourage participation.
11. Know when to quit and move on!

Activities

List Game:

1. List five benefits of regular physical activity.
2. List five types of regular exercise activities mentioned.
3. List five medical problems that exercise can improve.

Diaries:

1. Individual exercise plans, goals, and progress evaluation method.
2. Diary review of weight gain and exercise duration times.
3. Graded exercise protocol plan review.

How-To Seminars:

1. Videotape on different exercise and physical activities.
2. How to start an exercise program.
3. How to start physical activity programs for the family.
4. How to find a good weight-loss program.
5. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

Field Trips

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.





Journey of Hope

Speakers

1. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
2. Aerobic specialists.
3. Yoga instructors and relaxation specialists.

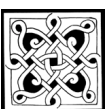
Evaluation

Part I: Use the following questionnaire to determine whether this section's objectives have been met and how much information the participants have retained.

Part II: Students' opportunity to question the presenter (Presenter should feel free to use own initiative and experience. "Fast Fact" section is available as a resource.) Encourage students to ask questions about the different topics covered.

Part III: Feedback about lectures and presentations—what works, what doesn't, what need work, and suggestions

Part IV: The trainer's own reflections. Have I learned anything? Would I do anything differently?





Physical Activity Evaluation Questionnaire

1. What are the reasons for having a physical activity program?
2. What are the possible problems with starting an exercise program?
3. List three features of a good exercise program?
4. What are the special recommendations regarding pregnancy and adolescents?
5. Where are the gymnasiums and physical activity centers in the community?
6. What kinds of activities might you start with your family?





Section 5: Counseling to Prevent Low Back Pain

Objectives

Participants will—

1. Learn how to improve the health of their families through low back injury prevention.
2. Discuss available low back pain prevention resources and programs in the United States.

Materials

1. Back Pain Assessment Questionnaire
2. Low Back Pain Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Low back pain affects 60-80 percent of U.S. adults at some time during their lives, and up to 50 percent have back pain within a given year. Back symptoms are among the 10 leading reasons for patient visits to emergency rooms, hospital outpatient departments, and physicians' offices. Although symptoms are usually acute and self-limited, low back pain often recurs, and in 5-10 percent of patients low back pain becomes chronic. Back pain is the most common cause of disability for persons under age 45. In addition, treatment (and disability costs) are expensive.

Many back injuries are occupational in nature. Occupational back injury is clearly related to lifting and repeated activities. Persons in occupations that require repetitive lifting, such as nursing and heavy industry, are especially at risk. Based on national data, occupational groups with the highest estimated prevalence of low back pain (10.1-10.5 percent) include mechanics and repairers of vehicles, engines, and heavy equipment; operators of extractive, mining, and material-moving equipment; and people in construction trades and other construction occupations. There is no specific information regarding the prevalence of back injury among the refugee population.





Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

1. Cultural attitudes towards exercise—some may find it offensive/accusatory, some may not understand the necessity for back injury prevention.
2. Emphasize precautions to take if pregnant and exercising.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about low back pain and be an introduction to cultural biases about low back pain.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





Journey of Hope

Back Pain Assessment Questionnaire

1. Do people suffer from back pain in your country?

2. Do you know anybody suffering from back pain?

3. Do you suffer from back pain?

4. Do you want to know how to prevent back trouble?

5. What kinds of jobs are likely to give you back trouble?





Outline/Lesson Plan

Fast Facts

Intervention Strategies

Activities

- *List Game*
- *Diaries*
- *How-to Seminars*

Field Trips

Speakers

Evaluation

Fast Facts

1. Among the most commonly proposed strategies to prevent low back pain and injury are:
 - ❖ Back stretching and general fitness exercises.
 - ❖ Improved back mechanic and ergonomic techniques (i.e., maximizing the efficient use of human energy in performing work).
 - ❖ Mechanical back supports (back belts or corsets).
 - ❖ Risk factor modification (such as reducing obesity and smoking).
2. Clinical strategies for preventing low back pain are aimed at subjects both with and without a history of back pain.
3. Exercise is typically aimed at strengthening back extensor or flexor muscles and increasing back flexibility to reduce injury risk, improving cardiovascular fitness to minimize injury and enhance recovery should injury occur, and improving mood and pain perception to reduce the impact of injury.
4. Studies support an association between greater fitness or higher levels of physical activity and reduced prevalence of low back pain or injury, but results are less consistent regarding the effect of greater strength or flexibility.
5. There is inadequate evidence to show a benefit from back belts; indeed, they may even cause harm. In addition, poor compliance in these and other studies raises the question of whether subjects will routinely use corsets for prevention of back pain.





Journey of Hope

6. Evidence suggests that several modifiable risk factors, including smoking, obesity, and certain psychological profiles, predispose certain individuals to develop low back pain. Risk factors are presumed to exert their influence either by increasing an individual's risk of hurting themselves or by increasing the chance that if they do hurt themselves, the experience will be painful or disabling.
7. Education through "back school" training, including information on back biomechanics, preferred lifting strategies, optimal posture, exercises to prevent back pain, and stress and pain management, has been effective in reducing employment-related injuries and relieving chronic low back pain.

Intervention Strategies

1. Counseling to promote knowledge about back injury is recommended for all children and adults.
2. Develop a method of presenting a back injury prevention program that is culturally sensitive to the participants.
3. In counseling about back injury prevention, emphasize the proven efficacy of regular physical activity in reducing the risk for coronary heart disease, hypertension, obesity, and diabetes.
4. Ascertain each individual's knowledge about back injury, their physical activity levels, and any bias and barriers they may have. Also provide information on the role of disease prevention.
5. Emphasize regular moderate-intensity physical activity rather than vigorous exercise. This emphasis encourages a variety of self-directed, moderate-level physical activities (e.g., walking or cycling to work, taking the stairs, raking leaves, mowing the lawn with a power mower, cycling for pleasure, swimming, racket sports) that can be more easily incorporated into an individual's daily routine.
6. Develop an agreed-upon method of evaluation based on the individual's initial goals.
7. Yoga, Tai Chi, and Step Aerobic exercises can be performed and taught on-site. Then progress is measured over an agreed upon time period.





Activities

List Game:

1. List five benefits of regular physical activity and back stretching exercises.
2. List five types of regular exercise activities mentioned previously.
3. List five habits that increase back injury.

Diaries:

1. Individual exercise plans, goals, and method of evaluation of progress.
2. Diary review of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise protocol plan review.

How-To Seminars:

1. Videotapes on different exercise and physical activities.
2. Videotape on how to prevent back injury.
3. How to find a good weight-loss program.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

Field Trips

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.

Speakers

1. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
2. Aerobic specialists.





Journey of Hope

Evaluation

Part 1: Use the following questionnaire to determine whether the objectives have been met and how much information the participants have retained.

Part II: Students ask questions of the presenter. Trainer should feel free to use own initiative and experience when answering student's questions. (The "fast fact" section is available if help is needed). Encourage students to ask questions about the different topics covered.

Part III: Feedback about lectures and presentations. What works, what doesn't, what needs help, and suggestions.

Part IV: The trainer's own reflections. Have I learned anything? Would I do anything differently?





Low Back Pain Evaluation Questionnaire

1. What are the different benefits of back prevention programs?
2. What is known and unknown about back injury and exercises?
3. What are the special recommendations regarding pregnancy and adolescents?
4. Where are the gymnasiums and physical activity centers in the community?
5. What kinds of activities might you start with your family?





Section 6: Hypertension (*High Blood Pressure*)

Objectives

Participants will—

1. Become familiar with the risk factors, symptoms, and complications of high blood pressure.
2. Learn how to prevent and manage high blood pressure in their families.

Materials

1. Hypertension Assessment Questionnaire
2. Hypertension Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

For blood to be carried from the heart to the body, pressure is needed to pump the blood against the arteries. In fact, each time the heart beats (about 60-70 times a minute at rest), it pumps out blood into the arteries. The blood pressure is at its greatest when the heart contracts and pumps the blood—this is called systolic pressure. When the heart is at rest, in between beats, the blood pressure falls—this is called diastolic pressure.

Blood pressure, therefore, is reported as two numbers—systolic and diastolic pressures. Both are important. Usually they are written one above or before the other, such as 120/80 mm Hg (millimeters of mercury—the standard unit of measurement for blood pressure), with the top number the systolic and the bottom the diastolic. When performing certain actions, the blood pressure rises; for example, if one is running, the body needs more blood, therefore, the blood pressure goes up. When one sleeps at night, however, the body is at rest and does not need a lot of energy and blood pressure goes down. These changes in blood pressure are normal. Problems with blood pressure occur when the blood pressure stays elevated for all or most of the time. In this instance, the blood pushes against the walls of the arteries with higher-than-normal force. If untreated, this can lead to serious medical problems.

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.





Differences to Consider

1. Cultural attitudes towards hypertension, exercise—some may find it offensive/accusatory, some may not understand the necessity for prevention.
2. Emphasize taking precautions during pregnancy with regards to hypertension, diabetes, and exercise.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about hypertension and to be an introduction to cultural biases regarding this disease.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





Journey of Hope

Hypertension Assessment Questionnaire

1. What do you know about hypertension?

2. Who is likely to have hypertension?

3. Do people in your country have hypertension?

4. How is hypertension treated in your country?

5. Would you like to know more about hypertension?

6. Do you know anyone with hypertension?

7. Do you know how to prevent hypertension?

8. Do you want to know how to prevent hypertension?

9. Do you want to know how to care for someone with hypertension?





Outline/Lesson Plan

Risk Factors for High Blood Pressure

Medical Problems Associated with Hypertension

Controlling High Blood Pressure

- *Blood Pressure Categories for Adults*
- *Recommended Steps for Controlling High Blood Pressure*

The Main Types of High Blood Pressure Drugs

Fast Facts

Activities

- *List Game*
- *Diaries*
- *How-To Seminars*

Field Trips

Speakers

Evaluation

Risk Factors for High Blood Pressure

While anyone can develop high blood pressure (nearly 50 million Americans have it), some groups of people are more likely to develop it than others. For example, high blood pressure is more common in African-Americans than in Caucasians (it develops earlier and is more severe). In the early and middle adult years, men have high blood pressure more often than women (probably due to the protective effect of estrogen in women), but as men and women age, the reverse is true. After menopause more women have high blood pressure than men of the same age (probably a result of the lowered estrogen in women undergoing menopause), but in the older age groups, the number of both men and women with high blood pressure increases. More than half of all Americans over age 65 have high blood pressure. There are also geographical variations; for example, older African-American women who live in the Southeast are more likely to have high blood pressure than those in other regions of the United States.

Heredity can make some families more likely than others to get high blood pressure. If one's parents or grandparents had high blood pressure, then one's risk may be increased. While it is mainly a disease of adults, high blood pressure can occur in children as well.

There is insufficient information regarding the incidence of hypertension among refugees.





Medical Problems Associated with Hypertension

Arteriosclerosis ("hardening of the arteries")	High blood pressure harms the arteries by making them thick and stiff. This speeds up the accumulation of cholesterol and fats in the blood vessels like rust in a pipe, which prevents the blood from flowing through the body and, in time, can lead to a heart attack or stroke.
Heart Attack	Heart attacks occur when the blood carried to the body is not sufficiently enriched with oxygen or when the arterial blood supply to the heart muscle becomes blocked—preventing the heart from getting enough oxygen. Reduced blood flow can also cause chest pain (angina)—which is also a precursor to heart attack.
Stroke	<p>High blood pressure is the key risk factor for stroke (other risk factors include cigarette smoking and being overweight). High blood pressure can harm the arteries, causing them to narrow faster, resulting in less blood getting to the brain. If a blood clot blocks one of the narrowed arteries, a stroke (thrombotic stroke) may occur. A stroke can also occur when very high pressure causes a break in a weakened blood vessel in the brain (hemorrhagic stroke).</p> <p>Eleven states—Alabama, Arkansas, Georgia, Indiana, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia—have such high rates of stroke among persons of all races and in both sexes that they are called the "Stroke Belt States."</p>
Enlarged Heart (Cardiomyopathy)	Often the heart enlarges to be able to generate the force needed to pump against the arteries or in order to accommodate large amounts of blood. High blood pressure, therefore, causes the heart to work harder. Over time, this causes the heart to thicken and stretch. Eventually the heart fails to function normally, causing fluids to back up into the lungs. Controlling high blood pressure can prevent this from happening.
Other Problems	High blood pressure can also damage other vital body organs. In the case of the kidneys, which normally act as a filter to rid the body of wastes, high blood pressure can, over a number of years, narrow and thicken their blood vessels. As a result, the kidneys filter less fluid and waste builds up in the blood. The kidneys may fail altogether. When this happens, dialysis (the mechanical filtering of the blood via machine) or a kidney transplant may be needed.

Controlling High Blood Pressure

An inflatable cuff around an arm is used to measure blood pressure. If the pressure is high, the test will be repeated on several days to get an accurate reading. Blood pressure is high if the systolic pressure is 140 or above, if the diastolic pressure is 90 or above, or both are high.

Those with high blood pressure often do not feel sick. In fact, high blood pressure is often called "the silent killer," because it may cause no symptoms for a long time. Women who have both diabetes and high blood pressure are





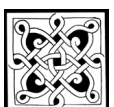
at an even higher risk of stroke, heart, and kidney problems than those who have only high blood pressure.

Blood Pressure Categories for Adults:

Category	Systolic**	Diastolic**	
Normal	<130	<85	
High Normal	130-139	85-89	
High Blood Pressure			
	Stage 1	140-159	90-99
	Stage 2	160-179	100-109
	Stage 3	180-209	110-119
	Stage 4	≥210	≥120
Key	" < " means less than " ≥ " means equal to or more than		
* <i>These categories for those 18 and older are from the National High Blood Pressure Education Program. The categories are for those not on a high blood pressure drug and with no short-term serious illness.</i>			
** <i>If the systolic and diastolic pressures fall into different categories, your overall status is the higher category.</i>			

Recommended Steps for Controlling Blood Pressure:

1. Lose weight if overweight.
2. Become physically active.
3. Control other medical problems, such as diabetes (*see Section 7: Diabetes*), which may worsen the body's reaction to blood pressure (and result in organ damage).
4. Limit alcohol intake.
5. If prescribed, take high blood pressure pills.
6. Limit nicotine intake (i.e.: stop smoking!).
7. Choose foods low in salt and sodium.





Journey of Hope

Tips to Cut Back Salt & Sodium:

1. Add less salt at the table and in cooking. Try reducing the amount a little at a time until you use none.
2. Season with black or green pepper, garlic, ginger, minced onion, or lemon juice.
3. Use fewer prepared sauces, mixes, and "instant" products, such as flavored rice, pasta, and cereals. These usually have salt added.
4. Store-bought snacks tend to be particularly high in sodium. To help cut back on sodium, snack on:
 - ❖ Bagels, raisin toast, or English muffins.
 - ❖ Air-popped popcorn with no salt or butter.
 - ❖ Unsalted pretzels and crackers.
 - ❖ Low-fat cookies (animal crackers, fig bars, ginger snaps).
 - ❖ Fruit juices and drinks.
 - ❖ Nonfat frozen yogurt, sherbet, and popsicles.
 - ❖ Hard candy or jelly beans.
5. Use vegetables that are fresh, or those that have been frozen or canned without added salt.
6. Check nutrition labels for a product's amount of sodium. Cans, boxes, bottles, and bags have these labels. Look for products that say "sodium free," "low sodium," "reduced sodium," "less sodium," "light in sodium," or "unsalted."
7. Ask a doctor before trying salt substitutes. These contain potassium chloride and can be harmful for women with certain medical conditions.





The Main Types of High Blood Pressure Drugs

Diuretics	These are sometimes called "water pills" because they work on the kidney and flush excess water and sodium from the body through urine, thus reducing the amount of fluid in the blood. Since sodium is flushed out of blood vessel walls, the vessels open wider and pressure goes down. There are different types of diuretics. They are often used with other high blood pressure drugs.
Beta blockers	These reduce nerve impulses to the heart and blood vessels. This makes the heart beat less often and with less force. Blood pressure drops and the heart works less hard.
Angiotensin antagonists	These are a new type of high blood pressure drug. They shield blood vessels from a hormone called angiotensin II, which normally causes vessels to narrow. As a result, the vessels are wider and pressure lowers.
Angiotensin converting enzyme (ACE) inhibitors	These prevent angiotensin II from being formed. They relax blood vessels and pressure goes down.
Calcium channel blockers (CCBs)	These keep calcium from entering the muscle cells of the heart and blood vessels. Blood vessels relax and pressure goes down. <i>(Note: One short-acting type of CCB has been found to increase the chance of a repeat heart attack. Short-acting CCBs are taken several times a day.)</i>
Alpha blockers	These work on the nervous system to relax blood vessels, allowing blood to pass more easily.
Alpha-beta blockers	These work the same way as alpha blockers, but they also slow the heartbeat like beta-blockers do. As a result, less blood is pumped through the vessels.
Nervous system inhibitors	These relax blood vessels by controlling nerve impulses.
Vasodilators	These open blood vessels by relaxing the muscle in the vessel walls.

Fast Facts

1. When blood pressure is lowered, the heart does not have to work as hard. As a result, women who have had a heart attack are less likely to have another if they reduce their blood pressure.
2. Drinking too much alcohol can raise blood pressure. Most women with high blood pressure, however, can have an occasional drink. Also, those trying to prevent high blood pressure can drink if they do so in moderation.





Journey of Hope

3. Research shows that eating lots of fruits and vegetables and low fat dairy products can lower blood pressure—as much as some medicines. Such foods supply plenty of potassium and calcium. Potassium is especially important for blood pressure and eating foods rich in potassium seems to help prevent high blood pressure. Most women get enough potassium in everyday foods. Good sources of potassium are many fruits and vegetables, some dairy foods, and fish.
4. Some populations with low intakes of calcium have a higher incidence of high blood pressure—it is not yet clear if the higher rates are from a lack of calcium or an as-yet-unknown cause. Women also need calcium to prevent osteoporosis, a severe thinning of bones (it tends to develop after menopause) that can lead to fractures. For women, 1,000-1,500 milligrams of calcium daily is mandatory. Good sources are dairy foods, such as milk, yogurt, and cheese—but be sure to choose low or nonfat types. They have as much or more calcium, but with less fat and fewer calories. If milk causes digestive discomfort, try yogurt or some lactose-free dairy products.
5. Scientists think a diet low in magnesium may cause an increase in blood pressure; however, they are not sure whether the increase is from the lack of magnesium or some unknown factor. A healthy diet provides sufficient amounts of magnesium. Good sources are whole grains, green leafy vegetables, nuts, and dry peas and beans.

Activities

List Game:

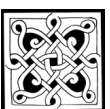
1. List the three causes of hypertension.
2. List five ways to prevent hypertension.
3. List five complications of hypertension.
4. List five risk factors for getting hypertension.

Diaries:

1. Individual exercise plans, goals, and method of evaluation of progress.
2. Diary review of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise plan review.

How-To Seminars:

1. Videotape on hypertension.





2. How to prevent hypertension.
3. How to monitor blood pressure at home.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

Field Trips

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, and swimming pools—free versus paying centers.
3. Trips to community clinics.

Speakers

1. Nutritionists, internists.
2. Different exercise instructors, gurus, and specialists in the martial arts of Tai Chi, Tai Kwon Do, etc.
3. Aerobic specialists.
4. Weight-loss experts.

Evaluation

Part I: Use the following questionnaire to determine whether the section's objectives have been met and how much information the participants have retained.

Part II: Students' opportunity to ask the trainer questions. (Trainer should feel free to rely on own initiative and experience when answering questions. The "fast fact" section is a resource.) Encourage students to ask questions about the different topics covered.

Part III: Feedback about lectures and presentations. What works what doesn't, what needs work, and suggestions.

Part IV: The trainer's own reflections. Have I learned anything? Would I do anything differently?





Hypertension Evaluation Questionnaire

1. What are the different benefits between taking medication for and the prevention of hypertension?
2. What are the risk factors?
3. What are the roles of diet and exercise in hypertension prevention?
4. What are the roles of diet and exercises on managing hypertension?
5. What are the special recommendations regarding pregnancy and adolescents?
6. Where are the gymnasiums and physical activity centers in the community?
7. What activities might you start with your family?





Section 7: Diabetes

Objectives

Participants will—

1. Learn about diabetes and methods to prevent it.
2. Discuss the complications of the disease.

Materials

1. Diabetes Assessment Questionnaire
2. Diabetes Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Diabetes is a very old disease—written records of it date back to 1550 BC; however, it was relatively rare until the 20th century. An estimated 16 million Americans currently suffer from diabetes mellitus (DM), and approximately half of these cases are undiagnosed. DM is the seventh leading cause of death in the United States.

Diabetes has two forms—Type 1 and Type 2. Nine out of ten people with diabetes have Type 2 diabetes. Type 1 diabetes is, at least initially, much more serious than Type 2. Type 1 diabetes is sometimes referred to as insulin-dependent diabetes. It used to be known as juvenile diabetes because most people develop it when they are children or teenagers. Type 2 diabetes is known as non-insulin-dependent diabetes. In the past it was often referred to as adult-onset diabetes because it usually occurs after age 40. Unlike Type 2 diabetes, there is no known way to prevent Type 1 diabetes.

Diabetes is a metabolic disorder—as a result, the body's normal metabolic processes, by which food is broken down into energy, do not function properly. Food eaten is usually broken down by digestive juices into chemicals, including a simple sugar called glucose. Glucose is the body's main source of energy. After digestion, glucose passes into the bloodstream, where it is available for cells to take up and utilize immediately or store for later use. The hormone that allows cells to take up glucose is insulin. Insulin acts as a "key" that unlocks "doors" on cell surfaces to allow glucose to enter the cells.





Journey of Hope

Insulin is produced by special cells (called islet cells) in the pancreas, an organ that is about six inches long and lies behind your stomach. In healthy people, the pancreas automatically produces the right amounts of insulin to enable glucose to enter cells. In people who have diabetes, cells do not respond to the effects of the insulin that the pancreas produces. If glucose cannot enter cells, it builds up in the bloodstream. The buildup of glucose in the blood—sometimes referred to as high blood sugar or hyperglycemia (which literally means "too much glucose in the blood")—is the hallmark of diabetes.

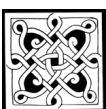
When the glucose level in the blood goes above a certain level, the excess glucose flows out from the kidneys (the two organs that filter wastes from the bloodstream) into the urine. The glucose takes water with it, which then results in increased or frequent urination and the person affected becomes extremely thirsty. These two conditions—frequent urination and unusual thirst—are usually the first noticeable signs of diabetes. Another symptom is weight loss, which results from the loss of calories and water in the urine.

In Type 1 diabetes, the pancreas cannot make enough insulin to help glucose get inside the cells. This usually occurs when the cells in the pancreas (that make insulin) are attacked by body's own immune system, which mistakes these insulin-producing cells for germs and tries to destroy them. Physicians do not know what the exact trigger is that causes this to happen; some think a virus may be the cause. People with Type 1 diabetes cannot survive for long without insulin, and must give themselves shots of insulin every day.

Considering its anthropological history, Diabetes is an important topic with regards to the refugee population. Over thousands of years, the human body has become very good at converting digested food into fat and storing the fat in cells to use later for energy. This ability to store food as fat was helpful for our ancestors, who often went long periods without food. When food was scarce, their bodies could rely on the stored fat for their energy needs. When there is too much food around, however, the ability to store fat can be a serious problem. When we gain weight, the extra weight causes our cells to become resistant to the effects of insulin. The pancreas responds by producing more and more insulin, which eventually begins to build up in the blood.

High levels of insulin in the blood lead to a condition called insulin resistance, which may cause problems such as high blood pressure and harmful changes in the levels of different fats (cholesterol) in the blood. Insulin resistance is the first step on the path to type 2 diabetes.

The second step to Type 2 diabetes is a condition called impaired glucose tolerance. Impaired glucose tolerance occurs when the pancreas becomes exhausted and can no longer produce enough insulin in response to blood glucose levels. Glucose then begins to build up in the blood. If this problem is





not diagnosed and treated in time, this gradual rise in glucose often leads to Type 2 diabetes, high blood pressure, and heart disease.

The reason that Type 2 diabetes is now widespread in every industrialized country in the world (more than 14 million Americans have Type 2 diabetes) is because increasing numbers of people are eating more, exercising less, and becoming overweight (obese). Also, as the population ages, more and more people are developing Type 2 diabetes, which usually occurs after age 40.

Type 2 diabetes is considered to be a "silent disease" because it works its destruction over many years without causing any noticeable symptoms. As a result, half of the people with Type 2 diabetes are not aware of it.

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

1. Cultural attitudes towards diabetes and exercise—some may find it offensive/accusatory, some may not understand the necessity for prevention.
2. Special requirements and precautions are necessary for pregnant women.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about diabetes and to be an introduction to cultural biases regarding this disease.

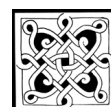
Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as participants' needs indicate.





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10. Do you have or have had the following: high blood pressure, an abnormal glucose tolerance or cholesterol test, or given birth to a larger than nine-pound baby?





Outline/Lesson Plan

Symptoms of Diabetes

Risk Factors for Diabetes

Tests for Diabetes

Complications from Diabetes

- *Damage to Blood Vessels*
- *Heart Disease & Stroke*
- *Nerve Damage (Neuropathy)*
- *Peripheral Vascular Disease*
- *Eye Damage*
- *Kidney Disease*

Methods to Prevent Diabetes-Related Complications

Preventing & Managing Diabetes

- *Examples of Good Eating Habits*
- *Eating a Healthy Diet & Getting the Essential Nutrients*
- *Exercise*
- *Medications*

Diabetes during Pregnancy

Intervention Strategies

- *List Game*
- *Diaries*
- *How-To Seminars*

Activities

Field Trips

Speakers

Evaluation

Symptoms of Diabetes

- ❖ Frequent urination.
- ❖ Unusual thirst.
- ❖ Extreme hunger.
- ❖ Unexplained weight loss.
- ❖ Extreme fatigue.





- ❖ Blurred vision.
- ❖ Irritability.
- ❖ Tingling or numbness in the legs, feet, or hands.
- ❖ Frequent infections of the skin, gums, vagina, or bladder.
- ❖ Itchy skin.
- ❖ Slow healing of cuts and bruises.

Risk Factors for Diabetes

- ❖ Age 45 years or older (If the results are normal, testing should be repeated at 3-year intervals.).
- ❖ Obesity.
- ❖ First-degree relative with diabetes.
- ❖ High-risk ethnic group (eg, African-American, Hispanic, Native American).
- ❖ Have given birth to a baby weighing more than nine pounds or have been diagnosed with gestational diabetes.
- ❖ Hypertension.
- ❖ A high-density lipoprotein cholesterol level of less than 35 mg/dL or a triglyceride level of 250 mg/dL or above.
- ❖ Impaired glucose tolerance or impaired fasting at a previous testing.

Tests for Diabetes

The following are tests that physicians perform to determine whether or not a person has diabetes.

- ❖ Fasting glucose test
- ❖ A fasting plasma glucose test is a blood test that measures blood glucose level after 10 to 16 hours of fasting, usually overnight.
- ❖ Oral glucose tolerance test. For this test, the individual is asked to eat a diet rich in carbohydrates (foods such as whole grains, dried beans, and vegetables) for 2 or 3 days and then to fast overnight (or for 10 to 16 hours) before the test. Then the person is given

1. A fasting glucose test.





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2. Then they are asked to drink a sweet-tasting glucose liquid.
3. Next, samples of the blood will be taken at every 30 minutes for a period of 3 hours. (Person may be asked to lie or sit quietly during the time because any amount of exercise can lower his/her glucose level, which would change the results of the test.)

Complications from Diabetes

Diabetes can have serious long-term complications. Over time, if the blood glucose level is not carefully controlled, diabetes can cause the following:

Damage to Blood Vessels:

The best way to avoid these serious complications is to maintain your blood glucose level in a healthy range.

Heart Disease & Stroke:

There is an increased risk of developing heart disease as a result of changes in the body's chemistry. One of the effects of these changes is the buildup of fatty deposits inside the arteries, the blood vessels that carry blood to the heart. These deposits are made up mostly of cholesterol, and can narrow the arteries and reduce the flow of blood to the heart or brain. If a fatty deposit gets too large, it can totally block blood flow through the blood vessel, causing a heart attack (damage to the heart muscle from lack of oxygen) or stroke (damage to the brain from lack of oxygen).

Symptoms of heart disease include:

- ❖ Mild tightness or heaviness in chest.
- ❖ Severe pain or pressure in chest.
- ❖ Chest pain or shortness of breath during physical activity, such as climbing stairs.
- ❖ Relief of chest pain brought on by physical activity shortly after the activity is stopped.
- ❖ Nausea, sweating, or dizziness.
- ❖ Difficulty breathing.
- ❖ Nerve damage.





Nerve Damage (Neuropathy):

This affects half of all people with diabetes. An uncontrolled high glucose level reduces the ability of nerves to carry messages (such as the sense of feeling) to various parts of the body, including the feet and legs, bladder, digestive tract, and reproductive system.

When feeling in the feet is reduced, they become easy to injure and not even know it. Reduced blood flow can slow the healing of even small cuts, which can become infected—which if it does not heal well can cause the tissue to die (gangrene). In severe cases, the toes may have to be amputated in order to save the rest of the foot and leg.

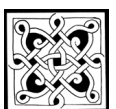
Depending on the nerves that are affected, a person may experience one or more of the following symptoms:

- ❖ Loss of feeling.
- ❖ Muscle weakness.
- ❖ Tingling, burning, or jabbing feelings.
- ❖ Fainting.
- ❖ Vomiting.
- ❖ Frequent bladder infections.
- ❖ Diarrhea.
- ❖ Sexual problems, such as impotence in men or an inability to achieve orgasm in either sex.
- ❖ Peripheral vascular disease.

Peripheral Vascular Disease:

This is a narrowing of the blood vessels that deliver blood to the extremities—hands, feet, and legs. The term "peripheral" means "outer"; "vascular" means "relating to blood vessels." Without a regular supply of nourishing oxygen-rich blood, the tissues that are farthest away from the heart can die. In severe cases, part or all of a foot or leg may need to be amputated.

Peripheral vascular disease can cause the following symptoms: pain in your thigh, calf, or buttocks during physical activity that is relieved upon cessation of the activity, infections that heal poorly, itchy skin, shininess of the skin on the legs, and loss of leg hair.





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Eye Damage:

Diabetes can damage the small blood vessels that supply the back of the eye, causing them to leak blood or other fluid into the eye. This condition, called diabetic retinopathy, is a major cause of blindness in people between 25 and 74. Having diabetes also increases risk of other vision-robbing eye disorders such as cataracts (clouding of the lens of the eye) and glaucoma (buildup of pressure from fluid inside the eye). These eye problems are sudden and may go unnoticed until they have progressed quite far. Diabetics should have their vision examined every year. Detecting retinopathy early can help prevent blindness.

People with the following symptoms should see their physician immediately:

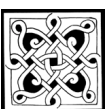
- ❖ Blurred vision.
- ❖ Seeing double.
- ❖ Seeing spots.
- ❖ Pain in one or both eyes.
- ❖ Feeling of pressure in one or both eyes.
- ❖ Inability to see to one side.
- ❖ Difficulty reading.

Kidney Disease:

Diabetes can cause narrowing of the blood vessels that carry blood to the kidneys, reducing the kidney's ability to filter out and eliminate wastes. Diabetes can also damage the kidneys by causing frequent infections of the urinary tract. In order to prevent damage to the kidneys, it is important to keep glucose levels under control.

Methods to Prevent Diabetes-Related Complications

1. Inspect feet every day for scratches, cuts, blisters, ingrown toenails, or warts on the soles of your feet (called plantar warts)—refer to physician.
2. Immediately report signs of infection, burning, tingling, or numbness in your feet to a doctor.
3. Do not cut or treat corns or calluses. Have a doctor remove them.
4. Make sure your doctor examines your feet at each visit.
5. Wash your feet every day and dry them well, especially between the toes.





6. Check inside shoes for pebbles, gravel, or other objects that could cause a cut or blister.
7. Break in new shoes slowly.
8. Wear comfortable, well-cushioned shoes that do not pinch at the toes or scrape at the heel. Try wearing shoes that are a half size larger than you normally wear. Do not wear high heels.
9. Change socks every day. Cotton socks, which absorb moisture, are best. Smooth socks or panty hose over feet carefully, leaving no lumps that could cause chafing or blisters.
10. Never walk barefoot—even in own home.
11. Absolutely no smoking. Smoking reduces blood flow to feet.
12. To prevent ingrown toenails and infections, be extra careful with trimming toenails. Cut nails straight across from side to side (ask your doctor to show you how). If there is numbness in your feet, have someone else trim your nails.
13. Do not test the bath-water temperature with feet.

Preventing & Managing Diabetes

The best way to prevent diabetes is to follow a healthy lifestyle, which is recommended for everyone. Eating a well-balanced diet that is low in fat and rich in high-fiber foods such as whole grains, vegetables, and legumes (beans and peas) can help ensure that the body has all the nutrients it needs to stay healthy. Along with eating a healthy diet, it is essential to keep weight down and exercise regularly (*see Section 1: Nutrition*).

Even a small amount of weight loss can be helpful. If a person is 40 pounds overweight, losing just 10 to 15 pounds may be sufficient to bring glucose down to a healthy level. In fact, some may be able to avoid diabetes altogether by maintaining a lower weight. Weight loss can also improve cholesterol levels and blood pressure, which are worsened by diabetes.

Weight lost gradually—one to two pounds a week—is more likely to stay off over the long term. A habit of nutritious eating, in addition to resulting in weight loss, will help improve overall wellness.

Examples of Good Eating Habits:

1. Stop eating when full.
2. Watch appetite when eating with other people. People tend to eat more when dining with friends or family than when dining alone.





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3. Eating several small meals and nutritious snacks throughout the day; this is healthier than eating one large meal.
4. Don't skip meals. If a person eats too little, their body will respond by burning fewer calories.
5. Eating breakfast sparks the body's calorie-burning furnace and helps it burn more calories throughout the day.
6. Avoid alcohol or limit to one drink a day if a woman, two drinks a day if a man.
7. Get most calories from starchy foods, such as whole-grain breads and cereals, pasta, and potatoes. These foods are less likely to be stored as fat.
8. Lose weight by limiting fat—reducing the amount of fat eaten can help with weight loss because when fat is cut out extra calories usually are eliminated too. It's also a good habit to continue over the long term because a low-fat diet can help keep cholesterol under control. An easy way to limit the amount of fat eaten is to read the nutrition facts on the labels of all packaged foods when shopping for groceries. The label details how many grams of fat are in each serving of the food. A good rule of thumb is to buy only those foods that have less than 3 grams of fat for every 100 calories in a serving.

Additional Tips for Limiting Fat:

- ❖ Eat more vegetables, fruits, and whole grains, which are usually low in fat as well as calories and provide a feeling of fullness.
- ❖ Eat meat in small portions—no larger than a deck of cards (about three or four ounces).
- ❖ Cook foods by baking, steaming, grilling, stir-frying, or microwaving, using little or no oil. Use nonstick pans or vegetable oil sprays.
- ❖ Avoid commercially prepared baked goods such as muffins, cookies, and croissants.
- ❖ Use nonfat salad dressing. The creamy nonfat salad dressings contain more starch than others so limit a serving of these to less than two tablespoons.
- ❖ Use egg substitutes (which are egg whites with food coloring) or substitute two egg whites for each whole egg a recipe calls for. (Egg whites contain no cholesterol and are lower in fat than yolks.)





The following lists the amount of fat recommended, relative to daily caloric intake.

Calories/day	Grams of Fat/day
1,200	40
1,400	46
1,600	53
1,800	60
2,000	66
2,200	73
2,400	80

Eating a Healthy Diet & Getting the Essential Nutrients:

Diets should include a variety of foods that provide all the essential nutrients the body needs—carbohydrates, protein, fat, vitamins, minerals, fiber, and water. The American Diabetes Association (ADA) provides nutrition recommendations for the appropriate proportions of each of these nutrients that should be eaten each day. Doctors and/or dieticians can help people incorporate these recommendations into an eating plan they can live with.

Carbohydrates: Starches and sugars found in fruits, vegetables, and grains. These are the body's main source of energy. There are two kinds of carbohydrates—simple and complex. Complex carbohydrates are found in starchy foods such as pasta, bread, dried beans, rice, and potatoes. Simple carbohydrates, which are also called simple sugars, are found in fruits, vegetables, and milk as well as in table sugar, desserts, and other sweets.

The largest portion of a person's diet should consist of complex carbohydrates, as they are better for the body than simple ones. Complex carbohydrates provide fiber and a variety of vitamins and minerals and are usually low in fat. They also take longer to digest, which helps keep glucose under control.





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Tips for choosing healthy carbohydrates:

- ❖ Eat whole-grain foods such as whole-grain bread and crackers, bran cereal, or brown rice. They provide lots of nutrients and are high in fiber.
- ❖ Eat legumes (dried beans, peas, or lentils); they're an excellent source of fiber and a good substitute for meat (which provides no fiber).
- ❖ Eat starches made with little fat. Low-fat breads include bagels, tortillas, English muffins, and pita bread.
- ❖ Use whole-wheat or other whole-grain flours in cooking and baking.
- ❖ Choose pretzels, low-fat (baked) potato chips, or low-fat crackers.

Fat: Fat is a source of stored energy. When a person eats fat, it travels in the bloodstream. Insulin enables the body's cells to take in fat and store it for when it is needed. Fats have more calories than any other food—nine calories/gram, which is more than twice as many as carbohydrates and proteins have. Fat is found in foods such as meat, oils, nuts, milk and other dairy products, fish and poultry, snacks, and desserts.

Limit fat because it is usually a source of extra calories. Limit fat to no more than 25 to 30 percent of the total daily calories. Monounsaturated fats are the healthiest. These fats are found in olive oil and canola oil. Monounsaturated fats can have a beneficial effect on the cholesterol (fat) in the blood.

Polyunsaturated fats: Like monounsaturated fats, polyunsaturated fats, in moderation, can be beneficial for cholesterol levels. Polyunsaturated fats are found in vegetable oils such as safflower oil, corn oil, and soybean oil.

When vegetable oils are turned into solid stick margarine in a process called hydrogenation, they become harmful and can worsen cholesterol.

Saturated fat: Saturated fat is found in meats, dairy products, and tropical vegetable oils (such as palm oil and coconut oil). It is the least healthy type and the one that should be avoided. Saturated fat raises blood cholesterol more than any other kind of fat, so it should be limited to no more than 10 percent of the total daily calories. Foods highest in saturated fat include red meats, poultry skin, butter, whole milk products, ice cream, cheese, and some baked goods.





Cholesterol: This type of fat is found only in animal products, such as meat, fish, dairy products, poultry, and eggs. While essential for many bodily functions, the body makes most of the cholesterol it needs.

Exercise:

Exercise is just as important as diet in helping to prevent Type 2 diabetes (see *Section 4: Counseling to Promote Physical Activity*).

Medications:

There are medications, available in pill form, that lower blood glucose levels. Taking an overdose of glucose-lowering medicines, however, can lead to a condition called hypoglycemia (low blood sugar) and can be serious. It can make a person feel tired, confused, shaky, hungry, or sweaty.

Other possible side effects include loss of appetite, upset stomach, diarrhea, rashes, or itching.

Diabetes during Pregnancy

Some women develop a form of diabetes when they are pregnant that goes away after the baby is born. This is a form of Type 2 diabetes called gestational diabetes ("gestation" means "pregnancy"). Doctors believe that this form of diabetes occurs when a pregnant woman's pancreas cannot produce enough insulin to counteract the effects of a pregnancy hormone her body produces that causes insulin resistance. Risk factors for gestational diabetes are:

- ❖ Older than 30.
- ❖ Weigh more than 20 percent over ideal weight.
- ❖ Have a relative (parent or sibling) who has diabetes.
- ❖ Had a still-born child.
- ❖ A previous pregnancy with an unusually large baby (over nine pounds).

Most women are given a blood test for gestational diabetes during the 24th and 28th weeks of pregnancy. This is usually when gestational diabetes develops. (Women who are younger than 25 years, of normal body weight, have no family history of diabetes, and are not members of ethnic groups that have a high prevalence of diabetes need not be screened.)





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Intervention Strategies

1. Counseling to promote knowledge about diabetes is recommended for all children and adults.
2. Develop a method of presenting a diabetes prevention program that is culturally sensitive to the participants.
3. In counseling about diabetes prevention, emphasize the proven efficacy of nutrition and regular physical activity in reducing the risk for diabetes complications as well as coronary heart disease, hypertension, and obesity.
4. During counseling preparation, first determine what the person knows about diabetes and their physical activity levels, biases and barriers, then provide them with information on disease prevention.
5. Assist the participants in selecting appropriate types of nutrition programs. Factor in medical limitations, present disabilities, history of diabetes complication, and activity characteristics that both improve health (e.g., increased caloric expenditure, enhanced cardiovascular fitness, low potential adverse effects) and enhance compliance (e.g., low perceived exertion, minimal cost, and convenience).
6. Develop an agreed-upon method of evaluation based on the individual's goals at the beginning of therapy.
7. Measure progress over an agreed upon time period.

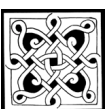
Activities

List Game:

1. List the three types of diabetes.
2. List five things about preventing diabetes.
3. List five complications of diabetes.
4. List five risk factors for getting diabetes.

Diaries:

1. Individual exercise plans, goals, and method for evaluation of progress.
2. Review of diary of weight gain, smoking cessation, and exercise duration times.
3. Graded exercise plan review.





How-To Seminars:

1. Videotape on diabetes and caring for a diabetic.
2. How to prevent diabetes.
3. How to monitor blood glucose levels at home.
4. How to avoid the pitfalls and abuse of some physical activity/lose weight fast programs.

Field Trips

1. Trips to gyms in the neighborhood.
2. Trips to different fields, tennis courts, basketball courts, or swimming pools—free versus paying centers.
3. Trips to diabetic clinics.

Speakers

1. Diabetologists, Internists and/or other doctors.
2. Different exercise instructors, gurus, specialists in the martial arts of Tai Chi, Tae Kwan Do, etc.
3. Aerobic specialists.
4. Weight loss experts.

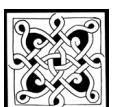
Evaluation

Part 1: Use the following questionnaire to determine whether the section's objectives have been met and how much information the participants have retained.

Part II: Students' opportunity to ask trainer questions. (Trainer should feel free to rely on own initiative and experience when answering questions. The "fast fact" section is available as a resource.) Encourage students to ask questions about the different topics covered.

Part III: Feedback about lectures and presentations; what works what doesn't, what needs work, and suggestions.

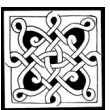
Part IV: The trainer's own reflections. Have I learned anything? Would I do anything differently?





Diabetes Evaluation Questionnaire

1. What are the different benefits of diabetes prevention programs?
2. What are the risk factors of diabetes?
3. What are the roles of diet and exercise in diabetes prevention?
4. What are the roles of diet and exercise on managing diabetes?
5. What are the special recommendations regarding pregnancy?
6. Where are the gymnasiums and physical activity centers in the community?
7. What activities might you start with your family?





Section 8: Gynecological Care

Objectives

Participants will—

1. Discuss women's health issues, including healthy habits about pregnancy, pap smears, etc.
2. Learn how to improve their families' overall wellness.
3. Learn about contraceptives and sexually transmitted diseases (STDs) and their prevention.
4. Become generally familiar with the American health care system.

Materials

1. Gynecological Assessment Questionnaire
2. Gynecological Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Of the two sexes, women have by far the most complex biological system—a system designed to undergo pregnancy, birth, and menopause. As a result of this complexity, women have special physical requirements that need to be taken into account and that are often overlooked or ignored when dealing with refugee populations.

Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

Differences to Consider

1. Cultural bias against contraception, fertility medication, etc.
2. Some women are very timid about touching themselves—be culturally sensitive.
3. Some women may have been victims of sexual abuse—this topic may strike a nerve.





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4. Female circumcision/Female genital mutilation is still a sensitive issue.
5. Some women may not be used to discussing personal issues openly, so great care needs to be taken.
6. Some issues may be religiously and culturally charged.

Assessment

The Gynecological Assessment Questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange about women's health and to be an introduction to cultural biases regarding gynecological care and other related issues.

Use the participants' answers to guide you as you use the curriculum. The material may be adapted or added to as the participants' needs indicate.





Gynecological Assessment Questionnaire

1. What kinds of care do women receive when they are well in your country?
Are women encouraged to see doctors when they are well?

2. Are there times when women, though well, should see doctors? Are you familiar with the recommendations about seeing doctors in America? If not, do you want to know what those recommendations are?

3. What is a Pap smear?

4. What is breast cancer?

5. Do you know what the common sexually transmitted diseases are? How to prevent them?

6. Are you aware of female circumcision/female genital mutilation (FC/FGM)?
The laws regarding FC/FGM in America?

7. What is a "normal" pregnancy?

8. What types of contraception are you familiar with?





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9. Are you familiar with the morning-after-pill?

10. Do you have any topics, besides those mentioned, that you wish to address today? If so, what are they?





Outline/Lesson Plan

Reproductive Health

- *Routine Gynecological Care*
- *Necessary Gynecological Care*

Pregnancy

- *Prenatal Care*
- *Exercise during Pregnancy*
- *Nausea & Vomiting*
- *Medications & X-rays during Pregnancy*

Family Planning & Contraception

- *Combination Oral Contraceptives*
- *Injectable Progestins*
- *Barrier Methods*
- *Intrauterine Devices*
- *Coitus Interruptus & Periodic Abstinence*
- *Sterilization*
- *Breastfeeding*
- *Family Planning & Islam*

Intervention Strategies

- *Breast Cancer*
- *Cervical Cancer*
- *Contraception*

Activities

- *List Game*
- *Diaries*
- *Exercises*
- *How-To Seminars*

Field Trips

Speakers

Evaluation

Reproductive Health

The lack of appropriate care can lead to or exacerbate many reproductive problems such as unwanted pregnancies; complications during pregnancy;





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cancer of the cervix, uterus, breasts, and ovaries; STDs; abnormal bleedings, and infertility. In order to address these problems properly, this section is divided into two parts: routine gynecological care and necessary gynecological care.

Routine Gynecological Care:

Proper routine care includes the following:

- ❖ A yearly physical
- ❖ A Pap smear (as necessary)
- ❖ Regular self breast exams
- ❖ Mammography (as necessary)
- ❖ Prenatal care and check-ups (as necessary)
- ❖ Contraception (as necessary)

The Pap Smear & Cervical Cancer:

About 14,500 cases of invasive cervical cancer (with approximately 4,500 deaths) are diagnosed yearly in the United States. The major risk factor for cervical cancer is a sexually transmitted infection caused by the human papillomavirus (HPV). Other risk factors include:

- ❖ Intercourse at an early age
- ❖ Multiple sexual partners
- ❖ The long-term use (>5 years) of oral contraceptives
- ❖ Low socioeconomic status
- ❖ Cigarette smoking

In both African-American and Caucasian women, the incidence of pre-cancerous cervical cell abnormalities reaches its peak between the ages of 20 and 30. After the age of 25, the incidence of invasive cancer in African-American women increases dramatically with advancing age; in Caucasian women, however, the incidence rises more slowly. Over 25 percent of invasive cervical cancers occur in women older than 65, and 40 to 50 percent of all women who die of cervical cancer are older than 65.

A Pap smear is a very simple process that involves obtaining a sample of cells from a woman's cervix. These cells are then examined in a lab for any abnormalities that would indicate the presence of a disease or





cancer. The full description of the Pap smear procedure is available in Appendix A: Health & Wellness—Section 5: Gynecological Care.

A Pap smear can easily detect cervical abnormalities before they become cancerous. Since the widespread adoption of the Pap smear, the result of early treatment has been an impressive 70 percent decrease in the number of incidents of and deaths from cervical cancer. Nonetheless, a large proportion of women, particularly elderly African-American women, refugees, and middle-aged women of lower socio-economic status, do not have regular Pap smears. In some geographic areas of the US, as many as 75 percent of women older than 65 have not had a Pap smear within the past 5 years.

While there is little specific information available with regards to refugees and Pap smears, economic conditions and other environmental variables of higher priority like safety and food make it difficult, if not impossible, for refugees to have regular health screenings. As a result, some women have quite probably not seen a doctor or any health professional in years, and their first contact with a physician is the mandatory physical exam required before resettlement. Furthermore, it is possible for refugees to acquire diseases and other health problems after passing their physical but prior to being resettled.

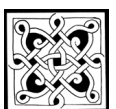
The time period between initial infection with HPV virus and the development of cervical cancer is 8 to 9 years. This long lead-time provides adequate opportunity to detect, via Pap smear, the presence of pre-cancerous or early-stage lesions and malignancies before the actual development of cancer. Despite this, it remains a severe problem for refugees, and is even the leading cause of death among Vietnamese refugee women.

For the U.S. Preventive Services Task Force's (USPSTF's) current recommendations regarding the use of the Pap smear see Appendix A: Health & Wellness—Section 5: Gynecological Care.

Breast Cancer & Mammography:

Breast cancer is the most common type of cancer in American women, and is the second leading cause of cancer death after lung cancer. As there is a little information regarding the incidence of breast cancer among refugee women, it can only be assumed that it is similar to that of women in the United States. According to the American Cancer Society (ACS), about 180,000 new cases of breast cancer are diagnosed each year in the United States with about 43,000 related deaths. While an American woman's average lifetime risk for developing breast cancer is approximately one in eight, death due to breast cancer increases consistently with age. Risk factors in addition to age include:

- ❖ A family history of breast cancer in a first-degree relative (sister or mother).





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- ❖ Childlessness (only a very modest increase in risk for this factor).
- ❖ First pregnancy after 30 years of age.
- ❖ Menstruation before 12 years of age.
- ❖ Menopause after 50 years of age.
- ❖ Postmenopausal obesity.
- ❖ Some types of benign (non-cancerous) breast disease.
- ❖ High socioeconomic status.
- ❖ A personal history of ovarian or endometrial cancer.

Since women who do not see their doctors regularly have an increased chance of dying from breast cancer, early detection is key. This is particularly important for refugee women, so the increased likelihood of early detection by breast self-exam and yearly physical check-ups should be emphasized.

The most effective approach to early detection of breast cancer is mammography. A mammogram is an x-ray of the breast. While there has been concern about radiation exposure, well-maintained, modern mammography equipment is very safe and uses only extremely low radiation levels.

Although it can detect small tumors in younger women, controversy exists regarding whether mammography screening is really useful in detecting tumors in women younger than 50. Screening does, however, carry the added risk of other problems attributable to unnecessary biopsies that are often performed following false-positive mammography results. As a result, recommendations for mammography are still controversial.

Some organizations believe that routine mammography screening (every 1 to 2 years) should begin at age 40, while most agree that it is necessary for women aged 50 and older. Many also recommend that screening continue until 70 years of age. For women 70 years of age or older, however, the American Association of Family Practitioners and the USPSTF state that there is insufficient evidence to recommend either for or against routine screening.

Mammography recommendations from other societies:

The American College of Preventive Medicine (ACPM) advises that women aged 70 or older should continue undergoing mammography screening provided their health status permits breast cancer treatment. However, the American College of Physicians discourages the use of mammography in women >75 years of age. Meanwhile, the American Geriatrics Society recommends that women >65 years of age receive mammograms at least every two or three years until at least age 85.





As a result of such conflicting information, women aged 70 and older should receive counseling about the differing mammography recommendations in order that they may make informed decisions regarding their health. Many healthcare organizations also recommend counseling about the potential risks and benefits of mammography and clinical breast exams for women under 50.

The decision about whether to screen or not to screen, therefore, should be left to the individual patient following counseling about potential risks and benefits.

Necessary Gynecological Care:

Necessary care addresses health problems such as:

- ❖ STDs
- ❖ Painful urination
- ❖ Abnormal bleeding
- ❖ Postmenopausal complaints
- ❖ Infertility

STDs:

Almost 12 million cases of STDs occur annually in the United States. Of these cases, 86 percent occur during the ages of 15 to 29. The list of STDs includes syphilis, gonorrhea, human immunodeficiency virus (HIV), chlamydia, genital herpes, HPV infection (*see previous subsection on Pap smears*), chancroid, hepatitis B, vaginitis, and ectoparasitic diseases (e.g. pubic lice, etc.)

Chlamydia is currently the most common STD in the United States, causing an estimated 4 million acute cases annually. The incidence of gonorrhea and syphilis decreased in the early 1990s, but they remain a persistent public health problem.

Acquired Immunodeficiency Syndrome (AIDS), which is caused by HIV, is the eighth leading cause of death in the United States. It is the leading cause of death among men aged 25 to 44, and the third leading cause of death among women of the same age group. No cure for AIDS currently exists, although treatment can delay onset of symptoms.

The consequences of STDs are particularly troublesome for women and children. Apart from AIDS, the most serious complications of STDs for women are pelvic inflammatory disease (PID) and an increased risk of cervical cancer, ectopic pregnancy, congenital infection and malformations, delivery of premature and low-birth-weight infants, and





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fetal death. Persons who are poor or lack medical care and racial and ethnic minorities contract a disproportionate number of STDs and the disabilities associated with them.

While the true incidence of STDs among refugee populations is not known, studies have shown that 12 percent of Vietnamese refugees test positive for syphilis; 42 out of every 100,000 Russian refugees are estimated to be infected with HIV; among Horn of Africa refugees, syphilis, gonorrhea, and Hepatitis B are common; and 5 percent test positive for syphilis and 7 percent test positive for HIV among Haitian refugees.

Individuals who are at increased risk for STDs (and HIV infection) include:

- ❖ Those who are or were recently sexually active, especially persons with multiple sexual partners.
- ❖ Those who use alcohol or illicit drugs.
- ❖ Gay or bisexual men who have sex with other men.
- ❖ Persons with a previous history of STD/HIV infection.
- ❖ Prostitutes and persons who are sexually active with infected prostitutes.
- ❖ Persons living in areas where the prevalence of HIV infection and STDs is high.

Other Gynecological Complaints:

Menopause:

Menopause is the natural ending of a woman's reproductive stage of life, which began with the onset of menstruation (usually at age 13 or 14); it occurs when a woman's ovaries stop producing estrogen. A number of symptoms are associated with menopause, the most common being hot flashes. Due to the profound reduction in estrogen availability, however, the full biological consequences of menopause are subtle. As estrogen levels decrease, the advantages of estrogen—such as its protective effect against heart disease and osteoporosis—are lost. As a result, during menopause estrogen supplements are often recommended and can be given in form of Estrogen Replacement Therapy (ERT).

Estrogen therapy after menopause helps to relieve vasomotor and urogenital symptoms (such as vaginal dryness and painful intercourse). It also reduces the incidence of health problems and death from coronary disease (a form of heart disease) and osteoporosis.

Recommendations about hormone therapy are best made on an individual basis, weighing probable benefits against the costs,





inconvenience, and possible adverse effects of estrogen and progestin (another reproductive hormone that is given as part of ERT). There is some evidence indicating that long-term use of hormones may increase the risk of breast cancer in older women; however, any increase in the incidence of death (if any exists) from breast cancer resulting from ERT is likely to be minimal. Regular mammography further reduces any risk, but participants will have to make their own decisions regarding the possible risks vs. the potential benefits of ERT. In fact, those women most likely to benefit from ERT include those with early or surgical menopause, those with other cardiac risk factors (especially an adverse cholesterol profile), and women at high risk of osteoporosis or fracture (women who are thin, smoke, or have a family history of fracture). Finally, since the risk of dying from heart disease is far higher than the risk of dying from breast cancer, doctors usually find it prudent to recommend ERT on an individual basis.

The participants should also understand that current estimates and recommendations are based on available knowledge, which is often incomplete, and may change with new information.

Painful urination:

Along with frequency, urgency, and sometimes blood in the urine (hematuria), painful urination is a classic symptom of bladder infection in women; however, menopause could also be the cause. If the painful urination is the result of an infection, this would be confirmed by a tender bladder (normally the bladder is not tender at all) upon examination by a doctor. Women should pay attention to pain during urination, as non-symptomatic (without symptoms) infection of the bladder is common and, if not detected, can lead to significant health problems such as kidney infections.

Loss of urine—Incontinence:

There are four main forms of urinary incontinence:

1. Loss of urine when coughing, sneezing, or straining (stress urinary incontinence).
2. Sudden, involuntary loss of urine accompanied by urgency (unstable bladder, irritable bladder, or a lack of appropriate coordination of bladder muscles [detrussor dysynergia]).
3. Involuntary loss of urine when getting up or standing.
4. Loss of urine at unpredictable times, which is not associated with urgency, frequency, or other activities.

Stress incontinence: Loss of urine when straining affects nearly all women at sometime in their life. If a woman's bladder is full enough and she strains hard enough, some urine will escape, due to the shortness of her urethra, the fragility of the normal





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continence mechanism, and its vulnerability to trauma during intercourse and childbirth. Genuine stress incontinence, which occurs more or less daily and requires the patient to wear a pad to avoid soiling her clothing, requires the attention of a gynecologist or urologist. Surgery is usually necessary to repair it.

Exercises to prevent/treat incontinence:

- ❖ Kegel exercises (periodic tightening of the muscles of the pelvic floor 10-15 times a day for 4 weeks).
- ❖ Frequent emptying of the bladder and "double voiding" (re-emptying the bladder 10-15 minutes after the initial void) to keep the bladder as empty as possible.
- ❖ Elimination of caffeine, alcohol, and tobacco (common bladder irritants) which may aggravate the incontinence.
- ❖ A course of oral antibiotics to eliminate any bladder infection that might be aggravating the incontinence.

Irritable bladder: Women with an "irritable bladder" will complain that when they have the urge to urinate, they must find a bathroom within one to two minutes or else they will involuntarily lose urine.

Because specialized instruments are needed to examine the urethra properly, women experiencing irritable bladder problems need to be examined by a gynecologist.

Abnormal bleeding:

Women experiencing abnormal vaginal bleeding need to be examined by a gynecologist.

Female Circumcision/Female Genital Mutilation (FC/FGM):

In many parts of the world, a type of circumcision (*for a more complete discussion, see Appendix D: Female Circumcision/Female Genital Mutilation*) is performed which involves the removal of clitoris, labia minora, and most of the labia majora (the Pharaonic type of infibulation). Circumcised women are at increased risk for infection and physical problems such as painful urination, intercourse, and labor. They also often suffer from profound psychological problems. Because circumcisions are often performed by traditional faith healers or midwives, women can also develop a hole between the vagina and bladder (Vesico-vaginal fistula) that causes them to leak urine. There is no health benefit to justify female circumcision and it is illegal to perform the procedure in the United States.





Pregnancy

Among refugees, the likelihood of complications during pregnancy is high, due to basic reasons, such as lack of prenatal care and access to care, malnutrition, stress, and infections. As a result, the need for prenatal care should be emphasized.

Prenatal Care:

While prenatal care is normally provided in a hospital or clinic setting, an awareness of the normal routine management of pregnant women may be helpful. The following prenatal care guidelines are recommended by ACOG.

- ❖ Routine visits: every 4 weeks until 28 weeks' gestation, every 2-3 weeks until 36 weeks' gestation, and every week from 36 weeks to delivery.
- ❖ Routine lab tests as early in pregnancy as feasible.
- ❖ Pap smear, Amniocentesis, or Chorio Vilionic Sampling (CVS) for women 35 or older at 10-17 weeks.
- ❖ A blood test of alpha-fetoprotein (AFP) levels to screen for fetal defects/abnormalities at 16-18 weeks. Both raised or depressed levels of AFP in the mother's blood can identify a problem pregnancy.
- ❖ A blood test of hemoglobin/hematocrit levels to screen for anemia (low levels of hemoglobin/hematocrit) at 26–28 weeks.
- ❖ A blood sugar test (glucose levels in the mother's blood) at 26–28 weeks to screen for gestational diabetes.
- ❖ Blood group and Rh testing of mother, followed by the administration of RhoGam (Rh immunoglobulin) if necessary (i.e.: the father is Rh positive) to Rh negative women to prevent the formulation of Rh antibodies that would endanger an Rh positive fetus.
- ❖ Estimating Gestational Age: A physician can use one of three methods:
 1. By menstrual period: The estimated delivery date is calculated by adding 280 days to the first day of the last menstrual period (LMP). An alternative method of determining the due date is to add seven days to the LMP, subtract three months, and add one year.
 2. By examination using a tape measure to determine the distance from the pubic bone up over the top of the uterus to the very top. That distance in centimeters is approximately equal to the weeks of gestation, from about mid-pregnancy until nearly the end of pregnancy.
 3. By the use of a sonogram very early in pregnancy.





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What to expect when visiting physicians office:

At each routine visit, the patient's weight, blood pressure, and fetal heart rate is recorded. The urine is tested for the presence of glucose and protein. By 17-18 weeks, the mother should start to feel the baby's movement (Quicking) and this should be recorded.

Exercise during Pregnancy:

In general, as long as the pregnancy is normal, moderate amounts of exercise, using the following guidelines, are acceptable.

1. Women should not start a new sport or exercise while pregnant, but may continue previous activities.
2. Activities which require a fine sense of balance to preserve the woman's personal safety are inadvisable (horseback riding, downhill skiing, etc.) because pregnant women are inherently and unavoidably unstable in their balance. Also, due to pregnancy-induced changes, the joints are unstable; it is, therefore, better to avoid activities which place great stress on any joints.

Nausea & Vomiting:

While common during pregnancy, it can be aggravated by strong smells (food, garbage, machine oil, etc.) and motion. Symptoms appear quite early and are usually mild, requiring no treatment; they generally disappear by the 16th week or sooner.

Medications & X-rays during Pregnancy:

No medication should be taken without physician's consent.

X-rays, however, are perfectly acceptable during pregnancy if there is a medical need for them (chronic cough, possible fracture, etc.). During the x-ray, the woman should shield the baby with a lead apron to minimize fetal exposure.

Family Planning & Contraception

While modern contraceptives have enabled women to increase control over their reproductive lives, in the United States 60 percent of all pregnancies are unplanned. Unplanned pregnancies affect women of all ages and circumstances, but their number is higher in certain population groups, such as teenagers (82 percent) and never-married women (88 percent). The consequences of these pregnancies in the United States include approximately 1.5 million abortions annually, children who are at increased





risk of health and behavior problems both in childhood and later in life, and pregnancies that have not benefited from risk identification and management.

Modern contraceptives marketed in the United States are safe and effective. Although most are relatively inexpensive, their costs vary.

Combination Oral Contraceptives (OCs):

The most popular method of reversible contraception, OCs are used by an estimated 10 million American women. The pill is generally taken daily for 21 days, followed by a sugar pill (used to mark time) or no pills for 7 days. The failure rate is about 3 percent per year with typical use and as low as 0.1 percent per year when used correctly and consistently.

The side effects, which include breakthrough bleeding, nausea, and breast tenderness, decline over time and in recent years have been minimized by lowering the dose of hormones. While there is an association between the early use of OCs and cardiovascular disease (myocardial infarction, stroke, and thromboembolic disorders), particularly in heavy smokers and older women, this is attributed to the blood-clotting effects of the higher hormone dose of the early OC formulations.

Any risks associated with current OCs seem to be minimal. Patient satisfaction is generally higher for OCs (94 percent) than most other methods. The lifetime risk of breast cancer is similar in OC users and nonusers, but some studies suggest a modest increase in early breast cancer among long-term users or those beginning OC use at a young age. The absolute increase in risk is small, may be due to factors other than OCs (e.g., delayed childbearing), and may not apply to current formulations. A modest increase in cervical cancer has also been reported, but the significance of this association is also controversial. Additional non-contraceptive benefits of OCs include a lower incidence of menstrual disorders, benign breast disease, uterine fibroids, and PID.

Postcoital administration of estrogen and progestin (Morning-after pill) can reduce subsequent pregnancy if initiated within 72 hours after unprotected intercourse. The best-evaluated regimen consists of two doses of 100 mg ethinyl estradiol and 1 mg levonorgestrel (i.e., two 50 mg combination OC pills), given 12 hours apart. Based on reported failure rates (0.2-7.4 percent), it is estimated to reduce the risk of pregnancy by 75 percent. Prominent side effects include irregular bleeding, nausea (up to 50 percent), and vomiting. Alternate regimens using danocrine (Danazol) have fewer side effects but have been less well studied. In two recent trials in Great Britain, mifepristone (RU 486) was as effective as, and better tolerated than, estrogen/progestin regimens for postcoital contraception. RU486 is not currently available in the United States.





Journey of Hope

Injectable Progestins:

Depot-medroxyprogesterone acetate (DMPA—i.e., Depo-Provera) and subdermal (under the skin) progestin implants (i.e., Norplant) provide long-term contraception without the need for a daily regimen. DMPA is administered 4 times a year as intramuscular (into the muscle) injections and has a failure rate of only 0.3 percent. Subdermal implants can be inserted and removed as an office procedure and provide effective contraception for up to 5 years. Satisfaction with subdermal implants seems high among selected groups, but it is not as high as with OCs. Common side effects with progestin-only contraceptives include irregular bleeding (up to 50-70 percent), headache, and weight gain. Cases of stroke and false tumors have been reported among Norplant users, but no causal association has been established.

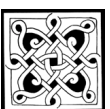
Barrier Contraceptive Methods:

These include the male and female condom and female barriers (such as the diaphragm, cervical cap, vaginal sponge, and vaginal film) used with spermicide. Barrier methods have fewer side effects than hormonal contraception, but average effectiveness is more variable due to inconsistent or incorrect use.

Latex condoms: When used reliably, condoms have a 3 percent failure rate, compared to 12-16 percent among average users. The female condom has failure rates comparable to other female barriers: 5 percent under perfect use and 20 percent under typical use. Cost (\$2.50) and unfamiliar appearance may be obstacles to regular use. Latex condoms (and presumably female condoms) also provide protection against HIV and other STDs. While condoms occasionally slip or rupture, most failure is due to inconsistent or improper use.

Diaphragms, cervical caps, & vaginal sponges: These have a failure rate of about 6 percent when used consistently, and 18-22 percent under average conditions. Among reliable users, failure rates appear higher (10 percent vs. 3 percent) in women who have frequent intercourse (>3 times per week). The cervical cap and contraceptive vaginal sponge are as effective as the diaphragm in women who have never given birth, but less effective in women who have (failure rates 20-36 percent). Both can be left in for longer periods than the diaphragm (24 hours); however, the only American manufacturer of sponges discontinued production in 1995.

Spermicides (foams, creams, and jellies): When used alone, they are estimated to have failure rates of 6 percent when used consistently and 21-25 percent under typical usage conditions. Both barrier methods and spermicides can reduce the risk of infection with gonorrhea and chlamydia, but effects on HIV transmission are uncertain.





Intrauterine Devices (IUDs):

These can provide very effective contraception (0.1-0.6 percent failure rate) for extended periods. Two IUDs are currently available in the United States: a copper IUD (Paragard), approved for continued use for up to 8 years, and a progesterone-releasing IUD (Progestasert), which should be replaced annually. The approval of a levonorgestrel IUD, which can be left in place for 5 years, is pending in the United States.

Coitus Interruptus (Withdrawal) & Periodic Abstinence:

These may be more acceptable alternatives for persons with religious objections to artificial contraception and others who are unwilling or unable to use other methods. It is often difficult to perform these methods correctly.

Abstinence during fertile periods can be based on the date of the LMP (calendar or "rhythm" method) or changes in temperature or cervical mucus (ovulation method). The ovulation method is more effective than the calendar method (1-3 percent vs. 9 percent failure rate under perfect use), but requires abstinence for approximately 17 days of each menstrual cycle. Coitus interruptus can fail if it is not timed properly or if pre-ejaculatory fluid contains sperm.

Due to these difficulties, the failure rates of withdrawal and periodic abstinence are 18-20 percent in actual practice. Combining these methods with other contraception during the woman's fertile period may improve effectiveness.

Sterilization:

This is the most common method of contraception in the United States and has no proven long-term risks. It differs from other methods in that it is intended to provide permanent contraception. The average failure rate is 0.1 to 0.2 percent for male sterilization (vasectomy) and 0.4 percent for female sterilization (tubal ligation). Between one and two percent of vasectomies are accompanied by side effects (hematoma, infection, or epididymitis) that soon stop. The complication rate from tubal ligation depends on the type of procedure (e.g., mini-laparotomy, laparoscopy, colpotomy), but is generally less than one percent. Within two years of the procedure, up to three percent of American women report regret over sterilization. Fertility can be restored in up to 50 percent of men after reversal of vasectomy, and up to 70 percent of women after reversal of tubal ligation. Sterilization does not protect against STDs, but tubal ligation is associated with lower risk of PID and ovarian cancer.





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Breastfeeding:

Breastfeeding is effective as a contraceptive method only if a woman is breastfeeding exclusively on her infant's demand (with no other food being given to the baby), if she is not menstruating, and if her infant is less than six months old. If any one of these three criteria are not met, then an additional method of contraception is advised.

Note: The above information on breastfeeding was taken directly from Reproductive Health in Refugee Situations: An Interagency Field Manual, 1999 UNHCR.

Family Planning & Islam:

Islam permits contraception as long as it does not separate marriage from its reproductive function. IUDs can be used as long as they do not cause abortion—use of the copper IUD or the Progestert is acceptable. Abortion is only permitted if the continuation of pregnancy poses a threat for the mother. Sterilization is frowned upon, and is only permitted when the woman has a reasonable number of children.

Islam allows the pursuit of pregnancy as long as Shari'a (Islamic law) is not broken. Artificial insemination and invitrofertilization are only permissible if the sperm used is that of the father/husband. Surrogate motherhood is not permitted.

Intervention Strategies

Breast Cancer:

1. Develop a method for explaining the need for breast self-exams and mammography (*see how to perform a breast self-exam in Appendix A: Health & Wellness—Section 5: Gynecological Care*).
2. Using video and other materials, discuss the devastating effects of breast cancer.

Cervical Cancer:

1. Develop teaching materials on cervical cancer.

Contraception:

1. Discuss the pros and cons of different contraceptive methods:
 - a. Starting with natural family planning, discuss
 - ❖ withdrawal,
 - ❖ the rhythm or calendar method,





- ❖ cervical mucus and the ovulation method, and
- ❖ breastfeeding.
- b. Emphasize the contraceptive advantages of condoms and other barrier methods.
 - ❖ Bring condoms to class and pass them around.
 - ❖ Bring a plastic penis to class and demonstrate the proper use a condom.
 - ❖ Bring a diaphragm, sponge, and cervical cap to class and demonstrate their use.
- c) Discuss the use of IUDs.
 - ❖ Bring a plastic model of an IUD for demonstration.
- d) Discuss the use of oral contraceptives
 - ❖ Bring an example of OC pills to class and explain how they work and how to take them.
- 2. Use this opportunity to discuss female hygiene, the use of tampons, and stable families.
- 3. Personalize your discussion, and get a firm commitment from each individual counseled.

Activities

List Game:

1. List five methods of contraception and family planning.
2. Identify three methods of contraception, then list three advantages and three disadvantages.
3. List five STDs.
4. List five signs and symptoms of STDs.
5. List three things about Pap smears.
6. List five reasons to do a breast self-exam and what to look for when performing one.
7. List five things that should be done when pregnant.





Journey of Hope

Diaries:

1. Encourage women to keep a health diary of doctors visits, weights, medications, menstrual periods, contraception method used, etc.
2. Review the diary individually.
3. Have drills about how to develop a diary for pregnancy.

Exercises:

1. Bring a speculum and allow women to handle it.
2. Bring a silicon- or water-filled breast, and demonstrate a breast self-exam.
3. Bring different types of contraception and, using a plastic pelvis, demonstrate how to insert female condom, cervical cap, diaphragm, etc.
4. Bring condoms and demonstrate how to properly fit it on a plastic penis.

How-To Seminars:

1. Videotapes on contraception, STD's, breast exams, Pap smears, and pregnancy.
2. Videotape on abortion as woman's right, however, use it to emphasize family planning.

Field Trips

1. Community clinics, radiology centers, etc. to demystify issues discussed.
2. Health departments.

Speakers

1. Gynecologists
2. Obstetricians
3. Nurse practitioners





Evaluation

Part 1: Use the following questionnaire to determine whether this section's objectives have been met and how much information people remember or retain.

Part 2: Opportunity for students to pose questions to trainer (Trainer should feel free to elaborate and use own initiative and experience).

Part 3: Feedback about lectures, what works, what doesn't, what needs work, and suggestions.

Part 4: The trainer's reflections: Have I learnt anything? What would I do differently?





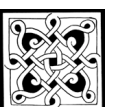
Gynecological Evaluation Questionnaire

1. What do you remember about STDs?
2. What are the STD prevention methods discussed?
3. What are the different contraception methods and how do you use them?
4. What should you expect when visiting a physician?
6. How do you do a breast self-exam?
7. What is the importance of the Pap smear and breast self-exam?
8. Were the class discussions helpful?





Section 9: Medications





MODULE V: DOMESTIC VIOLENCE

Objectives

Participants will—

1. Discuss the dynamics and definitions associated with domestic violence.
2. Learn about the American system of intervention by discussing prevention, identification, treatment, follow up, and reporting of spouse abuse (Physical—accomplished or threatened; Sexual—assaultive or nonassaultive, accomplished or merely threatened; Emotional or Mental—including failure to supply adequate food, clothing, shelter, or healthcare, or abandonment as defined by State or territorial statute).
3. Learn what family services are available in the United States (If required, the trainer will facilitate any necessary referrals to domestic violence support agencies.)
4. Improve the trainer's awareness of different cultures and their systems of addressing marital conflict.

Materials

1. Domestic Violence Assessment Questionnaire
2. Domestic Violence Evaluation Questionnaire
3. Flipchart
4. Markers

Introduction

Domestic violence is a social problem that is not only considered to be unacceptable, but is also illegal in the United States. A serious social problem for many Americans, it could be a more serious problem among the refugee population because of different cultural and religious influences on marriage.

The purpose of this module is to educate the participants about the American standard of assessment and treatment. This module covers the definition of domestic violence, how it is addressed in American culture, and how to seek advocacy if necessary.





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Note to Facilitators:

The intention of the information presented in this section is to provide a knowledge base for effective counseling on this topic.

In order to conduct this module properly, however, the trainer must be knowledgeable about the dynamics involved in domestic violence and must know how to refer a client for assistance if necessary. Before beginning this module, it is recommended that the trainer read all attached educational resources and explore resources in their specific region.

Methodology

1. Introduce the topic and inform the participants about the American definition of abuse and the intervention systems available. Initiate discussion on the participants' cultural views and practices regarding domestic violence. This will serve to educate the trainer about their cultures and the specific differences between American and their cultures' methods of intervention. Plan for follow-up as needed.
2. Handouts—distribute the wheels of power and control (*Diagrams 1 and 2*), and any other appropriate resources, to educate the group about the nature of abuse. Handouts should be selected based on the group members' level of interest.
3. Group discussion/evaluation regarding the information and its usefulness or lack thereof. If the participants determine that the intervention methods are not helpful for them, encourage discussion about what would be helpful.
4. If there are women who should be assessed for individual abuse, a separate private meeting should be held to continue the assessment. Personal disclosure during group meetings should be discouraged since this can leave the group member feeling vulnerable. She may regret her disclosure and this may effect the group dynamics. If disclosure occurs, gently suggest that the individual stay behind and discuss her situation privately. If necessary, refer her for follow up with an experienced domestic violence professional or a resettlement social worker. The trainer should not attempt treatment or intervention.



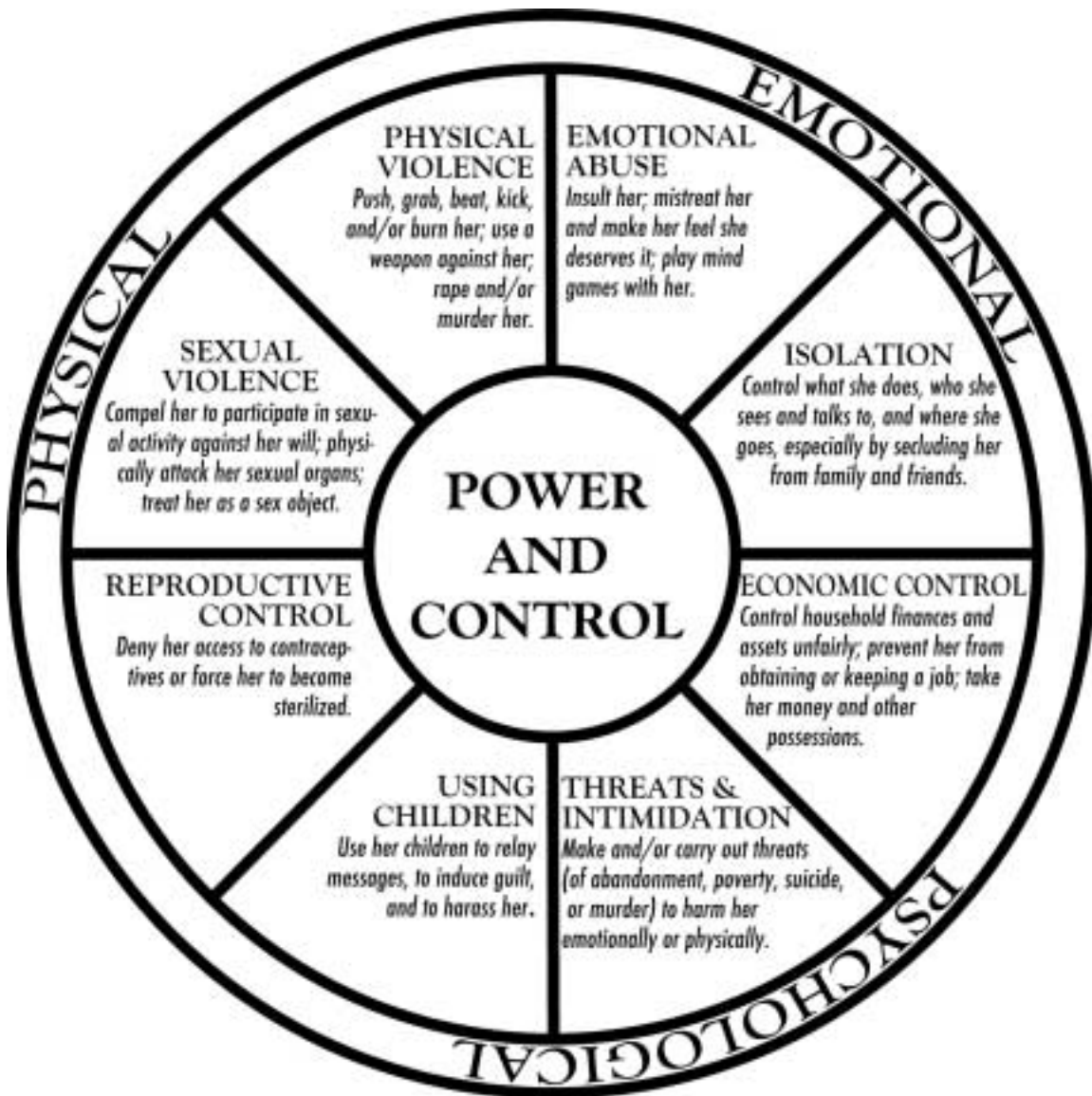


Diagram 1. This wheel demonstrates the various tactics of abuse that batterers use to control their partners.



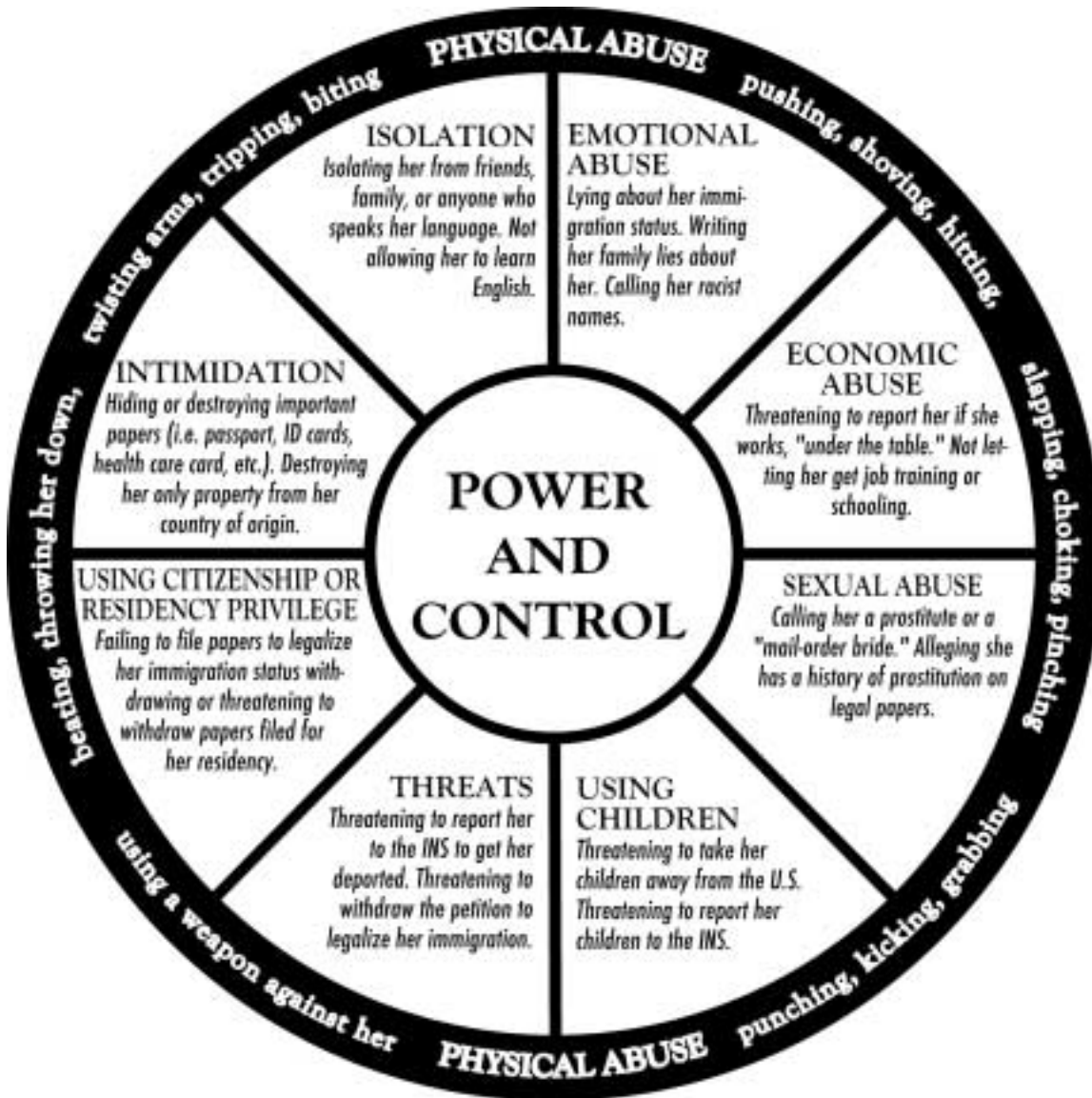


Diagram 2. This wheel focuses on the many ways that battered immigrant women can be abused.





Differences to Consider

Since the purpose of this module is to increase awareness of domestic violence, the information must be presented in a neutral way. The issue of domestic violence is perceived differently from person to person depending on their personal circumstances, cultural background, and awareness. In order to remain neutral and encourage group members to be comfortable with the topic, the subject should be presented as information that all women should have. It is also important to refrain from targeting any participant with personal questions.

If this were a group of abuse survivors, then individual circumstances would be acceptable for discussion. Remember that early disclosure of trauma, abuse, or mental health issues can cause a group member to feel uncomfortable and not return to the group. If a group member begins to disclose a personal abuse issue, promptly schedule some private discussion time for the purpose of referring her to a domestic violence professional.

Note to Facilitators:

Please remember that this is not a therapy group for victims. Consult with your local domestic violence program for assistance should you perceive a need for further discussion or intervention.

Assessment

The following questionnaire can be completed individually or as a group. It is designed to be an icebreaker to allow for cultural exchange and to be an introduction to cultural biases regarding domestic violence.





9. What behaviors are considered abusive in your country?

10. How is spouse abuse handled in your country?

11. How is violence in general perceived in your culture? Is the physical discipline of children acceptable?

12. What do you consider to be sexual abuse?

13. How is sexual abuse different from love between partners?

14. Do you feel safe at home?

15. Do you feel that your child is safe at home?

16. Are you satisfied with the way your partner disciplines your child?

17. Do you feel that your child is in harm's way by the way your partner disciplines your child?





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18. Do you know whom to call if you are hurt or afraid of your partner?

19. Are you familiar with shelters in your neighborhood?





Outline/Lesson Plan

Definitions of Abuse

- *Caution Concerning Labeling*

The Scope of the Problem

Risk Factors for Abuse

- *The Phases of Family Violence*

Typical Interventions

Fast Facts

Activities

- *List Game*
- *Diaries*
- *How-To Seminars*

Field Trips

Speakers

Evaluation

Definitions of Abuse

Domestic violence includes child abuse (physical and sexual abuse), domestic violence (physical or sexual abuse of spouse or intimate partner), and elder abuse (abuse or neglect of older persons). Any form of physical assault, including hitting, slapping, biting, or pushing, is considered abuse. Behaviors such as name calling, excessive rule making, and monitoring a person's whereabouts or denying them access to their money also fall within the definition of abuse.

It is important to be aware that different cultures and countries have different approaches to domestic violence. In Somalia, for instance, domestic violence is often considered to be a private issue to be addressed by family members only. The family honor may be seen as at stake and privacy is stressed. Extended family members such as parents, brothers, or uncles may become involved in mediation efforts to stop the conflict. Intervention, such as removing the woman from the home for safety, may also occur. It is also possible, however, for a woman to be encouraged to remain in an abusive relationship in order to preserve the honor of the family.

Islam does not condone domestic violence. Some people may argue that the Koran sanctions a husband hitting his wife because it is mentioned in one Surah (chapter); however, many scholars believe that in order to properly





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understand the Koran, the entire text must be read and taken into consideration. Please see References & Resources for more information.

Caution Concerning Labeling:

When discussing abuse, care must be taken not to label families as abusers, because cultural habits native to their countries could be considered as abuse in America. Understanding their cultural attitudes helps promote understanding and decrease anxiety about this very sensitive topic. For example, some Asian cultures have a view that suffering is inevitable and do not understand the nature of preventive services and other western health care technologies. Such misunderstanding often leads to mistrust and delay in seeking healthcare. Coining (rubbing a coin on the skin), hair pulling, cupping (filling a cup with burning paper, and placing it over the affected area), pinching, scratching, and other traditional practices can lead to inappropriate accusations of child abuse. Furthermore, the use of home remedies, herbal medicines, and healing ceremonies could cause the mislabeling of families.

The Scope of the Problem

Because many cases of family violence go unreported, the true magnitude of the problem can only be estimated. Though the prevalence of family abuse is not known among refugees, the consensus is that it probably parallels the situation in the United States, if not worse. In 1993, the child protective service agencies substantiated maltreatment of over 1 million children in the United States (a rate of 14/1,000 children) and over 1,028 deaths. Intentional injury is the leading cause of injury-related death in children under one year of age. Parents or other relatives are responsible for over 90 percent of reported cases of child abuse. In addition to physical injuries, children who have been victims of or witnesses to violence often experience abnormal physical, social, and emotional development; adolescents and adults who were abused as children are more likely to abuse tobacco and alcohol, attempt suicide, and exhibit violent or criminal behavior. For refugees in particular, this problem could be worsened by relocation and by previous experience with violence in their home country and in many refugee camps.

Note to Facilitators:

The following list may be adapted/translated into a handout.





Characteristics of Kids Living in Homes Where There Is Violence

—From CADA House

- ❖ Are lonely
- ❖ Feel isolated (tend not to bring friends home)
- ❖ Uses violence and threats to solve problems
- ❖ Has difficulty in developing close relationships (trouble separating self from conflict, trust)
- ❖ Blames self (fills in missing pieces of secret)
- ❖ Uses all energy to keep family secret (feels that if secret is known, then family will fall apart)
- ❖ Has a problem with trust (particularly of authority figures and peers)
- ❖ Development of "fantasy" world can go too far
- ❖ Has a fear of failure (afraid to try something new)
- ❖ Has limited physical expression (negative body image)
- ❖ Is accident prone
- ❖ Shame vs. guilt-based
- ❖ Confused about role in family (bad feelings about choosing sides, split alliance)
- ❖ Identifies with abuser—safer
- ❖ Reverses roles (sometimes encouraged by parent, sometimes from child—self-centered)
- ❖ Practices denial, minimizing (lose a piece of life, lapses in memory, mother-ambivalent)
- ❖ Exhibits pseudo maturity ("good kid")
- ❖ Exhibits developmental delays (repressed feelings, speech and motor, sensory)
- ❖ Is parent deaf
- ❖ Uses aggressive language, behavior
- ❖ Displays tantrums and other provocative behavior (only way to express)
- ❖ Is preoccupied with horror, violence
- ❖ Has an unusual degree of fear





Journey of Hope

- ❖ Associates love with violence
- ❖ Is overwhelmed with feelings of powerlessness, helplessness
- ❖ Fears abandonment
- ❖ Is pre-delinquent
- ❖ Displays regressive behaviors formed out of being unsafe, living in fear
 - bedwetting
 - babytalk
 - fear of dark
 - suddenly afraid to sleep
 - over/under eating
 - nightmares
 - phobias
- ❖ Runs away, expresses desire to leave home
- ❖ Other





In sexual abuse cases where the abuser was known to the child, over two-thirds involved abuse by family members. Girls are victims of sexual abuse two-and-a-half times more frequently than boys. Child sexual abuse often results in severe psychological trauma, has been associated with a variety of psychological problems persisting into adulthood, and can cause medical complications such as sexually transmitted diseases (STDs). Teens who have been sexually abused are significantly more likely than nonabused teens to be sexually active, to abuse alcohol or drugs, and to have attempted suicide.

Abusive mothers are often themselves victims of physical violence by their spouse or partner, and abusive parents often experienced abuse as children. Estimates of the prevalence of domestic violence among couples in the United States vary depending on the source of data and definition of violence. For example, over 1 million women (9.3/1,000) and nearly 150,000 men (1.4/1,000) are victims each year of assault, robbery, or rape committed by their spouse, ex-spouse, or intimate partner. Of these incidents, over half result in minor injury and three percent in serious injury (broken bones, loss of consciousness, hospitalization, etc.).

Family studies indicate that both men and women engage in violence against partners, but women are the primary victims of chronic battering and episodes leading to injury. Domestic violence tends to be repetitive—female victims reported an average of six violent incidents per year. The psychological consequences of abuse can be as important as physical injuries: abused women may suffer from posttraumatic stress disorder (PTSD) and they are more likely than nonabused women to be depressed, attempt suicide, abuse alcohol or drugs, and transfer their aggression to their children. This final consequence is of particular importance among refugees who have been forced to relocate and who already may feel powerless and fearful resettling in another country.

Risk Factors for Abuse

Risk factors include poor social support, low socioeconomic status, single parent families, and unplanned or unwanted pregnancy. Abuse, however, is usually the result of multiple interacting factors, and may be affected by abuse of drugs or alcohol, which are not clear independent risk factors. Refugees, because of low socioeconomic status and social isolation, are often at higher risk of abusing their spouse and children and, further complicating the situation, there can be a negative cultural bias in terms of treatment of women and children.

Women who are under age 35, have not attended college, are of lower socioeconomic status, or are unmarried are more likely to report being victims of domestic violence. One risk factor (the witnessing of parental violence as a child or adolescent) was consistently associated with being a battered





Journey of Hope

spouse. Pregnant women are also at risk from domestic violence. Many studies have reported an association between violence and worse outcomes in pregnancy—battered women are more likely to register late for care, suffer pre-term labor or miscarriage, or have low-birth weight infants.

The elderly are also vulnerable to physical or psychological abuse or neglect by family members or other caregivers. Factors that appear to increase vulnerability to abuse among older persons include poor or failing health, cognitive impairment, and lack of family, financial, or community support. The abuser is usually a relative, most often the spouse.

The Phases of Family Violence:

Abuse starts with Tension Building (tension and anger), leads into Battering/Abuse (batterer losing control and assigning blame, justifying reason for the battery), and finally to Contrition (batterer apologizes and promises not to repeat the incident). An understanding of the phases may help a victim plan their escape. (See *Diagram 3*.)

Note to Facilitators:

Diagram 3 can be adapted/translated into a handout.

There is also a continuum to family violence; for example, physical violence can go from simple pushing or shoving to punching, slapping, kicking, and choking to murder. Verbal and psychological abuse can go from name calling to isolation, then to threats, and finally to suicide. Sexual abuse could range from taking pictures to forced sex acts and rape. (See *Diagram 4*.)

Note to Facilitators:

Diagram 4 can be adapted/translated into a handout.

The sections about child discipline and self-esteem in Module II are also relevant to this module. The discipline section of Module II addresses child abuse and the self-esteem section addresses how family dynamics can impact the child. Both are important topics when dealing with domestic violence.





The Cycle of Violence

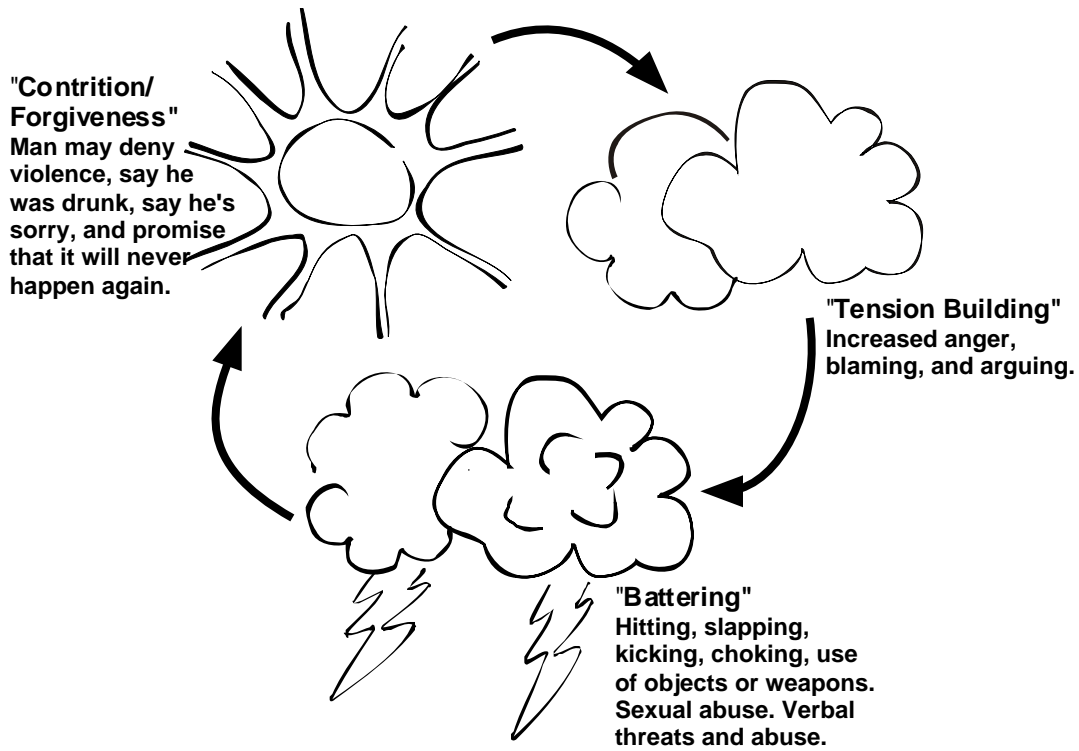


Diagram 3.





Continuum of Family Violence

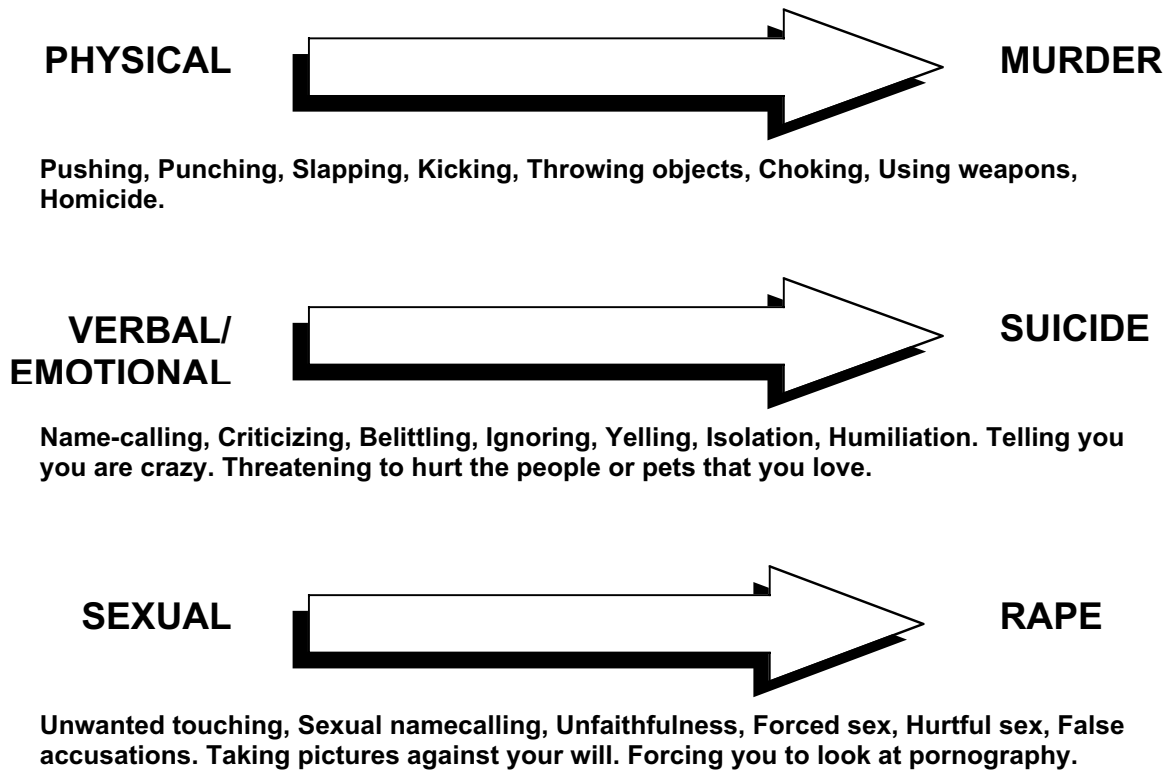


Diagram 4.





Typical Interventions

Typical interventions include social work services, law enforcement, the court systems, and sometimes even medical professionals. Most states have specific systems created to effectively address the issue of domestic violence. Women in the United States have the right to safety and independence.

Note to Facilitators:

The following lists may be adapted into translated handouts. Please refer to the educational resources provided in the Appendices, References, and Bibliography of this Manual for more detailed definitions of domestic violence, some information about the results of domestic violence, and for interventions.





Journey of Hope

Your Bill of Rights

- ❖ You have the right to be you.
- ❖ You have the right to put yourself first.
- ❖ You have the right to be safe.
- ❖ You have the right to love and be loved.
- ❖ You have the right to be treated with respect.
- ❖ You have the right to be human and imperfect.
- ❖ You have the right to be angry and protest if you are treated unfairly or abusively by anyone.
- ❖ You have the right to your own privacy.
- ❖ You have the right to have your own opinions, to express them, and to be taken seriously.
- ❖ You have the right to earn and control your own money.
- ❖ You have the right to ask questions about anything that affects your life.
- ❖ You have the right to make decisions that affect you.
- ❖ You have the right to grow and change (and that includes changing your mind).
- ❖ You have the right to say "No."
- ❖ You have the right to make mistakes.
- ❖ You have the right not to be responsible for other adults' problems.
- ❖ You have the right not to be liked by everyone.

**YOU HAVE THE RIGHT TO CONTROL YOUR OWN LIFE AND TO
CHANGE IT IF YOU ARE NOT HAPPY WITH IT AS IT IS.**





Laws for Battered Immigrants

- ❖ Domestic Violence is a crime.
- ❖ If anyone threatens to have you deported, he/she cannot. Only the INS can do that.
- ❖ If you are married to a U.S. citizen or legal permanent resident and this person is battering you, you may be able to get your green card (permanent residency) without your spouse's help.
- ❖ If you have a conditional green card and are waiting for your second interview, you may be able to apply for the **Battered Spouse Waiver**. This allows you to get your green card without your spouse at the second interview.
- ❖ If your spouse has never filed for your green card, you may be able to **Self Petition**, which means you can file for your green card completely on your own without your spouse's help or knowledge.
- ❖ If you are already in deportation proceedings, you may be able to apply for **Suspension of Deportation** as a battered immigrant. Contact an immigration or social service agency to find out if you can apply for your card through these laws. Do not try to submit an application on your own.
- ❖ You may get a divorce in the U.S. even if you are not a U.S. citizen or legal permanent resident and were not married in the U.S. You can get a divorce even if your husband does not agree. If you divorce in the U.S., only U.S. laws will be used by the court. If you are served with divorce or annulment papers, you should contact a lawyer immediately. An annulment or divorce could terminate your immigration status.
- ❖ If you testify in immigration court, you can request that the court provide an interpreter for you.





You Have Options!

As an immigrant, no one, not your spouse, partner, lover, or family has the right to hurt or beat you.

You have the right to:

- ❖ Make your own decisions about your life.
- ❖ Live without fear and violence in your home.
- ❖ Leave anyone who is hurting you physically, emotionally, or sexually.
- ❖ Seek protection from the police and courts.
- ❖ Seek shelter if you are trying to leave an abusive relationship.
- ❖ Seek medical services if you are hurt or injured.
- ❖ Seek immigration options for battered immigrants.

Suggestions

- ❖ Do not go to the INS without a lawyer or consulting with a lawyer. Your conversation with the attorney will be confidential and he/she cannot report you to the INS. If you cannot afford to pay an attorney, contact the nearest legal services office or call one of the immigration organizations.
- ❖ Battered women's shelters will often provide free housing and food for you and your children. They may also be able to help you find a job. Call the nearest shelter for information. In most states, your husband or the father of your children may be ordered to pay you money each month to support your children if he is employed.





Fast Facts

1. Ongoing abuse is often unrecognized. Victims of domestic violence can be identified through an interview, use of a standardized questionnaire, or a physical examination.
2. Questionnaires can identify risk factors for child abuse and neglect, but they also have the potential to falsely label families as "potential abusers."
3. Eliciting evidence of child physical or sexual abuse through an interview is difficult. Young children may not be able to answer reliably, both child and parent may be ashamed or fearful of admitting to abuse, and some abusive parents may not regard their use of physical punishment as abuse.
4. Most authorities recommend exploring for potential problems with open-ended, nonjudgmental questions about parenting and discipline (e.g., "What do you do when he/she misbehaves? Have you ever been worried that someone was going to hurt your child?").
5. In a survey of studies of sexually abused children, normal examinations were reported in up to 73 percent of girls and 82 percent of boys. As a result, the reliability of screening for abuse through a physical exam is unknown.
6. Studies have shown that home visits to high-risk families decrease the rate of child abuse and the need for medical visits early in life.
7. Recurrent abuse despite interventions may occur in up to 60 percent of cases. The effectiveness of treating sexual abusers of children remains controversial; one outpatient program reduced recurrence by half.
8. The effectiveness of early intervention for domestic violence is also difficult to determine. Most interventions for spouse abuse (e.g., shelters, legal action) are crisis oriented and are directed at women who have already been injured by domestic violence.
9. The options available to women are often limited by associated factors common in abusive relationships: financial dependence on an abusive partner, fear of retribution, alcohol or drug problems, or psychological vulnerability.
10. Legislation in all states requires health care professionals to report suspected cases of child abuse.





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Activities

List Game:

1. List five risk factors for domestic violence.
2. List five adverse effects of domestic violence on children.
3. List five social and medical problems associated with domestic violence.

Diaries:

1. Education plan: college workshops, GED (High School equivalency, resume workshops).
2. Diary review of abuse and neglect and counseling.
3. Self-esteem workshop.

How-To Seminars:

1. Videotapes on abuse/family violence.
2. How to stop being a victim of family violence.
3. How to know if one or one's child is a victim or potential victim of family violence.

Field Trips

Because of the sensitive nature of domestic violence, field trips would be inappropriate. Domestic violence shelters, courts, and hospitals maintain strict confidentiality policies and walk through groups are generally not allowed. Also, keep in mind that the participants are not necessarily in abusive relationships and may not wish to spend a great deal of time focusing on this topic.

Speakers

If the group is interested in the topic, a speaker from an area domestic violence program could be invited to address the women's questions. For speakers, contact your local domestic violence hotline.

Additional materials and handouts would also be useful for the group. Materials from local shelters, hospitals, etc. would be particularly helpful.





Evaluation

After the module has been completed, it is important to take into account the participants' responses. Trainers should be prepared for several different outcomes after the initial section on domestic violence.

1. The women may be very interested and discuss the subject openly; or
2. The women may feel insulted and may act distant. They may not want to discuss the subject either openly or at all.

Follow-up discussion is very important even if the women are resistant to this subject. Sometimes the group needs time to digest the information and observe their own culture in the new context before they can openly discuss the subject. This section should serve as a review and checkpoint. Hopefully, at the end of this section the trainer will have a comprehensive understanding of the group's perceptions and understanding of this topic.

At the very least, a group discussion should take place in order to review the material and discuss impressions. If appropriate, inform the women that they can make a positive impact on the community services for women from their country. This discussion should be held one or two weeks after the original meeting.

The following questionnaire is intended to provide feedback on how well the lesson went. Trainers should also use this section to write ideas or notes on the participants' responses for improvements for future use of this module; for instance, were there any aspects of the module that caused cross-cultural conflict or confusion?





Journey of Hope

Domestic Violence Evaluation Questionnaire

1. What were the benefits of the domestic violence section?

Refugee Women:

Trainer:

2. What did you not like about the domestic violence section?

Refugee Women:

Trainer:

3. Recommendations for future lessons on domestic violence:

Refugee Women:

Trainer:





MODULE VI: PUBLIC BENEFITS & COMMUNITY SERVICE

Objectives

Participants will—

1. Become familiar with public benefits and community services.
2. Develop the skills to access these benefits and services without the sponsoring agency's assistance.

Overview

Public benefits and community services may be new concepts for refugees. What they have been told overseas, whether through pre-departure orientation or through hearsay, may not be accurate. At times refugees may continue to receive inaccurate information after they arrive in the United States. Inaccurate information can lead to false expectations, some of which may be counterproductive to the goal of the refugee program—self-sufficiency. Recent changes in the welfare laws, as well as the impact those changes may have on refugee families, need to be addressed.

Also included in this module is a section on community services. Local community resources need to be identified and participants must learn how to access them in order to increase their sense of independence.

The sections in this module cover the following topics.

Section 1: Public Benefits & Community Services Assessment

Section 2: Family Assistance, Food Stamps, & Health Insurance Programs

Section 3: SSI & Disability Benefits

Section 4: WIC & Other Food Programs

Section 5: Community Services & How to Access Them

Methodology

This module uses a combination of methods. The trainer or speaker will teach participants the facts they need to know, such as the laws governing the eligibility for public benefits, work requirements, etc. Participants will then





Journey of Hope

discuss this information—expressing opinions and asking questions to clarify issues of concern to them.

1. *Activities:* Group discussions, an instructional field trip, and role-playing.
2. *Materials and Handouts:* Application Form for Public Benefits, Informational material published by the county's Department of Social Services (DSS).

Note to Facilitators:

Local DSSs may be called by different names, such as Department of Human Services (DHS), in different locals. It is recommended that trainers use the appropriate name for their county offices.

3. *Resources/Readings:*
 - ❖ Directory of Social Service Agencies in the community (May be compiled and published by the local United Way).
 - ❖ Resources produced by: Refugee Welfare and Immigration Reform Project, Institute for Social and Economic Development, 1901 Broadway, Suite 313, Iowa City, IA 52240 (www.ised.org); Phone: 1-800-888-4733; Updated Fact Sheets: A) Refugee Eligibility for Food Stamps, and B) Refugee Eligibility for Supplemental Security Income and Other Publications, and C) Refugees and Temporary assistance for Needy Families (TANF) as well as other publications. (*See Appendix C: Public Benefits & Community Service for above publications.*)
 - ❖ Resources published by Social Security Administration: Supplemental Security Income, Disability Benefits, How Work Affects Your Benefits, Basic Facts, Benefits for Children with Disabilities, and others. The Social Security Administration has a toll-free automated document fax service, 1-888-475-7000.

Differences to Consider

Several issues to consider in conjunction with this module:

1. Eligibility requirements for public cash benefits may vary from state to state, as well as by county. The trainer needs to obtain information appropriate to the county/state.
2. Likewise, community resources vary. The trainer needs to provide a listing of local resources.
3. The field trips and handouts suggested in this manual are to be used as necessary. Using the participants needs as a guide, the trainer should decide what are appropriate activities or resources to use.





Section 1: Public Benefits & Community Services Assessment

Objective

Participants will assess how much they know about the different public benefits and community services available to them.

Materials

1. Public Benefits Assessment Questionnaire
2. Flipchart
3. Markers

Introduction

For many years, the U.S. government guaranteed public assistance benefits (known as Aid for Families with Dependent Children [AFDC]) to families with minor children where one of the parents was unable to provide for the family because of disability or unemployment or where one parent was absent or deceased. In August 22, 1996, the federal government passed the Personal Responsibility and Work Opportunity Act (PRWORA), which made many significant changes to public benefits, eliminating AFDC and introducing a new program known as Temporary Assistance for Needy Families (TANF). In addition, the Balanced Budget Act of 1997 and Agricultural Research, Extension, and Education Act of 1998 restored eligibility for benefits for certain non-citizens who had lost them as a result of PRWORA.

The purpose of this module is to inform the participants of the public benefits that may be available to them and of the laws that apply to refugees. This module also provides information about community services and how to access these programs, as well as explaining how the participants can gain greater self-sufficiency through self-advocacy.

Differences to Consider

Eligibility and requirements for the above programs may vary from state to state and county to county. The trainer should obtain appropriate information about programs available in the community before the next section.





Journey of Hope

Assessment

Have the participants complete the Public Benefits Assessment Questionnaire. Once completed, have them share their answers with the rest of the group.

Note to Facilitators:

The following questionnaire is not designed to be just an ice breaker activity, but rather to help the trainer(s) understand the situations of the participants and particular issues they may be facing. Trainers should consider this section as an opportunity for the participants to educate the trainer(s). Trainers should expect to make modifications in the curriculum based on the outcomes of this first section, as well as knowledge of community issues prior to commencing the program.





Public Benefits Assessment Questionnaire

1. What government and/or social service programs were available to you and your family in your home country?
 - a. How did you meet your family's financial needs?
 - b. How did you know where to get help in your community?
 - c. What benefits and services did your family receive while in the camp?
2. What benefits do you think are available to refugees in the United States?
3. What are the main worries that you have about your ability to provide for your family in the United States?
4. How would you describe your present standard of living in this city compared to your standard of living in your country of origin?





Journey of Hope

5. What kind of lifestyle do you want your family to have many years from now?

6. What agencies in this community have you gone to in order to meet your needs? How did you find the agencies? Did someone help you?





Outline/Lesson Plan

Presentation & Group Discussion

Presentation & Group Discussion

Present a brief history of public benefits in the United States and provide an overview of some public benefit programs, such TANF, Food Stamps, Medicaid, Supplemental Security Income (SSI), Disability Program, etc., that will be discussed at length in the specific sections.

Present refugee-specific programs such as Refugee Cash Assistance and Refugee Medical Assistance. Explain how these programs differ from "mainstream" public benefits programs, particularly in regard to eligibility and time limitations.

Other programs to mention include: Women, Infants and Children (WIC) program, school breakfasts and lunches, child care subsidies, food programs, special milk programs, and the Nutrition Program for the Elderly.





Section 2: Family Assistance, Food Stamps & Health Insurance Programs

Objectives

Participants will—

1. Become familiar with Family Assistance, Food Stamps, and Health Insurance.
2. Differentiate between Cash Assistance, Food Stamps, Medicaid, and Children's Health Insurance Program (CHIP).
3. Discuss time limitations for refugees, eligibility requirements, work requirements, transitional benefits, and other related regulations.

Materials

1. Flipchart
2. Markers
3. Handouts and Materials

Introduction

The goal of this section is to discuss the current welfare program. The major public assistance programs, TANF, Food Stamps, and Health Insurance programs will be explained. The benefits and laws that govern their use will also be discussed.

Note to Facilitators:

TANF is called by different names from state to state, for example, it is known as CalWORKs in California.

Differences to Consider

Regulations may vary from state to state and from county to county. The instructor should be aware of local regulations. Refugees are eligible for some benefits for which other qualified Aliens (such as immigrants) may not be eligible. Some states fund their own food programs that cover certain non-citizens who are not eligible for federally funded food stamps. Trainers need to be sure they check into eligibility for their own state.





Outline/Lesson Plan

Presentation & Group Discussion

Presentation & Group Discussion

Introduce the general topic by asking the participants to identify what welfare benefits they are receiving. Pay special attention to women who are receiving benefits under TANF or the Safety Net Program. Encourage the group to ask questions about specific concerns throughout the presentation.

Describe the TANF, Food Stamps, and Health Insurance programs. Identify what benefits are received in each program (For example, Cash Assistance, Food Stamps, and Medicaid). Differentiate between TANF and Medicaid and Refugee Cash Assistance and Refugee Medical Assistance. If available at your agency, discuss welfare alternative programs such as Match Grant, Fish-Wilson, or Alternative programs and clarify how these programs differ from public benefits programs.

Describe the General Assistance program, if available in your state, and programs such as Employment Assistance, Child Care, and Transportation Assistance. Be sure to cover the laws that are important for refugees to know, such as time limitations, eligibility requirements, work requirements, transitional benefits, work exemptions, and rules regarding non-compliance.

Thoroughly explain the application process and initiate a discussion about the participants' experiences during their initial applications. Ask them if they are aware of the re-certification process and its requirements, and address any issues they may have.

Note to Facilitators:

The County Department of Social Services may have information available for applicants. The instructor should obtain copies from the Department and, in preparation for re-certification process, go over the application form with the participants.

This information may have been translated into appropriate languages; trainers should be sure to ask for materials in all languages that are available.





Section 3: SSI & Disability Benefits

Objectives

Participants will—

1. Become familiar with SSI and SSD.
2. Discuss the eligibility requirements and application process.
3. Consider the implications of the 40 quarters of work credit, and SSI eligibility of themselves and their family members.

Materials

1. Flipchart
2. Markers
3. Materials and Handouts

Introduction

Supplemental Security Income (SSI) is a federally funded program administered by the Social Security Administration (SSA) that provides monthly cash benefits to eligible people who are 65 or older, blind, or disabled. Cash benefits can also go to eligible disabled and/or blind children. Social Security Disability (SSD) also pays cash benefits to people who are not able to work for a year or longer because of disability. Disability is defined as no longer being able to do the kind of work which one was able to do, and that the disability has lasted or is expected to last for at least a year or to result in death. Such individuals need a work history (at least 20 credits during a 40 quarter period) to qualify. According to the SSA, disability is defined as "the inability to engage in any substantial gainful activity...." Usually individuals that receive SSI or SSD can also receive Food Stamps and Medicaid. Most refugees are eligible for these benefits; however, trainers should check the Institute for Social and Economic Development's (ISED's) fact sheet for specific eligibility rules.

Differences to Consider

SSI is for specific populations. The focus of this lesson should be adapted to meet the needs of the class. For example, if there are no elderly clients in the class or families with disabled children or adults, few details need to be discussed regarding the SSI program.





Outline/Lesson Plan

Presentation & Group Discussion

Presentation & Group Discussion

Explain the importance of each participant's Social Security Number (SSN) as an identification, the purpose of the Social Security deduction from their payment, and the 40 quarters of work credit toward an eligible member of the family (see *Appendix C: Public Benefits & Community Service*).

Hand out the ISED's Refugee Eligibility for SSI fact sheet (see *Appendix C: Public Benefits & Community Service*) and discuss the SSI and SSD eligibility requirements and application procedures, including where to apply for the different programs. Be sure to differentiate between temporary vs. long-term disability benefits.





Section 4: WIC & Other Food Programs

Objectives

Participants will—

1. Become familiar with the WIC Program.
2. Discuss other food programs available in the community.

Materials

1. Flipchart
2. Markers
3. Materials and Handouts

Introduction

Women, Infants and Children (WIC) is a federal nutritional program providing food, nutrition counseling, and referrals for health care to eligible pregnant women, breastfeeding women, and infants and children under 5-years-old. While anyone receiving Medicaid is eligible, referrals from a doctor, hospital, or health department are necessary. Some people who do not receive Medicaid may still be eligible for WIC because they meet financial eligibility requirements. There are also other available community food programs that can be accessed by the participants.

Differences to Consider

Community food programs may vary from community to community. Some items from community food pantries may not be appropriate for refugee families for cultural/religious reasons.

Outline/Lesson Plan

Presentation & Group Discussion

Field Trip





Presentation & Group Discussion

Begin by asking the participants if anybody is receiving WIC. The trainer may need to describe the WIC program by describing the food checks they are using.

Explain the eligibility requirements, application process, and purpose of the WIC program and hand out brochures from the local WIC program. Encourage those participants who are receiving WIC to talk about their experiences with the program, including which food checks they often use and which they do not use at all. Discuss ways of using the food checks appropriately.

Inform the participants of the other food programs that are available in the community, such as school breakfasts and lunches, child care food programs, special milk programs, and nutrition programs for the elderly. Briefly discuss food pantries and soup kitchens (a listing may be useful).

Field Trip

A field trip can be essential in promoting the self-sufficiency of the women participants in learning to access community services on their own.

The trainer can arrange a field trip to a supermarket to assist participants to learn how to substitute food products that will be acceptable in the WIC program. Before the field trip, the trainer needs to arrange it with a local supermarket. Customer service personnel may help the group in arranging this tour and provide the use of a meeting room for discussion.





Section 5: Community Services & How to Access Them

Objectives

Participants will—

1. Become familiar with the different community services that are available.
2. Discuss eligibility requirements, application procedures, and other potential barriers to accessing community services as well as ways to overcome these barriers.

Materials

1. Pens
2. Flipchart
3. Markers
4. Materials and Handouts

Introduction

Various community services are available to refugees. The goal of this section is to enable participants to identify and learn how to access the resources available in the community. Some community services include food pantries, counseling services, free or discounted clothing and household stores, legal services, etc.

Differences to Consider

The instructor may need to research available community resources that may be commonly used by refugees.

Outline/Lesson Plan

Presentation & Group Discussion

Activity

- Case Studies

Evaluation





Presentation & Group Discussion

Ask the participants what community services were available in their own countries and how these services were accessed. Assess what community services they are aware of or have used in the United States.

Identify community services available locally that participants and their families can utilize. Discuss the type of service provided, how to access it, the income eligibility requirements, and the cost. A handout listing these services (including the name, address, and telephone number of the agency, and a brief description), as well as a map with all of the locations marked with information on how to get there by bus would be useful to distribute to the class. A statement that the participants can use to practice accessing service through the telephone would also be helpful, as would a field trip to visit particular services.

Discuss what barriers the participants can identify or may have experienced in accessing the community services. Suggest ways in which these barriers can be minimized or eliminated.

Note to Facilitators:

The resettlement agency or the United Way in the community may have a directory of social service agencies that the participants and their families can use.

Activity

Case Studies:

Time: 20 minutes

In the sample cases following, Case #1 lists nine community/social service agencies available in the United States and Case #2 lists eight. See if your group can identify all of them.

The participants will also match the names of different social service agencies to description of the services provided by the respective social services. The names and the descriptions will be provided on slips of paper that the trainer will create.

Procedure:

1. Divide the participants into two groups.
2. Give each group one case study from the sample cases and ask them to read the text and to list (in the blank space on the page) the social services mentioned in the text.





Journey of Hope

3. Once they have listed the social services, distribute two sets of strips of paper to each group. One contains a one-sentence description of specific services offered by various social service agencies. The other contains names of different social service agencies.
4. Ask the participants to match the description with the appropriate name of the community/social service agency.

Note to Facilitators:

The case studies are samples to be adapted depending on the characteristics/ circumstances of the particular population(s) you are working with. If the participants are pre-literate, assign one literate person to each group and ask them to read the scenario to the group. In absence of literate participants, the trainer can read the scenario(s) to either the class or to smaller groups. With pre-literate participants, you may want to work only on identifying the service providers mentioned in the text and discuss what kinds of services they provide, while skipping steps three and four.





Case #1:

When M.F. arrived in the United States he told his resettlement caseworker that he wanted to see if he could find a job on his own initiative. He refused employment counseling classes which the VOLAG offered to their clients. He also refused an entry-level position offered by the VOLAG's job placement counselor. M.F. eventually found a job helping to maintain the vehicles and the area around the local fire department. M.F. was discovered drinking on the job, however, and was fired. He then started collecting Public Cash Assistance. At one point his wife moved into a women's shelter for a week with her children because M.F. was drinking and becoming abusive. She agreed to move back in with her husband when he agreed to stop drinking. M.F.'s wife found it almost impossible to live off of Public Assistance. She also wanted to improve her English and to gain some experience in the U.S. job market. She found a job, which meant that her family was no longer eligible for Public Assistance. M.F. contacted his caseworker at the VOLAG requesting some advice. He was no longer a client of the VOLAG, but a volunteer at the agency offered to help him sign up for employment counseling at the local employment center and to help him decide where to mail his resume. In the meantime, M.F.'s wife was unable to pay all the bills on her salary, so they could no longer afford day care. Eventually, M.F. found a job with a senior citizen's center. It involved delivering meals to senior citizens. Unfortunately, he hadn't stopped drinking and caused a car accident while he was making a delivery. He was taken to the emergency room at a local hospital and they found his blood alcohol level to be above the legal limit. As a result, his driving license was revoked and he is now attending Alcoholics Anonymous meetings in order to help him overcome his dependency on alcohol.

List the nine community/social service agencies mentioned in the above sample.





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Case #2:

S.M. and his wife A.M. contacted their VOLAG as soon as they arrived in the United States. They enrolled in employment counseling and ESL courses within their first two weeks of arriving and were willing to accept entry-level jobs. S.M. found a job as a cleaner and A. M. obtained work stocking shelves in a supermarket. They became self-sufficient quickly and did not need to register for Public Cash Assistance. Their children adapted to their new lives quickly. Their older son D.M. (19) started to attend community college because he wanted to become an accountant. Their youngest son F.M. (11) started to play basketball at the YMCA and was one of their best players.

S.M.'s English improved and after six months he found a job with the post office. Although it was better than his cleaning job, he still hoped to work as a driver as he had in his country. He visited the police station to find out what qualifications he would need to drive trucks. He was advised to go to the DMV to get information on the type of license he would need and to find out about the testing procedures. S.M. studied the manual and obtained his license. He began contacting companies that transported goods or supplies. It took a year of sending resumes and meeting with personnel officers but he was eventually offered a job.

List the eight community/social service agencies mentioned in the above sample.





Names & Descriptions of Social Services In the United States

Volag	Voluntary Agency. An agency that is responsible for assisting refugees in their initial resettlement. This includes, at minimum, one month of financial assistance and three months of "core services." Some local Volags are funded to provide additional ongoing social adjustment services.
Welfare Office	The government department that processes documents for unemployed people who are seeking financial assistance.
Employment Center/Workforce Development Center	This center announces job openings and provides employment counseling.
Fire Department	This is a community service that you should call in case of fire. Most frequently the number is 911.
Alcoholics Anonymous	This is a free service for people who are trying to stop drinking alcoholic beverages.
Women's Shelter	This place provides temporary housing for women who are being abused in their homes.
Resettlement Agency	This is another name for Voluntary Agency (Volag).
Day Care	This is a center that provides a safe environment for children while their parent(s) are working.
Senior Citizen's Center	This center provides services to help the elderly meet their physical and social needs.
Supermarket/Grocery Store	This is a store where you can buy food and toiletries.
Post Office	This is where you can go to mail a letter, send a package or buy stamps.





Journey of Hope

Community College	This is an educational institution where you can study for two years in order to achieve two years worth of credits towards a college degree or obtain an associate degree.
YMCA/YWCA	Young Men's Christian Association/Young Women's Christian Association. This is a place where young people can play sports or do other activities. Some centers have services for the entire family.
Police	This department is responsible for helping citizens maintain a safe community.
DMV	Department of Motor Vehicles. This is where you can apply for a driver's license, register your car or renew your driver's license.
Chamber of Commerce	This is an office that has information about the city, especially businesses.
City Bus System	People use this transportation system to go from place to place in their local community.
Emergency Room	This is a place in a hospital where you go if you have a problem and you need immediate attention.
Elementary School	Children receive their first eight years of education at this institution.
Before School/After School Programs	Children receive care and supervision while parents are working either before or after formal school hours.
Middle School/High School	Youth 12 to 18-years old continue their education at this institution.
Homeless Shelter	A temporary place of refuge if you have lost your home.
Mutual Assistance Association (MAA)/Ethnic Community-Based Organization (ECBO)	An organization founded and run by an ethnic-specific community to meet their community's ongoing needs.





Evaluation

Explain to the participants that you would appreciate their feedback on the classes. Pass out the following evaluations and have the participants complete them (or complete it as a group using a flipchart). The trainer should also provide feedback on the classes.



APPENDICES

These appendices have been divided as follows for ease of use with the modules of this manual.

Appendix A: Health & Wellness

Appendix B: Domestic Violence

Appendix C: Public Benefits & Community Service

Appendix D: Female Circumcision/Female Genital Mutilation

Appendix E: Surveys

Appendix A: Health & Wellness

This appendix includes information which has been specifically geared towards medical practitioners and patients, but which may be of value to trainers and class participants. It is up to the trainer to determine whether or not this material should be included in the class curriculum and how it should be presented. Information that can be readily transformed into a handout has been so noted.

This appendix covers the following sections.

- Section 1:** General Information
- Section 2:** Nutrition
- Section 3:** Substance Abuse
- Section 4:** Physical Fitness
- Section 5:** Gynecological Care

Section 1: General Information

This section contains a number of different documents. For ease of use, they are listed below.

Nine Core Competencies for an Interpreter in Community & Health Care Settings

Seven Ethical Standards for Interpreters in Community or Health Care Settings

The Muslim Patient: A Pamphlet to the Health Practitioner

Nine Core Competencies for an Interpreter in Community or Health Care Settings

Any job can be broken down into separate tasks, each requiring different skills, or competencies. Core competencies are those skills which you must master in order to carry out your professional role. A professional interpreter's role is to make possible communication between two people who do not speak the same language. A medical interpreter does this for a patient and a health care provider.

This list of core competencies is based on a list developed in 1995 by the Massachusetts Medical Interpreters Association, and endorsed in 1998 by the National Council on Medical Interpreting. These competencies are written to apply to medical interpreting in most social service or community settings.

The Competent Interpreter:

1. Introduces self and explains role.

Ideally, the interpreter consults first with the provider to learn the goals of the medical encounter. Then, the interpreter explains his/her role to both the patient and the provider, emphasizing the professional obligation to transmit everything that is said in the encounter to the other party and maintain confidentiality.

2. Positions self to facilitate communication.

The competent interpreter should be seen and heard by both parties, but should position himself/herself in the place that is least disruptive to direct communication between provider and patient.

3. Reflects the style and vocabulary of the speaker.

The competent interpreter attempts to preserve the style, dialect, and formality of speech, as well as the depth and degree of emotion expressed by the speaker.

4. Uses consecutive interpretation mode and speaks in first person.

The competent interpreter selects the mode that best enhances comprehension, which will usually be to interpret for the patient and the provider alternately.

The interpreter encourages direct communication between patient and provider by using "I" rather than "he said that..." or "she said that..."

5. Accurately and completely relays the message between patient and provider.

The competent interpreter re-expresses information conveyed in one language into its equivalent in the other language, so that the interpreted message has the potential for eliciting the same response as the original. The interpreter does not alter or edit statements from either party, or comment on their content. The goal is for the patient and the provider to feel as if they are communicating directly with one another.

Interviewer:

6. Respects the patient's privacy.

The ethical interpreter respects the patient's physical privacy. In addition, he/she refrains from becoming personally involved in a patient's life.

7. Maintains professional distance.

The ethical interpreter understands the boundaries of the professional role, promotes patient self-sufficiency and monitors his/her own personal agenda.

8. Knows limits.

The ethical interpreter refrains from interpreting beyond his/her training, level of experience, and skill.

9. Demonstrates professionalism.

The ethical interpreter clearly understands his/her role and refrains from delivering services that are not part of the role. In addition, he/she avoids situations that might represent a conflict of interest or may lead to personal or professional gain.

Seven Ethical Standards for Interpreters in Community or Health Care Settings

Ethno Med
Ethnic Medicine Guide
Harborview Medical Center, University of Washington
Ellie Graham, MD
March 1, 1995

Guidelines for Interpreted Visits:

1. Introduce yourself to the family and to the interpreter
2. Write down the interpreter's names and the interview language on the progress note.
3. Do a pre-visit conference with the interpreter. This can be done in the room with the family unless sensitive issues need to be discussed. The following should be covered.
 - ❖ **Establish the style of interpretation.** Phrased interpretation, where the provider interviews in short phrases that are translated as accurately as possible by the interpreter, is usually the easiest to use. Simultaneous interpretation is often confusing to both patient and provider but useful for short statement like how to take medicines. Summary interpretation, where the provider or the patient make long statements and the interpreter tries to summarize them can be used for simple problems and to explore sensitive areas such as sexuality, but can lead to errors...use with caution.
 - ❖ **Ask the interpreter for feedback.** Ask them to tell you if they don't understand terms you use or the terms aren't easily translated. Tell them to also tell you if it seems that the patient is expressing a culturally related idea or concept that they think that you may not understand.
 - ❖ **Tell the interpreter where you want them to sit.** Beside the provider or just in back of them is best because the patient looks at both the provider and the interpreter.
 - ❖ **Establish the content and nature of the visit.** "Nasara is coming in to see me today for a follow-up visit. She has been depressed and I will be discussing this first" ... " Anh is a new patient to our clinic. I will be asking him many questions about his past health and his family and then will do a complete physical examination"...
 - ❖ **Determine if there are any time constraints on the interpreter.**

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4. Ask the interpreter if they have any concerns that they want to share with you before the visit and step out into the hallway to talk with them.
5. Direct questions to patient, not to the interpreter—unless they are meant for the interpreter. If you are going to pause and ask the interpreter a question in English, tell the patient that is what you will be doing.
6. Do a post-visit conference with the interpreter outside the room if you have concerns about the interview. This is particularly helpful if the history seems very vague and unclear. It can help determine if there was a language problem...for instance, if the patient and the interpreter speak different dialects or have accents that are hard for each to understand, or if the patient is mentally ill or has some other problem that clouds communication.
7. The gender and age of the interpreter may be very important. In many ethnic groups, women and girls prefer a female interpreter and some men and boys prefer a male. Older patients may want a more mature interpreter. Don't use children as interpreters. This distorts power relationships within families and diminishes parents in the eyes of their children. It often provides poor quality interpretation because children may have limited native language skills.

The Muslim Patient: A Pamphlet to the Health Practitioner

I. Muslims & Medicine:

The efficiency of medicine and the skill of the physician are fully appreciated by all Muslims, as is the importance of preventive medicine. According to tradition, the Prophet Muhammad urged Muslims to develop the medical profession, because "for every sickness God created, He created a cure: some already known and others are not."

II. The Religion:

A. What Is Islam:

Islam is a universal monotheistic faith addressing all humanity. The most important component is the belief in One God, and in Muhammad as His prophet. The word Islam is Arabic for "submission" to God (Allah in Arabic). Muslims believe that His word was revealed in the Qur'an to mankind through his messenger Muhammad, the last of the prophets.

Muslims believe that Ibrahim (Abraham), Musa (Moses), and Isa (Jesus) were also God's prophets. They preached moral values, upright conduct, faith in one God, and passed along His revelations to the rest of mankind. Muslims believe that Qur'an, as the last revelation, completed the prior revelations that constituted the bases of the Jewish and Christian faiths. Members of these faiths are therefore considered to be part of the same family of religions: the Ahl al-Kitab, or "People of the Book."

B. Who Are the Muslims?

A Muslim is a person who practices the Islamic faith by submitting to God and accepting divine guidance. With more than one billion adherents worldwide, Islam is second only to Christianity in terms of the number of adherents. The areas of the largest concentration of Muslims are Central and East Asia, North Africa, and the Middle East. In the United States, Islam claims about six million adherents, making it the country's second largest religion.

III. The Importance of the Family:

The family is the central foundation upon which Muslim society is built. Governments may come and go in the Muslim world, but the family endures. For Muslims, the family is as much the source of love, nurturing, and solace as it is of pride and motivation. The vast majority of Muslim immigrants to the

United States continue to maintain close ties with their extended families, whether they live here or back in their home countries.

Physicians treating Muslim patients should make a special effort to reach out to their families. Family members should be consulted and kept informed of the patients' condition on an ongoing basis.

IV. Accommodating the Islamic Life Style:

A. Prayer:

Muslims conduct prayer five times daily: pre-dawn, noon, late afternoon, dusk and evening. They perform thorough ablutions before each prayer and take great care to maintain a high state of physical hygiene and cleanliness at all times. The daily prayers may be performed in a sitting position or, if necessary, lying in bed.

A close related form of worship, and one particularly suited to the person taking bed rest, is the recitation of the Qur'an and reflection upon its meaning. This practice also serves to uplift the morale of patients who are critically ill.

B. Fasting:

During the entire month of Ramadan, which comes 11 days earlier each year, Muslims fast from dawn until dusk, when a Muslim is ill, however, her or she is exempt from fasting.

C. Dietary Constraints:

In additions to the prohibition of consuming alcoholic beverages, Muslim's are forbidden to eat pork or lard. It is also important that cooking utensils used to prepare pork or lard not be used in preparing food for Muslim patients until they are thoroughly washed.

Even medicines intended for internal consumption that contain pork (e.g. insulin) or alcohol (e.g. certain cough syrups) should not be prescribed to Muslim patients unless absolutely necessary.

D. Circumcision:

There is no reference to circumcision in the Qur'an, but, according to tradition, male infants should be circumcised within the first seven days of life. Female circumcision is not an Islamic requirement.

E. Modesty:

Since, Islam teaches the importance of modesty in all social relations, Muslims of both sexes are not comfortable about removing their clothing even for the purpose of a medical examination. This is despite the fact that Islam allows them to do so. Appropriate coverage should be a consideration during any medical examination.

Attention should be paid to the patient's privacy in other ways as well, for instance, in a hospital room the curtains should be drawn and history taken should be muted. Some Muslim patients are shy about being examined by the opposite sex and may feel more comfortable with doctors and nurses of the same sex. The virginity of an unmarried girl is a matter of great importance. Vaginal examination should be avoided unless of vital importance. A rectal exam is alright.

V. Right to Life:

A. Euthanasia:

Active euthanasia is banned by Islam. Any treatment that carries no promise of eventual success ceases to be mandatory, but without abrogation of the usual rights of hydration, nutrition, nursing, and relief of pain. Recent conferences of notable scholars have accepted complete brain death (including the brain stem) as an indication of death. Artificial animation in medically hopeless cases is not a requirement.

B. Abortion:

Abortion is not permitted by Islam unless the life of the mother is in danger or the fetus is afflicted with a gross abnormality incompatible with future life. Family planning by natural or medical contraception is acceptable.

C. Organ Donation and Transplants:

Organ donation and transplant within current ethical guidelines are permissible and even encouraged.

For additional information, write to:

The Islamic Medical Association of North America
950 75th St.
Downers Grove, IL 60516
ph: (630) 852-2122
fax: (630) 435-1429

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e-mail: imana@aol.com
<http://www.imana.org>

The American Muslim Council (AMC)
1212 New York Avenue, NW, Suite 400
Washington, DC 20005
Phone: (202) 789-2262
Fax: (202) 789-2550
E-Mail: amc@amconline.org
<http://www.amconline.org>

Section 2: Nutrition

The Great Breastfeeding Cover-up

Tips on Discreet Nursing:

Are you embarrassed to breastfeed in front of others? Don't worry, you're not alone. Are you thinking of switching from breast to bottle because you feel uneasy about exposing your breasts while nursing the baby? Many mothers have made this choice—even though they enjoyed breastfeeding!

Think of This:

One mother nursed her baby all through Thanksgiving dinner and everyone thought the baby was sleeping.

Another mother took her infant and toddler to the playground and supervised her toddler playing—at the same time that she breastfed the infant.

And yet a third mother, whose husband was opposed to breastfeeding because he didn't want others to see his wife's breasts, learned to "cover-up" so well that even her husband was fooled!

American mothers for years have been "covering up." They have found many simple and effective ways to cover their breasts and baby so that others in the room are unaware that they are breastfeeding or can't see the mother's breasts. We will discuss ways that you can breastfeed your baby without being embarrassed that others will see your body.

In the Beginning:

When your baby is first born, you will feel awkward in your first attempts to breastfeed. This is normal. It's just like riding a bike or learning to roller skate! It takes practice. At the hospital, or when you first come home, try to breastfeed your baby alone so that you can build your confidence and learn what positions are most comfortable for you and your baby.

Practice Makes Perfect:

Practice breastfeeding your baby in front of the mirror. Lift up your blouse from your waist—only a small section of your blouse needs to be lifted—so that the top of your breast is still covered. Hold the baby in the crook of your arm so that your midriff is concealed by the baby's body. Draping a diaper,

baby blanket or shawl loosely over your shoulder and the baby's head will give others the impression that your baby is sleeping.

Leaking:

In the first weeks after birth, your breasts may leak milk because they are so full. To take care of leaking milk that may cause spots in your blouse, slip an absorbent lining inside your bra cup. Disposable pads can be bought at drug stores and reusable pads are available in department stores.

When you feel the tingle of the let-down reflex, you can prevent leakage by pressing against the nipple with the heel of your hand or your forearm for a few seconds.

What to Wear?

Jeans and a T-shirt or blouse is the easiest outfit in which to discreetly nurse a baby. The top can be lifted easily without having to unbutton a blouse or pull a dress over your shoulder. By pulling up a small section of your blouse or sweater—just enough so that the baby can find the breast—you won't have to uncover your breast. Wearing a nursing bra with a front opening will make nursing even easier.

How to Get the Baby Started:

You may feel awkward unhooking your bra and lifting your blouse to get the baby started. Find another room or simply retreat to a quiet corner for a minute or turn your back to the others. In seconds, you can settle the baby to the breast, drape a blanket or shawl over your shoulder and rejoin the group with a "sleeping" baby.

In Public Places:

Breastfeeding—if done discreetly in public—is a perfect way to ensure a quiet, "sleeping" baby; find another room (such as a restroom or waiting room) in which you can breastfeed your baby privately. If there is no other room to which you can retire, find a quiet corner and turn a chair away from the crowd. Throw a baby blanket or diaper loosely over your shoulder and everyone will think the baby is sleeping and that you are resting.

So, as you can see, there is no need to shy away from breastfeeding your baby if you feel embarrassed. By using some of these tips, you can relax and enjoy giving your baby a nourishing, nurturing start in life.

Developed by the

Patient Education Sub-committee
City-wide Coordinating Committee for Breastfeeding Promotion
Cynthia Carney, Editor

Produced by the

Department of Human Services
Commission of Public Health
WIC State Agency and the Bureau of Maternal and Child Health
September 1986

Section 3: Substance Abuse

Specific Substance Abuse Assessments

There are a variety of available screening questionnaires that focus on the consequences of drinking and perceptions of drinking behavior. Examples are the 25-question Michigan Alcoholism Screening Test (MAST) or the four-question CAGE (*see below*) questionnaire, which is the most popular screening test for use in primary care and has good sensitivity and specificity for alcohol abuse or dependence (74-89 percent and 79-95 percent, respectively). Both the CAGE and MAST questionnaires share important limitations as screening instruments, however, as they emphasize the symptoms of dependence rather than early drinking problems, they lack information on levels and patterns of alcohol use, and they fail to distinguish current from lifetime problems.

Some of these weaknesses are addressed by the Alcohol Use Disorders Identification Test (AUDIT), a 10-item screening instrument developed by the World Health Organization (WHO) in conjunction with an international intervention trial. The AUDIT incorporates questions about drinking quantity, frequency, and binge behavior along with questions about the consequences of drinking.

For our purpose, we would adopt the use of the above screening tools and modify them not only for alcohol, but also for drug and cigarette use disorders. The easiest screening tool for use is the CAGE questionnaire:

- C:** Have you ever felt you ought to **Cut** down on your drinking, smoking, or drug use?
- A:** Have people ever **Annoyed** you by criticizing your drinking, smoking, or drug use?
- G:** Have you ever felt bad or **Guilty** about your drinking, drug use, or smoking?
- E:** Have you ever had a morning **Eye** opener to steady your nerves or get rid of a hangover, or feel obsessed that you have to use drugs, smoke or drink?

Section 4: Physical Fitness

A Sample Walking Program

Note to Facilitators:

The following information can be converted into a handout if necessary.

	Warm Up	Target Zone Exercising *	Cool Down Time	Total
Week 1:				
Session A:	Walk normally 5 min.	Then walk briskly 5 min.	Then walk normally 5 min.	15 min.
Session B:	Repeat above pattern			
Session C:	Repeat above pattern			
* Continue with at least three exercise sessions during each week of the program. If you find a particular week's pattern tiring, repeat it before going on to the next pattern. You do not have to complete the walking program in 12 weeks.				
Week 2:	Walk 5 min.	Walk briskly 7 min.	Walk 5 min.	17 min.
Week 3:	Walk 5 min.	Walk briskly 9 min.	Walk 5 min.	19 min.
Week 4:	Walk 5 min.	Walk briskly 11 min.	Walk 5 min.	21 min.
Week 5:	Walk 5 min.	Walk briskly 13 min.	Walk 5 min.	23 min.
Week 6:	Walk 5 min.	Walk briskly 15 min.	Walk 5 min.	25 min.
Week 7:	Walk 5 min.	Walk briskly 18 min.	Walk 5 min.	28 min.
Week 8:	Walk 5 min.	Walk briskly 20 min.	Walk 5 min.	30 min.
Week 9:	Walk 5 min.	Walk briskly 23 min.	Walk 5 min.	33 min.
Week 10:	Walk 5 min.	Walk briskly 26 min.	Walk 5 min.	36 min.
Week 11:	Walk 5 min.	Walk briskly 28 min.	Walk 5 min.	38 min.
Week 12:	Walk 5 min.	Walk briskly 30 min.	Walk 5 min.	40 min.
Week 13:	and thereafter:			

Check your pulse periodically to see if you are exercising within your target zone. As you get more in shape, try exercising within the upper range of your target zone. Gradually increase your brisk walking time to 30 or 60 minutes, three or four times a week.

Here's how to check if you are within your target heart rate zone:

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1. Right after you stop exercising, take your pulse: Place the tips of your first two fingers lightly over one of the blood vessels on your neck, just to the left or right of your Adam's apple. Or try the pulse spot inside your wrist just below the base of your thumb.
2. Count your pulse for 10 seconds and multiply the number by 6.
3. Compare the number to the right grouping below: look for the age grouping that is closest to your age and read the line across. For example, if you are 43, the closest age on the chart is 45; the target zone is 88-131 beats per minute.

Age Target Heart Rate Zone:

Age	Beats Per Minute	Age	Beats Per Minute
20	100-150	50	85-127
25	98-146	55	83-123
30	95-142	60	80-120
35	93-138	65	78-116
40	90-135	70	75-113
45	88-131		

Remember that your goal is to get the benefits you are seeking and enjoy your activity.

Section 5: Gynecological Care

This section contains a number of different documents. For ease of use, they are listed below.

USPST's Pap Smear Recommendations

The Pap Smear Procedure

How to Perform a Breast Self-Examination

STD Interventions for Doctors & Health Care Workers

Basics of Counseling to Prevent Unintended Pregnancy, for Medical Professionals

USPST's Pap Smear Recommendations

The following are the U.S. Preventive Services Task Force's (USPST's) current recommendations regarding the use of the Pap smear.

1. All women who are or have been sexually active should have regular Pap tests.
2. Testing should begin at the age when the woman first engages in sexual intercourse.
3. Adolescents whose sexual history is thought to be unreliable should be presumed to be sexually active at age 18.
4. There is little evidence that annual screening achieves better outcomes than screening every three years. Pap tests should be performed at least every three years.
5. The interval for each patient should be recommended by the physician based on risk factors (e.g., early onset of sexual intercourse, history of multiple sexual partners, low socioeconomic status).
6. Women infected with human immunodeficiency virus (HIV) require more frequent screening according to established guidelines.
7. There is insufficient evidence to recommend for or against an upper age limit for Pap testing, but recommendations can be made on other grounds to discontinue regular testing after 65 years of age in women who have had regular previous screening with consistently normal results.

Women who have undergone a hysterectomy in which the cervix was removed do not require Pap testing, unless the hysterectomy was performed because of cervical cancer or its precursors.

The Pap Smear Procedure

Note to Facilitators:

The following information can be converted into a handout if necessary.

1. A speculum is used to facilitate the scraping of the cells.
2. Do not douche on the day of the examination.
3. If you have significant menstrual flow or obvious inflammation, the doctor may not be able to perform the Pap test.
4. After the speculum exam, the doctor will perform a bimanual (hand exam).
5. The traditional gold standard for the adequacy of a Pap smear has been the presence of endocervical cells in the sample: Scientists believe that 90 percent of cervical cancers develop at the junction between the squamous epithelium section of the ectocervix and the columnar epithelium of the endocervix (located at the external os in young women and inside the endocervical canal in older women).
6. There may be slight spotting following the examination. A variety of instruments may be used to obtain Pap smear samples—simple cotton swabs, wooden and plastic spatulas, and brushes. Bleeding is common after use of a brush.
7. The results of the Pap test can range from "normal" to "abnormal." Abnormal cells can vary from ASCUS (Atypical Squamous Cells of Undetermined Significance): The prognosis of women with ASCUS varies depending on the cytopathologist or laboratory. Clinicians communicate with the cytopathologist and determine whether to do a colposcopy or not. Colposcopy involves a speculum insertion just like regular exam, then a solution is applied to cervix, which turns abnormal areas white. The clinician then examines the cervix through a special microscope (colposcope).
8. During colposcopy, the doctor may obtain a sample (biopsy) of the lesion.
9. Only about 60 percent of women with abnormal Pap smear results return for follow-up. Doctors should establish a tracking system to make sure that Pap smears are performed regularly, that results return in a timely fashion, that patients with abnormal results are contacted, and that women who are not seen frequently are called or contacted by letter about the importance of getting Pap smears and other needed preventive care.

How to Perform a Breast Self-Examination

Note to Facilitators:

The following information can be converted into a handout if necessary.

All women should check their breasts for lumps, thicknesses, or other changes every month. By examining their breasts regularly, they will know how their breasts normally feel. If a change should happen in their breasts, they will be able to identify it and inform their doctor.

1. Women should check their breasts about one week after their last period.
2. Pressing firmly with the pads of their fingers, they should move their left hand over their right breast in a circle. They need to check the entire breast in this manner, including the armpit (*see diagram*).
3. They should next check their left breast in the same manner.



Women should also examine their breasts in a mirror for any changes in appearance.

If any lumps, thickenings, or changes are found, the woman should inform her doctor right away. Most breast lumps are not cancerous, but they need to be checked to be sure. If discovered early, most breast cancer can be successfully treated.

STD Interventions for Doctors & Health Care Workers

1. Women at risk of STDs should be advised of options to reduce their risk in situations when their male partner does not use a condom, including the female condom.
2. Warnings should be provided that using alcohol and drugs can increase high-risk sexual behavior. Persons who inject drugs should be referred to available drug treatment facilities, warned against sharing drug equipment and, where possible, referred to sources for uncontaminated injection equipment and condoms.
3. All patients at risk for STDs should be offered testing in accordance with USPSTF recommendations for screening for syphilis, gonorrhea, chlamydia, genital herpes, hepatitis B, and HIV infection.
4. Determine every patient's risk for STDs, including HIV infection. Tailor counseling to the behaviors, circumstances, and special needs of the person being served.
5. Risk-reduction messages must be personalized and realistic. Counseling should be culturally appropriate, sensitive to issues of sexual identity, developmentally appropriate, and linguistically specific.
6. HIV counseling is not a lecture; an important aspect of HIV counseling is the clinician's ability to listen to the patient.
7. Provide patients with materials about HIV transmission and prevention that are appropriate for their culture and educational level.
8. Advise all patients that any unprotected sexual behavior poses a risk for STDs and HIV infection. A person who is infected can infect others during sexual intercourse, even if no symptoms are present.
9. Caution patients to avoid sexual intercourse with persons who may be infected with HIV, such as those who have injected drugs, individuals with multiple or anonymous sex partners, or those who have had any STD within the past 10 years, even if they have no symptoms.
10. Advise patients not to make decisions about sexual intercourse while they are under the influence of alcohol or other drugs that cloud judgment and permit risk-taking behavior.
11. Provide patients with educational materials and information that explain that STDs and HIV infection are best prevented by the following measures:
 - ❖ Abstinence
 - ❖ Limiting sexual relationships to those between mutually monogamous partners known to be HIV-negative.

- ❖ Avoiding sex with high-risk partners
 - ❖ Avoiding anal intercourse
 - ❖ Using latex condoms if having sex with anyone other than a single, mutually monogamous partner known to be HIV-negative.
12. Provide patients with educational materials and information indicating that partners can transmit infection even if males withdraw before ejaculating and that infection can be transmitted during all forms of sexual intercourse, including oral sex.
 13. Provide educational information indicating that the risk of HIV infection is increased through co-infection with other STDs, such as syphilis, genital herpes, and gonorrhea.
 14. Instruct all sexually active patients about the effective use and limitations of condoms, stressing that they are not foolproof, must be used properly, and may break during intercourse. The best preventive measure against transmission of HIV and other STDs, after abstinence, is the use of latex condoms (not "lambskin" or natural-membrane condoms). Scientific research has demonstrated that latex condoms, when used consistently and correctly, are highly effective in stopping HIV transmission. Condom failure (slippage, breakage, or leakage) is caused usually by user error.
 15. Dispel myths about HIV transmission by informing patients that they cannot become infected from mosquito bites; contact with toilet seats or other everyday objects, such as doorknobs, telephones, or drinking fountains; or casual contact with someone who is infected with HIV or has AIDS, such as shaking hands, hugging, or a kiss on the cheek.
 16. Use patient-centered counseling to assess, inform, and advise about STDs and HIV prevention. In patient-centered counseling, the provider asks the patient what they know about HIV transmission and provides the correct information in response to any misconceptions the patient expresses.
 17. Establish a trusting, caring relationship with the patient to enhance the efficacy of counseling on safe sex practices and risks for STD and HIV infection.
 18. Listen carefully to the patient to identify any specific barriers to preventing STD and HIV infection that the patient has and to assist the patient in identifying a personal, workable preventive plan without lecturing the patient.
 19. Provide counseling that is culturally appropriate. Present information and services in a manner that is sensitive to the culture, values, and traditions of the patient.
 20. Counseling should be sensitive to issues of sexual orientation.

Journey of Hope

21. Provide information and services at a level of comprehension that is consistent with the age and learning skills of the patient, using a dialect and terminology consistent with the patient's language and communication style.
22. Advise all patients of the adverse health consequences of injected drug use. Refer patients with evidence of drug dependence to appropriate drug-treatment providers and community programs specializing in treatment of drug dependencies and actively assist the patient in obtaining assessment for drug treatment.
23. Persons who continue to inject drugs should have periodic screening for HIV and hepatitis B. Hepatitis B vaccination should be considered for individuals who do not have hepatitis B. Measures to reduce the risk of infection caused by drug use should also be discussed: use a new, sterile syringe for each injection; never share or reuse injection equipment; use clean (if possible, sterile) water to prepare drugs; clean the injection site with alcohol before injection; and safely dispose of syringes after use. Patients should also be informed of available resources for obtaining sterile supplies.
24. Contact the state or local health agency responsible for communicable disease reporting to determine the local prevalence of HIV infection and other STDs. This agency also can provide information regarding state and local laws regulating patient testing and confidentiality.

Basics of Counseling to Prevent Unintended Pregnancy, for Medical Professionals

1. The main goal is to make sure family planning is a part of primary care for all sexually active patients. Assess sexual practices and the need for contraceptive counseling for every patient, including women in their 40s and men. Counseling of refugee patients can be sensitive, therefore, address this issue with openness and a nonjudgmental attitude.
2. Determine each patient's level of knowledge about contraceptive options. What methods have they tried in the past? Have these methods been acceptable and effective for the patient and partner or partners? What medical and life-style factors could influence the patient's choice of an appropriate contraceptive?
3. Educate patients about the important characteristics of different contraceptive methods. Present the patient with a range of contraceptive options. Assist patients in carefully choosing a contraceptive method that is appropriate for their abilities, motivation, and life-style, thereby increasing the likelihood that it will be used correctly and consistently. Encourage patients who are already using a method correctly and successfully to continue to do so.
4. Discuss the ability of different contraceptive methods to protect against STDs and HIV infection. Latex condoms, used consistently and correctly, are effective for both birth control and reducing the risk of disease. Other forms of birth control, such as IUDs, diaphragms, cervical caps, and oral contraceptives, do not give the same protection. Stress to patients that even if they use another form of birth control, if they are not involved in a mutually monogamous relationship with a person known to be free of infection, they also need to use condoms to reduce the risk of STDs.
5. Contraception is a responsibility of both partners. If possible, involve both partners in counseling and discussion of contraceptive options. Also discuss ways in which males can participate in family planning.
6. After patients choose a method, conduct an in-depth discussion of:
 - ❖ How it works
 - ❖ Theoretical and actual effectiveness
 - ❖ Advantages/benefits
 - ❖ Disadvantages/risks
 - ❖ How to use the method
 - ❖ Nuisance side effects

Journey of Hope

- ❖ Warning signs
 - ❖ Back-up methods.
7. Provide patients with printed material about the contraceptive method chosen.
 8. Follow-up counseling is particularly important in the first few weeks of contraceptive use, in order to deal with any difficulties associated with use and side effects. Ask patients how they are using the method, correct misinformation, and discuss any impediments to proper use of the method. Continue counseling during each patient visit, especially until patients are very comfortable with use of the contraceptive method. Many compliance problems can be resolved relatively simply with reassurance and changes in dose or technique of use.
 9. Morning after pill
 - ❖ OCs can also be prescribed as a postcoital ("morning after") method to prevent pregnancy. The Food and Drug Administration announced in February 1997 that certain combined oral contraceptives were safe and effective for use as postcoital emergency contraception. This approach to emergency contraception has been reported to reduce the risk of pregnancy by 55.3 to 94.2 percent after unprotected intercourse if treatment is initiated within 72 hours.

Instruct the patient to take the first dose as soon as possible (but no more than 72 hours) after unprotected intercourse; the second dose is taken 12 hours after the first dose. The most common side effects of these regimens are nausea and vomiting.

Appendix B: Domestic Violence

This section contains a number of different documents. For ease of use, they are listed below.

Make a Safety Plan for Escape

A Sample Pamphlet

Make a Safety Plan for Escape

Note to Facilitators:

The following information can be converted into a handout if necessary.

Before the abuser becomes violent, consider the following.

1. Try not to let the abuser trap you in the kitchen (too many potential weapons) or bathroom (no place to dodge blows, and too many places to be pushed or knocked against).
2. Stay out of areas where there are known weapons such as guns. Do not attempt to threaten him with guns because they can be turned against you too easily.
3. Think through all possible escape routes—not only doors, but also first floor or basement windows. If you feel that an attack is imminent make your escape before it starts.
4. Think through now, before the attack, where you will go. If you have no friends or family, consider a shelter. At the very least, go to some place public, such as McDonald's, the library, hospital or shopping center. If he should follow you there, go to the nearest police or fire station.
5. Tell a neighbor about the situation and work out a signal that would let them know that you were in trouble, and that they should call the police.
6. Pack a bag and keep it at a neighbor's house or another safe place. The bag should contain:
 - ❖ extra cash and checks;
 - ❖ an extra set of keys to your house and car;
 - ❖ important documents—birth and marriage certificates, passports, green card, social security numbers, health insurance and medical records, bank account numbers, important phone numbers;
 - ❖ a change of clothes for yourself and your children; and
 - ❖ a familiar toy or book for each child.
7. Talk to your children about safety:
 - ❖ Develop a code the children will understand to mean that the abuse is serious and requires that they leave the house immediately to go to a safe place.
 - ❖ Teach older children to call a relative, friend, neighbor, or police when they see or hear violence.
8. Have a back-up plan ready in case the first one doesn't work.

9. As a last resort, if the violence occurs and you cannot get away, consider pretending to faint or have a seizure—it may stop the attack.
10. If attacked, go to the hospital for medical attention; have the abuse documented on the hospital record. Keep a record of injuries, including photographs.

NEVER SHARE YOUR SAFETY PLANS WITH THE ABUSER

A Sample Pamphlet

For more materials of this type, please see the Resources & References and Bibliography sections of this manual.



Appendix C:

Public Benefits & Community Service

This section contains a number of different documents. For ease of use, they are listed below. Information that can readily be readily transformed into a handout has been so noted.

An Overview of Welfare Reform and Its Impact on Refugees

Supplemental Assistance

FACT SHEET: Refugees and Temporary Assistance for Needy Families (TANF)

FACT SHEET: Refugee Eligibility for Supplemental Security Income (SSI)

SSI Eligibility Checklist

FACT SHEET: Refugee Eligibility for Food Stamps

Food Stamp Program Eligibility Checklist

Sample Pamphlets

An Overview of Welfare Reform and Its Impact on Refugees

*Toyo Biddle, Director, Division of Refugee Self-Sufficiency,
Office of Refugee Resettlement/HHS*

General Overview of Welfare Reform:

Before Reform:

When we talk about welfare reform, we are talking about the reform of the welfare program for families with dependent (minor) children. Before welfare reform, the program providing welfare to these families was called Aid to Families with Dependent Children (AFDC.) AFDC was an entitlement program, which means that appropriated funds were made available to cover every eligible family in need of assistance. In addition, under the old AFDC program, there were no time limits on how long a family could receive welfare. Families were eligible until the youngest eligible child turned 18. The emphasis of the AFDC program was on income maintenance, providing a monthly income to needy families. The emphasis was not on finding employment and moving recipients off welfare.

After Reform:

Now, with the passage of The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, enacted on August 22, 1996, welfare is no longer an entitlement. States are given a block grant that is capped at a certain level, based on the number of welfare recipients that each state had in its caseload during a previous fiscal year.

In addition, the AFDC program has been replaced by a new program, called Temporary Assistance for Needy Families (TANF), which imposes a Federal life-time limit of no more than five years of eligibility for recipients. This means that needy families, including refugee families, may not receive more than five years of federally funded TANF assistance in their lifetime. However, under the welfare reform law, states may choose to impose a shorter lifetime limit than the Federal five-year limit for TANF eligibility. Some examples of shorter state-imposed limits will be discussed later.

Under welfare reform, the focus is getting welfare recipients employed and self-sufficient, and off welfare as soon as possible. This focus is much more in sync with the early employment and self-sufficiency goals of the refugee program. The previous system did not encourage people to seek early employment, which made it more difficult for refugee resettlement programs to persuade refugees to take jobs as soon as possible.

The TANF program emphasizes taking responsibility—if a TANF recipient wants assistance, he/she must get a job or participate in other work activities in return. If a recipient fails to cooperate, he/she is sanctioned and welfare is terminated.

In the first year after the enactment of welfare reform, from August 1996 to September 1997, the welfare caseload shrunk nationwide by 2.4 million recipients due partly to increased employment and partly to sanctioning. Following are some individual state caseload reductions: Idaho - 77 percent; Wisconsin - 40 percent; Florida - 30 percent; Texas - 28 percent; New York - 15 percent; California - 14 percent; and the State of Washington - 12 percent. On the other side of the spectrum, there were a few states whose caseloads increased such as Hawaii with an 13 percent increase in the caseload.

What Refugees Need to Know about Welfare Reform:

Because TANF program characteristics vary considerably from state to state and are likely to change over time, it is important to limit what is communicated to refugees during cultural orientation to the few major features of welfare reform that are uniform across states in order to avoid confusion and minimize misinformation. Two important points that refugees need to know about TANF are:

- ❖ There is a lifetime limit on welfare.
- ❖ TANF recipients must participate in work activities in return for cash assistance.

Federal Requirements in the TANF Program:

The welfare reform law imposes the following Federal requirements on all TANF programs:

- ❖ TANF work participation rates are required by statute. A specified percentage of the single parent caseload in each state must participate in work activities. For example, in FY 1998, 30 percent of the single-parent caseload is required to participate in TANF work activities. For two-parent families the required participation rate is much higher at 75 percent for FY 1998.
- ❖ There is also a required number of hours per week of participation in work activities for TANF recipients—20 hours per week for single-parent families and 35 hours per week for two-parent families.
- ❖ Work activities that are countable towards TANF participation requirements are specified in the welfare reform law. ESL is not one of these activities. Therefore, if a welfare recipient is in an ESL class for 3–5 hours a week, it is not likely to be considered a countable TANF work activity. The work requirement activities are

geared to employment. Some job search and job readiness assistance is included in the list of countable work activities, but only for a limited period of time: four consecutive weeks out of a total of six weeks a year. Recipients do not have to participate in all 12 activities. The employment plan may be custom-designed for each client.

- ❖ As mentioned earlier, Federal welfare reform law requires a five-year lifetime limit for TANF.

Program Differences among States:

Beyond these Federal requirements, states may design their TANF program as they wish. As a result, TANF programs vary from state to state; there is no longer a uniform welfare program in the United States. Following are some of the ways in which state TANF programs vary:

1. Time Limits

States may elect to choose a lower lifetime limit than the Federal five-year limit and some states have done so.

- ❖ Twenty-six states have chosen to follow the five-year Federal time limit. Examples: New York, Pennsylvania, Washington, Minnesota, and Wisconsin.
- ❖ Nine states have chosen to impose a shorter lifetime limit. For example, Florida has a lifetime limit of 48 months, while Connecticut's is 21 months. In 6 of these states, families are already reaching their limit and are being terminated. No one yet knows what is happening to people whose benefits are being cut.
- ❖ Eleven states have an intermittent time limit, which means that within a 60-month lifetime limit, a recipient may be on aid for a certain period of time and then will have to terminate assistance for a certain number of months. For example, TANF recipients in Virginia may receive assistance for 24 consecutive months within a 60-month lifetime limit. After 24 consecutive months, recipients are terminated from assistance for a period of time before becoming eligible again.

2. Income Disregards

In 25 states, 50 percent or more of a recipient's earnings are disregarded if he/she has a full-time minimum wage job. This means that 50 percent or more of a person's income is disregarded when calculating the welfare payment. A person in such a state could work full-time, get 50 percent of their earnings disregarded and still get some level of welfare payment.

In 16 states, the income disregard is less than 50 percent.

3. *Exemptions to Participation in Work Activities*

These also vary among states. In 34 states, a recipient who is a caretaker of a child is exempt from participation in work activities until his/her child is 12 months old. In 17 states, the age exemption is less than 12 months of age. In some states, a caretaker recipient is only exempt if the child is under 3 months of age.

4. *Family Cap*

Twenty-three states impose a family cap. In these states, the monthly welfare check to a family does not increase with the birth of additional children while the family is on welfare. (Under the former AFDC program, the payment level increased if the size of the family increased).

5. *Countable Work Activities*

States vary on how they define each of the Federal countable work activities. For example, some states include an ESL component in their definition of on-the-job training or skills training, while other states do not. Therefore, the extent to which a refugee will be able to receive ESL as part of the 35 hours of required work participation per week will depend on how TANF work activities are defined in the state in which to refugee is resettled.

6. *Structure of TANF Programs*

States also vary in the way they structure their TANF programs. In some states, the TANF program is state-administered, while in other states such as California, Colorado, and Florida, TANF is county-administered. In the latter structure, each county operates its own individual welfare program following the state's legislative requirements.

States vary in regard to which agency is responsible for providing TANF work activities. In Florida, for example, the Department of Labor is the agency which provides job search services to all TANF recipients during their first three weeks after intake, while the Florida Department of Children and Families is responsible for providing the monthly welfare checks. Each welfare recipient is required to conduct an independent job search in these three weeks, making a certain number of contacts with employers each week. This movement is especially challenging for refugees with limited English ability. If recipients have not found employment during that time, they are then referred to a local coalition board in the county in which they live for further work activities. The local coalition board contacts with service agencies to provide a variety of countable work activities.

State TANF programs also vary in the extent to which states contract with the private sector to provide services. For example, in Dade County, FL, the main contractor for the local TANF coalition board is the Lockheed

Corporation, which is responsible for providing work activities to TANF recipients in Dade County.

How TANF Affects Refugees: the Pluses and the Minuses:

The Pluses

Refugee TANF recipients, like other TANF recipients, will have to adhere to TANF work participation requirements, which means that there will be high participation among refugees in employment activities. We see this as a positive effect because refugees are more likely to receive the preparation and training they need to become self-sufficient than was the case under the former AFDC program.

The Minuses

In some states, the TANF payment level is too low for large refugee families. In Idaho, for example, the maximum monthly grant level is a flat \$276 regardless of the number of people in the family.

TANF services are not designed for refugees. Since state TANF programs are designed for the mainstream recipient population, they are often not well-suited to a specialized population such as refugees, particularly newly arrived refugees who do not speak English and have not yet acculturated. We are concerned that refugees participating in TANF may not receive the linguistically and culturally adapted services and world preparation they need to obtain employment quickly and move off welfare.

For example, most state TANF programs provide TANF recipients with a short orientation on TANF, its work requirements, and the responsibilities of TANF participants before participating in job club/job search for a period of time. Our experience in the refugee program has shown that refugees new to the US require extensive and sometimes repeated orientation in the American work culture and the expectations of American employers to properly prepare them for placement in a job in the United States. Orientation for non-English speaking refugees, by necessity, must be conducted in the native language of the refugees. State TANF programs usually are not designed to provide such specialized orientation.

We also know that refugees who are limited English-speaking are able to successfully obtain employment through assisted job search and job placement in which refugees are aided by bilingual employment counselors, both in making employer contact and in the job interview. However, in most state TANF programs, participants are required to engage in intensive unassisted job search for a period of time, in some cases as long as 12 weeks. While this method may be appropriate for mainstream TANF recipients, unassisted job search is not an effective method of finding employment for newly arrived refugees who do not speak English and are not familiar with American

culture. As a result, time spent in TANF job search is often wasted time that does not bring a refugee any closer to employment.

It is difficult for refugees to obtain certain services they need under TANF. Providing ESL services to refugees has become a challenge because ESL is not a countable work activity.

Refugees are no longer being served by refugee service agencies. Refugee TANF recipients are being referred along with other TANF recipients to mainstream agencies for work activities. The major challenge in the domestic refugee program is to obtain agreements with state TANF agencies to have refugee TANF recipients referred to the refugee service system for TANF work activities instead of to mainstream agencies.

Supplemental Assistance

Note to Facilitators:

The following information can be converted into a handout if necessary.

There are a variety of federal, state and community services and supplemental income programs available to assist you and your family for a temporary period of time. Eligibility is often based on your legal status, need, personal income, age, health, or number of dependents.

Not Everyone Is Eligible for These Programs

Temporary Assistance to Needy Families (TANF):

Federal program with a five-year, lifetime limitation that provides assistance to low-income (or no income) families with children. Some states (nine) have shorter lifetime limitations. Some states limit aid to 24 months at any one time. Some states provide aid to mothers of newborn children so that they need not work during the first year of the child's life—some states provides aid for a shorter period of time.

Refugee Cash Assistance Program:

Eight-month program for families without children. Also funds programs to help refugees prepare for jobs (ESL, job-training).

Match Grant Program (Alternative to TANF):

Four-month state program (not all states offer this program) for families who want to become employed quickly.

Refugee Medical Assistance (RMA):

Eight-month federal program (if you are eligible for a state medical aid program). It covers real emergency care at municipal hospitals.

Supplemental Security Income (SSI):

Federal program that provides cash benefits to low-income people who are over age 65 or who are seriously disabled. After receiving benefits for seven years, all recipients must become U.S. citizens before receiving further benefits.

Food Stamps:

Federal program that provides coupons to purchase food (no cigarettes, alcohol, paper products).

Energy Assistance:

Pays for heating.

Title XX:

Federal program that pays for some child care programs and public health programs in which your family may participate.

Mutual Assistance Association (MAA):

MAA's are usually made up of former refugees and immigrants. They provide orientation programs, temporary transportation, assistance with clothing, furniture, ESL classes, etc.

FACT SHEET:

Refugees and Temporary Assistance for Needy Families (TANF)

REVISED, September 1, 1999

Note: The primary goal of this fact sheet is to help professionals who work with refugees understand federal TANF policies and state policy options as they apply to refugees. The fact sheet does not include details of each state's TANF program. However, the Refugee Welfare and Immigration Reform Project welcomes inquiries about a particular state's TANF program or other TANF-related issues affecting refugees in your area.

Introduction:

The 1996 welfare law substantially changed the nature of public assistance.⁽¹⁾ The legislation makes public assistance temporary for most recipients—regardless of their income level—and requires most parents to participate in some form of work activity while receiving TANF assistance. Refugee service providers are in a key position to make refugees aware of the time-limited nature of public assistance, to help them plan how to make the best use of their benefits, and to guide them in developing strategies for achieving self-sufficiency as quickly as possible. For most refugees, this will mean becoming integrated into the American workplace as soon as they can and then seeking advancements in their positions, wages, and benefits.

What is TANF?

TANF—Temporary Assistance for Needy Families—is the program established by PRWORA,⁽¹⁾ which was enacted on August 22, 1996. The new law ended the federally funded AFDC (Aid to Families with Dependent Children) program and created federal block grants to the states. The states have broad discretion to design and administer their own welfare programs. Through TANF, each state provides cash benefits to certain groups of low-income families with minor children. States determine benefit levels and can set limits on the length of time families can receive TANF assistance. States also may provide supportive services, such as child care and transportation.

Who Can Receive TANF Assistance?

Refugees⁽²⁾ can receive TANF assistance *if their family meets all the requirements for eligibility in their state* (such as having limited income and assets) and they are a member of one of the following groups:

- ❖ **Citizens.** Refugees who have become naturalized citizens are eligible for TANF assistance under the same rules as native-born citizens. Citizen children of refugee parents are eligible for TANF assistance.
- ❖ **Refugees in the U.S. before August 22, 1996.** As a result of federal- and state-level legislation, almost all refugees in the U.S. at the time the welfare law was enacted are eligible for TANF assistance to the same extent as citizens. PRWORA requires that *all* refugees are eligible for TANF assistance *for their first five years in the country*. Almost all states have chosen to continue this eligibility past the five-year period for refugees (and other qualified aliens⁽³⁾) who entered the country before August 22, 1996.⁽⁴⁾
- ❖ **Refugees arriving in the U.S. after August 22, 1996.** PRWORA requires that *all* refugees are eligible for TANF assistance for their first five years in the country. Most states have chosen to continue this eligibility past the five year period for refugees (and other qualified aliens) who entered the country after August 22, 1996.⁽⁴⁾
- ❖ **Long-term workers and certain of their family members.** Legal permanent residents who have worked or can be credited with 40 quarters of work under the Social Security Act are eligible for TANF assistance to the same extent as citizens. Spouses receive credit for the quarters worked by their husbands/wives; children receive credit for the quarters worked by their parents while the children were under the age of 18 (even if the children are now over the age of 18).⁽⁵⁾
- ❖ **Armed Forces active personnel and veterans, and certain of their family members.** Refugees who are currently in the Armed Forces and those who are veterans with honorable discharges who have met minimum active-duty requirements are eligible for TANF assistance to the same extent as citizens. The unmarried dependent children and most spouses of these refugees also can be eligible for TANF assistance if they are legally residing in the United States.

Determining a non-citizen's eligibility for TANF assistance can be a complex task. You may wish to contact your local welfare office for the most current information about refugee eligibility for TANF assistance in your state. If you are told a particular refugee is not eligible for TANF assistance due to her/his immigration status, you may wish to review your state's TANF legislation and regulations to verify this information.

Residency requirements. Some states have placed restrictions on eligibility or benefit level for TANF assistance applicants who have not resided in the state for a certain length of time, such as thirty days or twelve months. Some of these residency requirements have been declared unconstitutional by courts and are not in effect. Contact your local welfare office for information on residency requirements in your state.

Is There a Limit on the Length of Time a Family Can Receive TANF Assistance?

Nearly all states have set limits on the length of time a family can receive TANF assistance. States may use federal funds to provide TANF assistance for a family that includes an adult up to a lifetime limit of 60 months. States can use federal funds beyond 60 months for up to 20 percent of a state's TANF caseload. The federal law imposes no time limits on assistance provided with state funds. About 30 states have set a lifetime limit of 60 months. Some states have set lifetime limits shorter than 60 months. One state does not have a time limit; another state requires work rather than reducing or terminating assistance once the time limit is reached. In both of these states, parents must meet program (including work) requirements to continue receiving TANF assistance.

States have differing policies on when a family can be exempt from time limits and when benefits can be extended when a time limit is reached. In some states, for example, families are exempt from time limits if the adult is incapacitated or caring for a disabled family member. In some states, families may be exempted from the lifetime limit or have their benefits extended upon reaching the lifetime limit if the family includes an individual who has been subject to domestic violence.

In general, states do not apply time limits to "child only" cases. (For example, these could be families in which a child lives with parents who are ineligible. They could also be families in which a child lives with adults, usually relatives, who are not the parents of the child and the adults do not receive assistance themselves.) In a handful of states, the family may continue to receive benefits for the child once the adult's time limit has been reached. In determining whether an adult has reached the time limit, states do not generally count months when the adult received TANF assistance as a minor child.

Requirements for Continuing to Receive TANF Assistance

States have established requirements that recipients must meet to continue to receive TANF assistance. All states include the following types of requirements in their TANF plans. Your state may have adopted additional requirements. Contact your local welfare office for information about the specifics of your state's plan.

Work-related activities. States must assure that recipients are involved in some form of work-related activity. However, the work requirement might not take effect immediately, and some recipients may be exempted from this work requirement.

Child support. Individuals must cooperate with the state in obtaining child support payments unless they have received a "good cause" exemption.

Teen parents. Parents under the age of 18 must live with their parents, guardians, or other adult relatives, or in other supervised living arrangements unless their current living situation is found to be appropriate. They must also pursue a high school diploma or its equivalent or participate in an alternative educational or training program that has been approved by their state.

How Can I Obtain More Information about Eligibility for TANF Assistance?

For more information about eligibility for TANF assistance, you may contact your local welfare office or the Refugee Welfare and Immigration Reform Project (the address and telephone number are at the end of this Fact Sheet).

Endnotes:

1. The law is called the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).
2. Asylees (but not asylum applicants), aliens granted withholding of deportation, Cuban and Haitian entrants, and Amerasian immigrants from Vietnam are treated the same as refugees for the purpose of determining federal benefits eligibility.
3. The following groups of people are qualified aliens: legal permanent residents (including Amerasians from Vietnam), refugees, asylees, those granted parole for more than one year, those granted withholding of deportation, conditional entrants before 1980, Cuban-Haitian entrants, and certain victims of domestic violence.
4. In some states, refugees who have been in the country longer than 5 years are required to adjust their status to legal permanent resident to remain eligible for TANF assistance.
5. For qualifying quarters worked after December 31, 1996, to be credited, the refugee and anyone else whose quarters the refugee is claiming cannot have received "federal means-tested public benefits"—which include TANF assistance, Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Food Stamps, Medicaid, and Children's Health Insurance Program (CHIP) benefits—during the quarter.

Sources:

Center for Law and Social Policy: *A Detailed Summary of Key Provisions of the Temporary Assistance for Needy Families Block Grant of H.R. 3734: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Mark Greenberg and Steve Savner, 8-13-96 (<http://www.clasp.org/pubs/>)

Journey of Hope

TANF/detail.pdf). Limits on Limits: State and Federal Policies on Welfare Time Limits, Mark Greenberg, Steve Savner and Rebecca Swartz, 1996.

Welfare Policy Center, Hudson Institute. *Chart of Time Limits Based on TANF Programs. Time Limits*, Peggy Flaherty Haering, December 1996.

Immigrant Policy Project at the National Conference of State Legislatures. *Welfare Reform: State Trends, 10-21-97. Welfare Reform: Temporary Assistance for Needy Families, 3-18-98.*

National Governors' Association. *Summary of Selected Elements of State Plans for TANF, 3-14-99.* (<http://www.nga.org/Welfare/TANF1998.PDF>)

Notes:

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This document was developed with funding from the Office of Refugee Resettlement of the U.S. Department of Health and Human Services (DHHS). The views expressed are those of ISED and may not reflect those of DHHS.

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FACT SHEET:

Refugee Eligibility for Supplemental Security Income (SSI)

REVISED, September 1, 1999

What is Supplemental Security Income (SSI)?

SSI is a federally-funded program that provides cash benefits to low-income people who are aged, blind, or disabled.⁽¹⁾ Since SSI is a federal program, the rules about which noncitizens are eligible are the same regardless of the state in which one lives. SSI is administered by the Social Security Administration.

Can refugees receive SSI benefits?

Refugees⁽²⁾ can receive SSI benefits if they meet all the requirements for eligibility (such as having limited income and resources and being aged or disabled) and meet one of the following six criteria:

- ❖ **All refugees during their first seven years in the U.S.** During their first seven years in the U.S., low-income refugees are eligible for SSI under the same rules as native-born citizens.⁽³⁾ This rule applies to all refugees, regardless of when they entered the country or whether they have adjusted their status since entering the U.S.
- ❖ **Refugees who were receiving SSI benefits on August 22, 1996.** Refugees who were receiving SSI benefits on August 22, 1996, can continue to receive these benefits as long as they continue to meet all other SSI eligibility requirements.
- ❖ **Refugees who were living in the U.S. on August 22, 1996, and become disabled after that date.** Refugees who were living in the U.S. on August 22, 1996, and become blind or disabled after that date are eligible for benefits if they meet other SSI requirements, regardless of when they apply or when the disability begins.
- ❖ **Long-term workers and certain of their family members.** Refugees who have worked 40 quarters or can be credited with 40 quarters of work that qualify under the Social Security Act and who have adjusted their status to legally admitted permanent resident are eligible for SSI under the same rules as native-born citizens. Spouses receive credit for the quarters worked by their husbands/wives, and children under the age of 18 receive credit for the quarters worked by their parents. For qualifying quarters worked after December 31, 1996, to be credited, the refugee cannot have received Temporary Assistance for Needy Families (TANF), Aid to Families with Dependent Children (AFDC), SSI, Food Stamps,

Medicaid, or Children's Health Insurance Program (CHIP) benefits during the quarter.⁽⁴⁾

- ❖ **Armed Forces active personnel and veterans, and certain of their family members.** Refugees who are currently in the Armed Forces and those who are veterans⁽⁵⁾ with honorable discharges who have met minimum active-duty requirements are eligible for SSI under the same rules as native-born citizens. The unmarried dependent children and spouses (including unremarried surviving spouses of deceased veterans) of these refugees also can be eligible for SSI if they are legally residing in the United States.
- ❖ **Citizens.** Refugees who have become naturalized citizens are eligible for SSI under the same rules as native-born citizens.

Some people have found it difficult to figure out whether they are eligible for SSI. What makes this so confusing?

Determining whether a refugee is eligible for SSI can be confusing for four reasons: (1) eligibility varies for different refugees' circumstances; (2) there were several changes in SSI eligibility rules for refugees during the August 1996 to September 1997 time period; (3) refugees sometimes are confused with immigrants; and (4) some states have created their own cash assistance programs.

1. As the information above shows, whether a particular refugee can become eligible for SSI depends on several factors, such as their length of time in the U.S., previous SSI history, veteran status, and work history.
2. There have been several changes in SSI eligibility rules for refugees since August 1996.⁽⁶⁾ Refugees who are not aware of all these changes may be making decisions based on outdated information.
3. Refugees sometimes are confused with immigrants, whose eligibility for SSI is more limited.⁽⁷⁾ Unless refugees make sure that Social Security Administration staff recognize that they are refugees rather than immigrants,⁽⁸⁾ they may be denied benefits for which they are eligible.
4. In some states—such as California, Colorado, Nebraska, New York, Pennsylvania, Rhode Island, and Washington—refugee residents are eligible for state-funded cash assistance. Refugees may wish to ask their state welfare offices if they are eligible for state-funded old age, disability, general assistance, or unemployment benefit programs.

How do refugees apply for SSI?

Refugees, like native-born citizens, may apply for SSI at their local Social Security Administration offices. The initial determination of whether an applicant is eligible for SSI benefits probably will be made within three months of the date the application is filed.

How can I obtain more information about SSI eligibility rules?

For more information about SSI eligibility rules, you may call the Social Security Administration (SSA) toll-free at 1-800-772-1213 or contact your local Social Security office. SSA also has a web site (<http://www.ssa.gov>) and a toll-free automated document fax service (1-888-475-7000) that include information about SSI. Some of the web and fax documents are available in languages other than English.

Endnotes:

1. The Social Security Administration defines disability as the inability to engage in substantial gainful employment because of a medically determinable impairment that has lasted or is expected to last at least 12 months or to end in death.
2. Asylees, persons granted withholding of deportation, Cuban and Haitian entrants, and Amerasian immigrants from Vietnam are treated the same as refugees for the purpose of determining benefits eligibility.
3. Asylees and persons granted withholding of deportation have access to SSI for their first 7 years after being granted such status. Refugees lose eligibility the first month after the date of their seventh anniversary in the U.S. unless they are eligible for SSI under one of the other criteria listed in this document. Asylees and aliens whose deportation has been withheld lose eligibility the first month after the seventh anniversary of the date this status was granted. If they had been receiving SSI prior to this anniversary date, their benefits will cease the next month unless they are eligible for SSI under one of the other criteria listed in this document.
4. Federal law provides that refugees and other qualified aliens cannot include months in which they received any "federal means-tested public benefits" in the 40 quarters of work that would make them eligible for SSI benefits. "Federal means-tested public benefits" has been interpreted to include the six programs listed. If a spouse or child (under the age of 18) of a refugee who has worked 40 quarters is applying for SSI benefits, they cannot count in the 40 quarters of work any quarters in which either the refugee or the spouse or child has received federal means-tested public benefits.
5. The Balanced Budget Act of 1997 (BBA) added to the veteran definition individuals who served in the Philippine Commonwealth Army during World War II or as Philippine scouts following the war. A nonbinding Sense of the Congress resolution in the BBA provides that Hmong and other Highland Lao veterans who fought under U.S. command during the Vietnam War and who have been lawfully admitted to the U.S. for permanent residence should be considered as veterans for the purposes of continuing benefits. However, because the BBA did not change the definition of "veteran," which does not include Hmong and other Highland

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Laotians, they cannot become eligible for SSI benefits based on veteran status.

6. For example, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the welfare reform law) provided that refugees who enter the country on or after August 22, 1996, could be eligible for SSI for five years. The Balanced Budget Act of 1997 (BBA) extends this eligibility period to seven years.
7. For example, immigrants entering the country on or after August 22, 1996, are not eligible for SSI unless they meet the citizenship, Armed Forces status, or 40 quarters of work criteria described in this fact sheet or are Amerasian immigrants from Vietnam within their first seven years in the U.S. (see *endnote #2*).
8. Refugees should have either: a) an I-94 card stamped with a message stating that they entered the U.S. as a refugee admitted under section 207 of the Immigration and Nationality Act, or b) a Green Card (I-551) with the code RE-6, RE-7, RE-8, or RE-9. If a refugee does not have his or her I-94 or I-551, Social Security staff usually can verify the person's entry as a refugee with the Immigration and Naturalization Service.

Sources:

1997 Balanced Budget Act Amendments to Public Benefits Provisions of PRWORA. National Immigration Law Center, September 25, 1997.

ORR State Letter #97-17. Office of Refugee Resettlement, Department of Health and Human Services, August 15, 1997.

Welfare Reform and Immigrants: State Trends. Immigrant Policy Project at the National Conference of State Legislatures, October 21, 1997. (<http://www.StateServ.hpts.org/public/pubhome.nsf>; "Immigrant Policy"; "Issue Briefs"; "State Trends")

Notes:

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To the best of our knowledge, information contained in the Fact Sheet was accurate on September 1, 1999. Federal eligibility requirements for SSI may have changed between then and the date on which you are reading the Fact Sheet. Eligibility for state-funded old age and disability benefits also may have changed as a result of legislative action.

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Acknowledgments:

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SSI Eligibility Checklist

Note to Facilitators:

The following information can be converted into a handout if necessary.

Supplemental Security Income (SSI) is a federally-funded program that provides cash benefits to low-income people who are aged, blind, or disabled.

I am a refugee.

Am I eligible for Supplemental Security Income (SSI)?

As a refugee, you may be eligible for SSI if:

- (1) You are low-income according to Social Security guidelines; **AND**
- (2) You are blind or disabled or age 65 or older; **AND**
- (3) At least one of the following statements is true:
 - ❖ You are a U.S. citizen; You were receiving SSI benefits on August 22, 1996; You have been living in the U.S. for no more than seven years;
 - ❖ You are disabled and were living in the U.S. on August 22, 1996;
 - ❖ You and/or certain of your family members have worked in the U.S. for a sufficient number of years and you have adjusted your status to legally admitted permanent resident; or
 - ❖ You or certain of your family members are in the U.S. Armed Forces or are a U.S. Armed Forces veteran (and meet certain other requirements).

For additional information about eligibility for SSI:

Call the Social Security Administration (SSA) toll-free at 1-800-772-1213 or your local Social Security Administration office. Call 1-888-475-7000 toll-free to obtain a copy of the SSA's Fax Catalog Document Index, which lists documents available by fax in various languages.

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FACT SHEET:

Refugee Eligibility for Food Stamps

REVISED, September 1, 1999⁽¹⁾

What is the Food Stamp Program?

The Food Stamp Program provides monthly coupons or benefits to low-income households⁽²⁾ for the purchase of food. Most of the cost of providing benefits and administering the program is paid by the federal government. State welfare offices administer the program and pay part of the administration costs.

Can refugees receive federally-funded food stamps?

Refugees⁽³⁾ can receive federally-funded food stamps *if their household meets all the requirements for eligibility* (such as having limited income and resources) and they are a member of one of the following groups:

- ❖ **Citizens.** Refugees who have become naturalized citizens are eligible for food stamps under the same rules as native-born citizens.
- ❖ **All refugees during their first seven years in the U.S.**
- ❖ **Long-term workers and certain of their family members.** Refugees who have worked 40 quarters or can be credited with 40 quarters of work that qualify under the Social Security Act *and* who have adjusted their status to legally admitted permanent resident are eligible for food stamps under the same rules as citizens. Spouses receive credit for the quarters worked by their husbands/wives; children receive credit for the quarters worked by their parents while the children were under the age of 18 (even if the children are now over the age of 18).⁽⁴⁾
- ❖ **Armed Forces active personnel and veterans, and certain of their family members.** Refugees who are currently in the Armed Forces and those who are veterans with honorable discharges who have met minimum active-duty requirements are eligible for food stamps under the same rules as citizens. The unmarried dependent children and most spouses (including unremarried surviving spouses of deceased veterans) of these refugees also can be eligible for food stamps if they are legally residing in the United States.
- ❖ **Hmong and Highland Laotians.** Members of a Hmong or Highland Lao tribe when the tribe assisted the U.S. Armed Forces during the Vietnam era (and their spouses, unmarried widows/widowers, and unmarried dependent children) are eligible for food stamps under the same rules as citizens.

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- ❖ **Elderly refugees living in the U.S. on August 22, 1996.** Refugees living in the U.S. on August 22, 1996 who were 65 or older on that date are eligible for food stamps under the same rules as citizens.
- ❖ **Refugee children living in the U.S. on August 22, 1996.** Refugees living in the U.S. on August 22, 1996 who are under the age of 18 are eligible for food stamps under the same rules as citizens.
- ❖ **Disabled refugees living in the U.S. on August 22, 1996.** Refugees living in the U.S. on August 22, 1996 who are receiving benefits for disability or blindness at the time of application are eligible for food stamps under the same rules as citizens.

Do states also provide food assistance?

Some states provide state-funded food assistance to certain refugees and immigrants who have lost federal food stamp eligibility due to the welfare reform law. Specific eligibility requirements and benefit levels vary from state to state.

Does the food stamp program have work requirements?

The federal food stamp program has work requirements for some recipients. State food assistance programs also may have work requirements.

- ❖ States may require parents of children above a certain age to work or be engaged in a work-related activity, such as job searches or job readiness courses.
- ❖ *Refugee employability services* approved, funded, or operated by the Office of Refugee Resettlement (ORR) are federally recognized training programs for purposes of food stamp eligibility. Refugees participating at least half-time in these programs are exempt from Food Stamp Program work requirements and time limits.
- ❖ Generally, able-bodied adults between the ages of 18 and 50 who do not have dependent children will be ineligible to continue receiving food stamps if they have received food stamps for any 3 months in a 36-month period while not working or participating in a work program at least 20 hours per week or working off their benefits in a food stamp workfare program.⁽⁵⁾ As noted above, this time limit does not apply to refugees participating at least half-time in employability services approved, funded, or operated by ORR. In some circumstances, individuals who have used their first three months of benefits, gone to work, and then are laid off can receive up to three months of additional benefits.

Most states have waivers of the three-month food stamp work requirement in areas of high unemployment or insufficient jobs. Able-bodied adults without dependent children who receive food stamps in these waived areas still may

have to meet state work requirements, such as job search and job readiness activities, to continue receiving food stamps.

States also have an option under the welfare law to exempt an additional 15% of their non-waivered caseload from the work requirements. If states accept this option, they select which groups of people will be exempted.

Can refugees receive any other nutritional assistance benefits?

Refugees are eligible for several other nutritional assistance programs to the same extent as citizens: emergency food assistance; school breakfasts and lunches; summer food service and child care food programs; the Women, Infants, and Children (WIC) program; the Commodity Supplemental Food, Homeless Children Nutrition, and Special Milk Programs; and the Nutrition Program for the Elderly.

How can I obtain more information about food stamps?

For more information about food stamp eligibility rules, contact your local welfare office. These web sites also may be helpful: the Food and Consumer Service of the U.S. Department of Agriculture (<http://www.usda.gov/fcs>) and FRAC, the Food Research and Action Center (<http://www.frac.org>).

Endnotes:

1. This revised Fact Sheet incorporates changes to Food Stamp eligibility rules included in the Agricultural Research, Extension, and Education Act of 1998. These changes went into effect on November 1, 1998.
2. The Food Stamp Program defines "household" as a person or group of people living together, not necessarily related, who purchase and prepare food together.
3. Asylees, persons granted withholding of deportation, Cuban and Haitian entrants, and Amerasian immigrants from Vietnam are treated the same as refugees for the purpose of determining food stamps eligibility.
4. For qualifying quarters worked after December 31, 1996, to be credited, the refugee and anyone else whose quarters the refugee is claiming cannot have received "federal means-tested public benefits"—which include Temporary Assistance for Needy Families (TANF), Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Food Stamps, Medicaid, and Children's Health Insurance Program (CHIP) benefits—during the quarter.
5. Individuals who are exempt from work registration requirements under the Food Stamp Act (such as students enrolled at least half-time in a recognized training program, persons with physical or mental conditions preventing them from working, and pregnant women) are exempt from

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this time limit. Individuals who lose food stamp benefits because they have reached the three-month cutoff point may regain eligibility by working or participating in work programs at least 80 hours in a 30-day period or by working off a month's benefits in a workfare program, which generally requires no more than 24 hours per month.

Sources:

Nutritional Assistance. Immigrant Policy Project, October 27, 1997.

Nutrition Security Hotline. U.S. Department of Agriculture, August 18, 1997. (<http://www.usda.gov/fcs/library/nsh.htm>)

Summary of Nutrition Provisions in the Welfare Reform Act. Food Research and Action Center, October 16, 1996. (<http://www.frac.org/html/news/101696.html>)

Notes:

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Food Stamp Program Eligibility Checklist

Note to Facilitators:

The following information can be converted into a handout if necessary.

The Food Stamp Program provides monthly coupons or benefits to help low-income households purchase food.

*I am a refugee.
Am I eligible for Food Stamps?*

As a refugee, you may be eligible for Food Stamps if:

(1) You are low-income according to U.S. Department of Agriculture guidelines

AND

(2) At least one of the following statements is true:

- ❖ You are a U.S. citizen;
- ❖ You have lived in the U.S. less than seven years;
- ❖ You and/or certain people in your family have worked in the U.S. for a sufficient number of years and you have adjusted your status to legally admitted permanent resident;
- ❖ You or certain people in your family are in the U.S. Armed Forces or are a U.S. Armed Forces veteran (and meet certain other requirements);
- ❖ You or certain people in your family were members of a Hmong or Highland Lao tribe when that tribe assisted the U.S. Armed Forces during the Vietnam era;
- ❖ You were living in the U.S. on August 22, 1996 and were age 65 or older at that time;
- ❖ You were living in the U.S. on August 22, 1996 and you are now 17 or younger;
- ❖ You were living in the U.S. on August 22, 1996 and you receive benefits for disability or blindness.

For additional information about eligibility for Food Stamps:

- ❖ Call your local welfare office or

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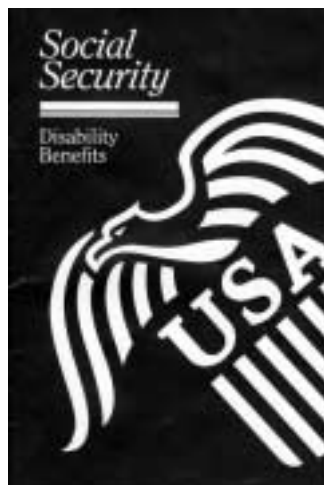
- ❖ Contact ISED to obtain a copy of Fact Sheet: Refugee Eligibility for Food Stamps (available only in English):

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Sample Pamphlets

For more materials of this type, please see the Resources & References and Bibliography sections of this manual.



Appendix D: Female Circumcision/ Female Genital Mutilation

A Manual on Female Circumcision/Female Genital Mutilation As It Relates to Newcomer Immigrant & Refugee Women

*Written by Sarah Alexander, LICSW and Elizabeth Nolan
Sponsored by The Immigration and Refugee Services of America (IRSA)*

Table of Contents

- 1. Purpose of This Manual**
- 2. What is FC/FGM?**
 - Where Is FC/FGM Practiced?
 - What Are the Government Efforts in Countries that Practice FC/FGM?
- 3. Social and Cultural Beliefs Supporting the Practice of FC/FGM**
 - Physiological Beliefs
 - Social Beliefs
 - What Will My Client's Attitude toward FC/FGM Likely Be?
 - Special Issues for Refugee Women
 - What Is the Proper Term for FC/FGM?
- 4. Health Risks & FC/FGM**
 - Medical Options in the United States
 - FC/FGM and Pregnancy
 - FC/FGM & HIV
 - How Can I Support My Client with Regard to Health Issues and FC/FGM?
- 5. FC/FGM & U.S. Law**
- 6. Strategies for Community Outreach**
 - Questions Teachers and Caseworkers Frequently Ask
 - Questions Newcomer Women Frequently Ask
- 7. Annex A: Full Text of U.S. Law**
- 8. Annex B: Country-Specific Chart of FC/FGM Prevalence in Africa**
- 9. Annex C: List of Advocacy Organizations**
- 10. Annex D: Useful Reading Materials**

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Zeinab Eyega of RAINBO and Lisa Hibler of the Center for Reproductive Law and Policy contributed enormous expertise in editing this manual. Genet Bekele, Halima Ali, and Aweke Kifle of the International Institute of Boston offered on-going advice. We also wish to thank Dr. Nawal Nour of Brigham and Women's Hospital in Boston, and Rana Badri of Equality Now for their suggestions and edits.

Purpose of this Manual

The purpose of this manual is to provide a concise overview of the issues surrounding Female Circumcision/Female Genital Mutilation (FC/FGM), for caseworkers, educators, and social service advocates who are working with refugee and immigrant women and families who come from areas where the procedure is practiced. We hope that this information will provide a broader understanding of FC/FGM, clarity to the U.S. law prohibiting FC/FGM, and suggest directions for accessing further information. Additionally, the manual is intended to provide suggestions for counseling newcomers on FC/FGM, and for educating a broader spectrum of the provider community on the issue of FC/FGM.

What is FC/FGM?

Female circumcision/female genital mutilation (FC/FGM) is an umbrella term that describes three discrete surgical procedures: clitoridectomy, excision, and infibulation (also known as pharonic circumcision). It is a custom that involves the cutting of parts of the external genitals of girls and women to fulfill cultural and traditional beliefs. The origin of the practice is unknown. Female circumcision cuts across country, ethnic, cultural, religious, and class lines of very diverse African populations. Therefore, the way the practice is performed and the reasons given to explain it may differ from one society to the other. The age at which girls or women are circumcised also varies, depending on the country, tribe, or clan. In some groups, it is done as early as the ages of one or two or between the ages of four and twelve, while in others it is done just before marriage or before the birth of the first child.

Although it is not performed with malicious intentions, female circumcision has come to be viewed as unnecessary and damaging to girl's and women's physical and mental well-being. It interferes with their natural bodily functions, and numerous health complications, as well as psychological and emotional consequences, of the practice have been documented.¹ Moreover, in the last decade, several countries in Africa, Europe, Australia, New Zealand, and North America have instituted laws prohibiting the practice. Contrary to popular belief, FC/FGM is not a requirement of a specific religion. Women who practice Christianity, Islam, Judaism and other religions may also practice FC/FGM.

Types of FC/FGM²

Clitoridectomy: The partial or total removal of the clitoris.

Excision: Removal of clitoris and labia minora (inner lips).

Infibulation: Removal of the clitoris, labia minora (inner lips) and incision of the labia majora (outer lips), with stitching together of the remaining skin into a hood that covers the entrance to the vagina.

Unclassified: These involve different forms of cutting, including pricking and tattooing of the clitoris and stitching around the vagina.

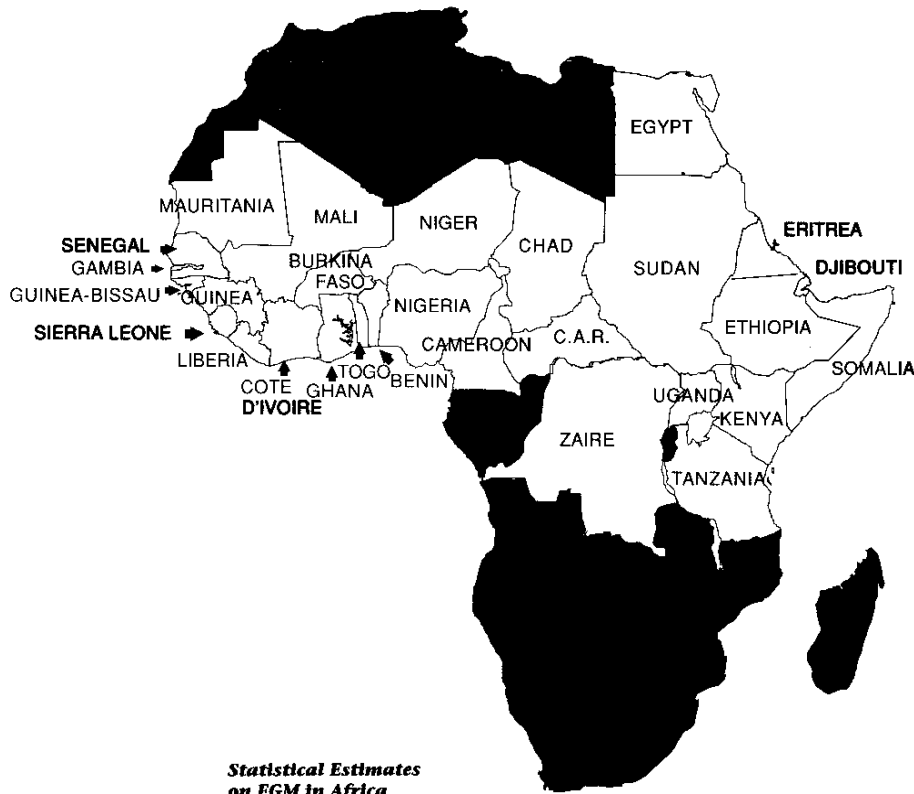
Where Is FC/FGM Practiced?

FC/FGM is practiced in 28 African countries and a few isolated areas in Iraq and Yemen. It should be noted that within countries and smaller regions, the extent of practice and kind of procedure vary widely. Below is a map of the countries in Africa in which it is practiced. Annex B of this Appendix contains more comprehensive information on the prevalence and type of FC/FGM as it relates to each country in Africa.

What Are the Government Efforts in Countries that Practice FC/FGM?

In recent years, both women and men in Africa have taken steps to make the practice of FC/FGM illegal. Previously, most anti-FC/FGM legislation was passed by colonial governments who looked upon the indigenous culture with disdain.³ In more recent times, nine African countries have passed their own specific legislation against FC/FGM: Burkina Faso, Central African Republic, Cote d'Ivoire, Djibouti, Ghana, Guinea, Senegal, Tanzania, and Togo. In most countries, penalties for performing the procedure range from one to five years of imprisonment or a fine. Most laws call for increased penalties when the practice of FC/FGM results in death. As of January 1999, at least three countries had prosecuted individuals for the practice: Egypt, Burkina Faso, and Ghana.⁴ However, legal prohibition and government policies discouraging the practice are relatively recent and are not uniform in all countries.

It is too early to determine the effectiveness of legislative and government policies in preventing this practice. It is important for westerners to realize that opinion on the practice will vary widely within national and cultural groups. Some newcomers may be very attuned to advocacy efforts in their home country, while others may be completely unaware of the larger context of the issue in Africa. Listed at the back of this manual are some of the organizations working in Africa and in other countries to address this practice.



**Statistical Estimates
on FGM in Africa**
Estimated prevalence
rates have been developed
from reviews of national
surveys, small studies and
country reports and from
the Hosken Report, Fourth
Edition, 1993.

Social/Cultural Beliefs Supporting the Practice of FC/FGM

It is essential to understand the beliefs that many women hold, or were taught to believe, in continuing the practice of FC/FGM.

Physiological Beliefs:⁵

- ❖ FC/FGM maintains cleanliness, because secretions produced by the glands in the clitoris and labia minora and majora are thought to make the female body unclean.
- ❖ FC/FGM is a fertility enhancer because the secretions produced by her glands will act as a contraceptive.
- ❖ FC/FGM is a contributing factor to the overall good health of women, because the procedure is credited with healing powers and is claimed to have cured those suffering from depression, melancholia, hysteria, insanity, and epilepsy.

Journey of Hope

- ❖ FC/FGM is more attractive, because the normal female genitalia are unattractive to look at or to touch.

Social Beliefs:

- ❖ FC/FGM promotes social acceptability and integration among females within many ethnic groups. A woman who has not undergone FC/FGM may face estrangement from her family and her community and be considered unmarriageable.
- ❖ FC/FGM is a way of preserving virginity before marriage. Virginity increases the desirability of the young woman, and reflects the moral quality of the bride's family.
- ❖ By ensuring virginity, FC/FGM establishes paternity for the children, and insures the inheritance rights of the children.
- ❖ FC/FGM is a safeguard against promiscuity, because the clitoris is thought to cause women to become over-sexed. FC/FGM protects women from their own sexuality and from the risk of promiscuous behavior, which brings family shame and public disgrace.
- ❖ FC/FGM is a means of enhancing male pleasure. FC/FGM is praised as a means of bringing sexual harmony to the household.
- ❖ It is popularly believed that religion requires FC/FGM, although religious scholars dispute this, and religious leaders are beginning to speak against the practice.

Women from any particular area may have perspectives that vary from these. Marital practices and beliefs vary as widely as the countries and ethnic groups that populate Africa. Consequently, it is important to keep these general beliefs in mind, but do not assume that each family necessarily holds all these justifications to be true.

What Will My Client's Attitude toward FC/FGM Likely Be?

First and foremost, make no assumptions about your client's attitudes. She may know of and support the political movements that worked to end FC/FGM in her country, and may have incorporated this into her life and her family's. Or she may know of the work and support it, but felt she could not change the practices of her own family at this time. Or she may disagree with the movement completely, but accepts the fact that if she lives in the United States, she must abide by the U.S. law. Alternatively, she may be unaware of any of the political work and be quite shocked by the heavy penalties against the practice in the United States. She may be repulsed by the U.S. authorities' focus on an issue so private.

Second, remember that the practice is a centuries old tradition, maintained by a range of beliefs and often carried out by grandmothers, aunts, or other

women in the woman's life. Mothers and other family members arranged for the procedure. Therefore, women have been both victims and perpetrators of the practice. For a woman to stop the practice, she defies long-standing practices that perhaps her mother, grandmother, and many female relatives supported. It is crucial to remember this fact when providing information, support, and advocacy for women. Counselors must respect the mixed feelings a woman may have about this issue. Offer her facts and information; advocacy should come only when the woman is ready.

Third, FC/FGM was a part of a larger social system that helped to organize relationships, marriages, and family life. In the United States, there is a bigger question for many women: how will male-female relationships work for them and their families without the former traditions that managed such issues as pre-marital sex, monogamous relationships, and respect for families of marriage partners. Issues such as dating, boyfriends, pre-marital sex, divorce, and dress may be of greater concern to a client than the issue of FC/FGM because these issues represent the western approach to male-female partnering, which she may find confusing and unacceptable. Furthermore, the U.S. media portrayal of family life and relationships with frequent sexual activity outside of marriage may be a model an African mother wants to protect her family from, but her own model and the structures that sustained it were lost by coming to the United States. The entire context of relationships and marriages is different, and thus may be of much greater concern to a family.

Fourth, the role of women is quite different in the United States, so that again, these issues may be in the forefront of her mind. For example, she may earn as much or more than her husband, she is expected to take responsibility for many affairs outside of the home, she can gain access to housing or other resources herself, she is expected to have a separate opinion and speak it, and she has more legal protection in many instances. Her new role, or one that is expected of her, and how this integrates into her marriage and other relationships, may be the area about which she has the most questions.

Special Issues for Refugee Women:

Women who came to the United States as refugees or asylum seekers, or immigrant women who have faced serious trauma, may see the issue of FC/FGM as secondary to much of their wartime or other trauma experience. Loss of their family members and homes, the witness of killing, the experience of beatings, humiliation, and sexual assault outweighs their concern about FC/FGM. The U.S. laws on FC/FGM may feel like yet another assault on the life they once had; therefore, outreach on this issue should be specially tailored to suit their needs. For example, women may feel that getting their family together again, or finding a less expensive place to live, is a bigger priority than addressing the health issues that affect them because of FC/FGM.

However, FC/FGM may be a vehicle to address other issues such as child rearing, domestic violence here or in their country of origin, wartime rape, or many other family issues. It is crucially important to give women time and support to address other issues that come up in an information session, and to put these issues into the context of their lifetime experience. This should be combined with individual support and social services to address their concrete needs or to give women time one-on-one. With this kind of attention, women will feel supported around these issues, rather than assaulted by new laws and different values.

What is the acceptable term for FC/FGM?

Much controversy surrounds the terminology for FC/FGM. The more formal term used is "female genital mutilation," which was first used by activists who opposed the procedure. The term circumcision came into use because it was a term that many women who had undergone the practice did not find offensive.⁶

We suggest that when speaking of the practice to your clients, you ask them what terms they would use to refer to it. This respects the language and opinions of your client, and avoids the political controversy of the term.

Health Risks and FC/FGM

The health risks related to FC/FGM are well documented. These can create life-long health problems for women. They include:

- ❖ Painful urination, urinary stones, and kidney damage
- ❖ Painful menstruation
- ❖ Painful or difficult intercourse
- ❖ Anemia, which can impair the growth of a poorly nourished child
- ❖ Infertility
- ❖ Retention of urine or menstrual fluid
- ❖ Complications in pregnancy, including intrauterine fetal death and maternal death⁷

Medical Options in the United States:

Although FC/FGM can never truly be reversed, there is a safe, low risk surgical option available to women in the United States that helps them to live less painful lives. This surgery, called de-infibulation, lasts about two hours and can be performed with local anesthesia. De-infibulation is a day surgery, so the patient doesn't need to stay overnight in the hospital. Healing takes

about two weeks. De-infibulation can restore normal anatomical functioning, but the clitoris cannot be reconstructed, and the re-growth of nerves will never occur.⁸

FC/FGM & Pregnancy:

Childbirth poses considerable health risks for infibulated women and their unborn babies, particularly in communities where health services are limited. De-infibulation can be performed safely up until the fifth month of pregnancy, and there is no question that the surgery will ease the labor and delivery for both mother and child. De-infibulation also lessens the chances that the mother will need a cesarean section.

FC/FGM & HIV:

The risk of HIV transmission may be increased for women with FC/FGM, because of scar tissue, the small vaginal opening being prone to laceration during sexual intercourse, or anal intercourse resulting from inability to penetrate the vagina. HIV may also potentially be transmitted when groups of children are simultaneously circumcized with the same unsterile instruments.⁹

How Can I Support My Client With Regard to Health Issues and FC/FGM?

Health issues and questions are the opportunity to have individual, private conversations with women about FC/FGM. Ask a woman if she would like you to accompany her to the appointment; if she is open to this, give her information about the health risks and options around FC/FGM. Inform her about the strictness of U.S. law. Make sure she goes to a sensitive and knowledgeable physician, who will respect her and reassure her about care for herself. You can give that physician articles ahead of time, so that (s)he is better informed about FC/FGM. (See *Annex D* for recommended articles.)

If she doesn't already know, give your client a broader picture of the political and religious movements going on in Africa regarding FC/FGM. If you have a good relationship with the client already, you might ask how her husband feels about the issue. Let her know that many African men are now speaking out and standing against this issue. In some places, organizations have developed special counseling for both the wife and the husband around this issue. This might be an option for them, or suggest that if her husband has questions, he can visit her doctor to talk about health issues with FC/FGM.

We strongly encourage the use of female physicians, health care providers, and translators, so that the client is less likely to face the gender barrier in an already intimate appointment. As with any counseling, a client should lead the way; listen to her feelings and do not overload her with information if she is not ready. Most important, she should not be pushed into any appointment or procedure she does not want.

FC/FGM & U.S. Law

In 1995, Congress passed a law banning clitoridectomy, excision, and infibulation on U.S. soil.¹⁰ Briefly, the law makes it a crime to circumcise, excise, or infibulate the whole or any part of the genitalia of a female under the age of 18. (*The full text of this law is listed in Annex A.*) A person convicted under this law faces imprisonment of up to five years and/or a fine.

Note to Facilitators:

It is particularly important for our clients to understand the immigration implications of this law: a person who is convicted has committed a felony and may be deported by the Immigration and Naturalization Service (INS).

The only exceptions to the prohibition on these procedures are when they are performed by medical professionals for reasons that are necessary to the health of the patient or relate to pregnancy.

Note to Facilitators:

It is important for our clients to understand that criminal liability could extend to a parent or relative who arranges for FC/FGM.

As of this writing, no one has yet been charged or convicted. Anecdotal evidence suggests that the practice may take place in the United States, or that refugee children may undergo the procedure in Canada, Europe, or other countries in Africa or the Middle East.

Thirteen states have also passed laws banning FC/FGM: California, Colorado, Delaware, Illinois, Maryland, Minnesota, New York, North Carolina, North Dakota, Rhode Island, Tennessee, Washington, and Wisconsin.¹¹ These state laws enable state officials to investigate and prosecute FC/FGM without relying on federal officials.

In addition to these criminal laws, the Health and Human Services Appropriation Act of 1997 requires the INS, in cooperation with the State Department, to provide information on the physical, psychological, and legal consequences of FC/FGM to anyone who receives a U.S. visa from an FC/FGM practicing country. As of July 1998, this information had not yet been distributed. Additionally, the Health and Human Services Administration (HHS) was required under federal legislation to compile data on the prevalence of FC/FGM and to provide outreach into communities where many affected immigrants lived. HHS was also required to educate health professionals on how to respond to women who have undergone FC/FGM.¹²

While it is at least partially the responsibility of resettlement staff to communicate the law and the consequences, staff must also recognize the inherent conflicts for the family in this law. A parent or caretaker who attempts to raise his or her daughters according to her tradition acts out of love and care for his or her child's future. Yet s/he may face any or all of the following consequences:

- ❖ Removal of her/his child from the home for a temporary or permanent period.*
- ❖ Removal of other children from his/her home as a precautionary measure for a temporary or permanent period.*
- ❖ Possible conviction for a federal or state felony.
- ❖ Possible consequences to his/her legal immigration status, including deportation.
- ❖ Possible imprisonment in the United States
- ❖ Possible public notice for having FC/FGM performed on the child, which may be experienced as highly shameful to her/him and the ethnic community.*
- ❖ S/he may be required to participate in parenting classes, counseling, and other forms of oversight of parenting, which may or may not meet the family's needs. S/he may experience the government intrusion as humiliating and find that the oversight undermines him/her as a loving parent.*

** These particular consequences may differ among states, according to each state's child protective laws and procedures.*

Strategies for Community Outreach

Resettlement agencies have the obligation to inform newcomers of U.S. laws concerning FC/FGM. Additionally, some resettlement agencies may wish to engage in more extensive outreach to well-established newcomer communities. In recognition of diversity within the cultures that perpetuate FC/FGM, as well as the diversity of newcomer groups across the United States, there is no universal blueprint for successful outreach programming that provides education, advocacy, and a direct service response. However, several fundamental principles have broad applicability:

- ❖ We recommend that FC/FGM be addressed within a broader context of maternal and child health, family law in the United States, and women's issues. For example, an agency or individual counselor should emphasize that U.S. law forbids FC/FGM rather than characterize FC/FGM as a harmful practice. This establishes a better dialogue with women who accept and believe in the practice, but now reside in the United States
- ❖ Anyone attempting to engage in outreach about FC/FGM must have prior well-established links within the community. In general, immigrant community members should be the primary actors in both the design and implementation of the outreach initiative.
- ❖ Some level of community support must exist prior to the establishment of an outreach initiative. Due to the sensitive nature of FC/FGM, certain

Journey of Hope

elements within the community may express high levels of resistance to outreach.

- ❖ Health and social service providers may benefit from further reading or audio-visual materials. Consult the resource organizations and the bibliography listed at the back of this manual for ideas.
- ❖ Do not develop a program without the necessary support structures (health, mental health, family support, etc.) in place. For example, if a woman asks which doctor will help her with health problems, make certain you can refer her to a physician who is knowledgeable about and sensitive to these issues, and make sure you have a woman interpreter to assist her.
- ❖ Community meetings or structured discussions about FC/FGM should be conducted in the clients' native languages. Sensitive interpretation is crucial, as is support for the bicultural workers who may come under criticism from the community for the role they play in the educational forum.
- ❖ Male community members should not be left out of the process. Male community leaders or religious leaders, if willing, may be helpful in the educational effort.
- ❖ Issues may be most effectively addressed by referring to "family members" or "friends who might be interested in this information," rather than saying, "You might be interested in this information." The people who come to an informational meeting are ambassadors to the community; they may or may not need the information themselves. It is also less threatening if they are taking the information back to the community for someone else.

Questions Teachers & Caseworkers Frequently Ask:

Q: Is there any evidence to suggest that FC/FGM has already been performed in the United States?

A: No, there is only anecdotal evidence of immigrant family members performing FC/FGM on their daughters at home. The U.S. Center for Disease Control estimates that each year more than 150,000 girls residing in America undergo FC/FGM or are at risk of experiencing the procedure.¹³

Q: Does U.S. law prevent parents from sending their children abroad to have the surgery performed?

A: No. This has occurred in European countries. U.S. criminal laws cannot be used to prosecute conduct that occurs outside the United States. It is possible that child protection laws could be used against parents upon their return to the United States; for example, the child or other female

children could be removed from the parents. However, there are no known cases of child protection laws being used in this manner to date.

Q: What should I do if my client confides in me about a child residing locally who is about to experience FC/FGM?

A: Work with your supervisor to determine if there is any real basis for the information. Work through community contacts to connect with the client and/or family, and offer the family as much information as possible about the health risks for the child and the legal risks to the caretaker. Child protection services may need to be informed or involved to protect the child, if it appears the child continues to be at risk for the procedure. All possible steps should be taken to maintain family confidentiality, and extensive education and advocacy with child protective services may be necessary. Additionally, a trained counselor familiar with the culture and the law should assist the family in managing the complicated feelings that would accompany any such intrusive government intervention.

Q: What should I do if my client confides in me about medical complications resulting from FC/FGM that took place long ago? Or recently?

A: Offer to help the client find a sympathetic physician or nurse practitioner (preferably female) to get help, or offer to accompany the client to a physician, or refer the client to a counselor within your agency who can take her. You may want to provide the health professional with information if they know nothing about FC/FGM. At the end of this booklet, useful articles are recommended for physicians.

Q: Is it illegal in the United States for a physician to reinfibulate a woman over the age of 18?

A: No. However, reinfibulation may be medically harmful, and could result in professional sanctions being applied by such organizations as the American Medical Association and the American College of Obstetricians and Gynecologists. We recommend that women receive extensive counseling during pregnancy about the dangers associated with FC/FGM. Above all, pregnant couples should be dissuaded from resorting to illegal community practitioners who perform reinfibulation under non-hygienic conditions.

Questions Newcomer Women Frequently Ask:

Q. FC/FGM is a personal matter. Why can the government violate my privacy?

A: The government has many laws to protect children. If you did not feed your child, the government would step in to save your child. If you or anybody else hurts your child, they will again step in to protect your child. U.S. law considers FC/FGM as physically harming a child, so they will take action.

Journey of Hope

Q: What if my child returns home to my country uncircumcised? Who will marry her?

A: That is a risk. But many women and men in Africa are working to change the laws there, too, about FC/FGM. Islamic and other religious leaders are also speaking against this practice. As these movements in Africa grow, family beliefs will also change. And, when you live in the United States, you have to live by the U.S. laws; otherwise you can be deported.

Q: How would anybody know my child had FC/FGM done?

A: A teacher, nurse, doctor, or youth worker is required by law to report to the authorities about a child who was hurt by an adult. Maybe that teacher heard about it recently from a friend of the child, or hears the child talk about it herself. Your child could be taken away from you for some time, if the procedure was done in the United States*

** These laws can vary from state to state.*

Q: When people criticize FC/FGM, I feel shame about our traditional values. In my community, FC/FGM was important to my family and relatives.

A: It is true that most westerners see FC/FGM as a harmful practice that needs to change, as do many Africans. You have the right to disagree with this attitude and feel no shame about your opinion and values. We hope, but cannot guarantee, that your western friends and acquaintances will respect your beliefs. Also, so many traditions that families bring to America are much broader than the procedure of FC/FGM, and it is important to teach those values to your children, if you choose, and to feel pride about those traditions.

The reason we address FC/FGM specifically is because the laws in the United States are very strict. If you don't know about the law, your family may be hurt very badly with legal prosecution, possible deportation, and forced family separations. We also want you to live in good health and without pain. Sometimes FC/FGM can cause pain, which can be lessened with medical help.

Q: Can an asylum seeker cite fear of FC/FGM as the basis for an asylum claim in the United States?

A: Yes, although these cases are rare because so few young women have the resources to travel to this country to make a plea for asylum. Organizations such as RAINBO have been called upon to provide expert testimony in such cases. In the first such granting of asylum in 1996, the Board of Immigration Appeals declined to establish standards for granting asylum in future cases. Thus, each asylum seeker must establish a well-founded fear of persecution on the basis of FC/FGM in her particular socio-cultural situation. A recent case in New Jersey, in which an immigration judge ultimately denied a Ghanaian woman's petition for asylum that was on grounds of FC/FGM, was ultimately reversed by the

U.S. Court of Appeals, but only after the woman had spent two years and five months in detention.

Endnotes

- 1 N. Toubia. *Caring for Women with Circumcision: A technical manual for health care providers*. RAINBO, Feb, 1999
- 2 WHO. *Female Genital Mutilation. An Overview*. Geneva, 1998
- 3 Ibid
- 4 Center for Reproductive Law and Policy. *Female Circumcision/Female Genital Mutilation: Global Laws and Policies towards Elimination*. February, 1999
- 5 Most of these arguments are explored in greater depth by Koso-Thomas, Olaykina. *The Circumcision of Women*. London: Zed Books Limited, 1987, 7-14 and Harvard Law Association. "What's Culture Got to Do With It?" *Harvard Law Review* (June 1993), vol. 106, no.8.
- 6 Toubia, Nahid (1995). *Female Genital Mutilation: A Call for Global Action* (2nd ed.)
- 7 Hicks, Esther K. *Infibulation*, New Brunswick: Transaction Publishers, 1993.
- 8 Nahid Toubia's article, "Female Circumcision as a Public Health Issue," *The New England Journal of Medicine*, Sept. 15, 1994, pp. 712-716, is a useful reference for health care professionals who want to know more about this procedure.
- 9 World Health Organization, "Health Consequences", FC/FGM Infopac, 1998
- 10 Congressional Record-House H 11829/SEC.645. *Criminalization of Female Genital Mutilation*, October 1996.
- 11 Dugger, Celia W. "New Law Bans Genital Cutting In United States", *New York Times* (October 12, 1996).
- 12 Legislation on Female Genital Mutilation in the United States, Center for Reproductive Law and Policy, October, 1997.
- 13 Legislation on Female Genital Mutilation in the United States, Center for Reproductive Law and Policy, October, 1997

Annex A: Full Text of U.S. Law

SEC. 644. INFORMATION REGARDING FEMALE GENITAL MUTILATION.

- (a) **PROVISION OF INFORMATION REGARDING FEMALE GENITAL MUTILATION.**—The Immigration and Naturalization Service (in cooperation with the Department of State) shall make available for all aliens who are issued immigrant or nonimmigrant visas, prior to or at the time of entry into the United States, the following information:
- (1) Information on the severe harm to physical and psychological health caused by female genital mutilation which is compiled and presented in a manner which is limited to the practice itself and respectful to the cultural values of the societies in which such practice takes place.
 - (2) Information concerning potential legal consequences in the United States for (A) performing female genital mutilation, or (B) allowing a child under his or her care to be subjected to female genital mutilation, under criminal or child protection statutes or as a form of child abuse.
- (b) **LIMITATION.**—In consultation with the Secretary of State, the Commissioner of Immigration and Naturalization shall identify those countries in which female genital mutilation is commonly practiced and, to the extent practicable, limit the provision of information under subsection (a) to aliens from such countries.
- (c) **DEFINITION.**—For purposes of this section, the term "female genital mutilation" means the removal or infibulation (or both) of the whole or part of the clitoris, the labia minora, or labia majora.

SEC. 645. CRIMINALIZATION OF FEMALE GENITAL MUTILATION.

- (a) **FINDINGS.**—The Congress finds that—
- (1) the practice of female genital mutilation is carried out by members of certain cultural and religious groups within the United States;
 - (2) the practice of female genital mutilation often results in the occurrence of physical and psychological health effects that harm the women involved;
 - (3) such mutilation infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional;

- (4) the unique circumstances surrounding the practice of female genital mutilation place it beyond the ability of any single State or local jurisdiction to control;
- (5) the practice of female genital mutilation can be prohibited without abridging the exercise of any rights guaranteed under the first amendment to the Constitution or under any other law; and
- (6) Congress has the affirmative power under section 8 of article I, the necessary and proper clause, section 5 of the fourteenth amendment, as well as under the treaty clause, to the Constitution to enact such legislation.

(b) CRIME.—

- (1) IN GENERAL.—Chapter 7 of title 18, United States Code, is amended by adding at the end the following;

"§116. Female Genital Mutilation

- (a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both.
- (b) A surgical operation is not a violation of this section if the operation is—
 - (1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner; or
 - (2) performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such as practitioner or midwife.
- (c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual."
 - (2) CONFORMING AMENDMENT.—The table of sections at the beginning of chapter 7 of title 18, United States Code, is amended by adding at the end the following new item:

"116. Female genital mutilation."
- (d) EFFECTIVE DATE.—The amendments made by subsection (b) shall take effect on the date that is 180 days after the date of the enactment of this Act.

Annex B: Country-Specific Chart of FC/FGM Prevalence in Africa

Estimated Prevalence of FC/FGM in African Countries Where It Is Practiced

Country	Estimated Prevalence	Number of Women (000s)**	Source of the Prevalence Rate
Benin*	50%	1,370	
Burkina Faso	70%	3,650	Report of the National Committee (1995).
Cameroon	20%	1,330	Estimated prevalence based on a study (1994) in southwest and far north provinces by the Inter-African Committee, Cameroon section.
Central African Republic	43%	740	National Demographic and Health Survey (1994/1995). Signs of decline amongst younger age groups. Secondary or higher education can be associated with reduced rates of FC/FGM. No significant variations between rural and urban rates. The prevalence of FC/FGM is highest amongst the Banda and Mandjia groups where 84% and 71% of women respectively have undergone FC/FGM.
Chad	60%	1,930	1990 and 1991 UNICEF sponsored studies in three regions.

Country	Estimated Prevalence	Number of Women (000s)**	Source of the Prevalence Rate
Côte d'Ivoire	43%	3,020	National Demographic and Health Survey (1994). A reduced rate of FC/FGM amongst younger women. No significant variations occurred between urban and rural rates. Secondary and higher education can be associated with reduced rates of FC/FGM. The highest prevalence of FC/FGM appears amongst the Muslim population 80%, compared with 15% amongst Protestants and 17% of Catholics.
Djibouti*	98%	290	Type III widely practiced, UN ECOSOC Report (1991).
Egypt*	80%	24,710	Type I and Type II practiced by both Muslims and Christians. Type III-infibulation, reported in areas of south Egypt closer to Sudan.
Eritrea*	90%	1,600	
Ethiopia	85%	23,240	A 1995 UNICEF sponsored survey in five regions and an Inter-African Committee survey in twenty administrative regions. Type I and Type II commonly practiced by Muslims and Coptic Christians as well as by the Ethiopian Jewish population, most of who now live in Israel. Type III is common in areas bordering Sudan and Somalia.
Gambia	80%	450	A limited study by the Women's Bureau (1985). Type II commonly practiced.
Ghana	30%	2,640	Pilot studies in the Upper East region (1986) and amongst migrant settlement in Accra (1987) by the Ghana Association of Women's Welfare.
Guinea*	50%	1,670	

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Country	Estimated Prevalence	Number of Women (000s)**	Source of the Prevalence Rate
Guinea-Bissau	50%	270	Limited 1990 survey by the Union démocratique des Femmes de la Guinée-Bissau.
Kenya	50%	7,050	A 1992 Maendeleo Ya Wanawake survey in four regions. Type I and II commonly practiced. Type III by a few groups. Decreasing in urban areas, but remains strong in rural areas.
Liberia*	60%	900	
Mali*	75%	4,110	
Mauritania*	25%	290	
Niger*	20%	930	
Nigeria	50%	28,170	A study by the Nigerian Association of Nurses and Nurse-midwives conducted in 1985-1986 showed that 13 out of the 21 States had populations practicing FC/FGM, prevalence ranging 35% to 90%. Type I and Type II commonly practiced.
Senegal	20%	830	Report of a national study by ENDA (1991).
Sierra Leone	90%	2,070	All ethnic groups practice FC/FGM except for Christian Krios in the western region and in the capital, Freetown. Type II commonly practiced.
Somalia	98%	4,580	FC/FGM is generally practiced; approximately 80% of the operations are infibulation.

Country	Estimated Prevalence	Number of Women (000s)**	Source of the Prevalence Rate
Sudan	89%	12,450	National Demographic and Health Survey (1989/1990). A very high prevalence, predominantly infibulation, throughout most of the northern, northeastern, and northwestern regions. Along with a small overall decline in the 1980s, there is a shift from infibulation to clitoridectomy.
Togo*	50%	1,050	
Uganda*	5%	540	
United Republic of Tanzania*	10%	1,500	
Zaire*	5%	1,110	
Total		132,490	
* <i>Anecdotal information only; no published studies.</i>			
** <i>Number of women calculated by applying the prevalence rate to the 1995 total female population reported in the United Nations Population Division population projections (1994 revision). Totals may not add due to rounding.</i>			

Sources:

Estimated prevalence rates have been developed from national surveys, small studies, and from the following:

Hosken, Fran. *The Hosken Report: Genital and Sexual Mutilation of Females*. Fourth Revised Edition. Lexington, MA. WIN NEWS, 1993

National Demographic and Health Surveys, Macro International, Inc., 11785 Belville Drive, Calverton, MD 20705, USA.

Journey of Hope

Toubia, Nahid. *Female Genital Mutilation: A Call for Global Action*, New York: Women, Ink.

World Health Organization. *Female Genital Mutilation: An Overview*. Geneva, 1998

Annex C: List of Advocacy Organizations:

Atlanta Circumcision Information Center
David J. Llewellyn, Director
2 Putnam Drive, N.W.
Atlanta, GA 30342

Center for Reproductive Law and Policy
120 Wall Street
New York, NY 10005
Tel. (212) 514-5534
Fax: (212) 514-5538
Internet Address: www.crlp.org

Equality Now
226 West 58th Street
New York, NY 10019
Tel. (212) 586-0906
Fax. (212) 586-1611
Internet Address: www.equalitynow.org

National Organization of Circumcision Information Resource (NOCIRC)
P.O. Box 2512
San Anselmo, CA 94979-2512
(415) 488-9883

PATH (Program for Appropriate Technology in Health)
1990 M. Street, NW, #700
Washington, DC 20036
Tel. (202) 822-0033
Fax (202) 457-1466
Internet address: www.path.org

RAINBO (Research, Action & Information for Bodily Integrity of Women)
915 Broadway, #1109
New York, NY 10010-7108
Tel. (212) 477-3318
Fax: (212) 477-4154
Internet address: www.rainbo.org

Women's International Network News
Fran Hosken, Editor
187 Grant Street
Lexington, MA 02173
(617) 862-9431

Annex D: Useful Reading Materials

Please see the References & Resources section of this manual for this material.

Appendix E: Surveys

This section contains a number of different surveys. For ease of use, the two main ones are listed below.

Confidential Refugee Women's Survey

Confidential Refugee Service Provider Survey

Confidential Refugee Women's Survey

Name (optional) _____ **Age** _____

City & State _____

Names (optional) & Ages of Family Members: _____

When did you arrive in the U.S.? _____

How long have you been in this location? _____

Section 1—Child Care/Child Development:

1. Number of Children _____ Ages: _____

2. Who takes care of the children? (not necessarily primary financial provider)

3. Would you feel comfortable leaving your children at a free/low-cost daycare or before/after school program? Yes _____ No _____

4. How would you describe your relationship with your children?

5. Would you consider joining a parent/child support group? Yes _____ No _____

6. Do you have concerns or questions about being a parent in America? If so, what are they? _____

For Refugee Service Provider:

Section 1—Child Care/Child Development was administered
_____ Individually _____ In a group

Section 2—Community

7. Do you have telephone numbers or contact information for any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Police Department | <input type="checkbox"/> Soup kitchen |
| <input type="checkbox"/> Fire Department | <input type="checkbox"/> Local mosque/church/synagogue |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Poison control center |
| <input type="checkbox"/> Domestic abuse hotline | <input type="checkbox"/> Local women's/children's shelter |

8. What other community services would you like contact information for?

9. Do you have any interest in activities in the community such as:

- | | |
|---|--|
| <input type="checkbox"/> Local/state/federal government | <input type="checkbox"/> Religious groups |
| <input type="checkbox"/> Women's groups | <input type="checkbox"/> Community volunteering |
| <input type="checkbox"/> Self-help/support groups | <input type="checkbox"/> Drug/alcohol abuse prevention |
| <input type="checkbox"/> Ethnic associations | <input type="checkbox"/> Domestic/child abuse prevention |
| <input type="checkbox"/> Parent-child programs | <input type="checkbox"/> Public library |
| <input type="checkbox"/> English language classes | <input type="checkbox"/> Museums |
| <input type="checkbox"/> Parks | <input type="checkbox"/> Zoos |
| <input type="checkbox"/> Open markets | Other: _____ |

10. Why would you not be able to participate in activities like those above?

- | | |
|---|---|
| <input type="checkbox"/> Not aware that they exist | <input type="checkbox"/> Transportation not available |
| <input type="checkbox"/> Activity too far away from home | <input type="checkbox"/> Child care not available |
| <input type="checkbox"/> Classes are not at a convenient time | <input type="checkbox"/> Clear information not available |
| <input type="checkbox"/> Staff does not speak client's language | <input type="checkbox"/> Staff is/was rude or insensitive |
| <input type="checkbox"/> Family commitments | <input type="checkbox"/> No one is available to go with you |

Other: _____

For Refugee Service Provider:

Section 2—Community was administered

- Individually In a group

Section 4—Employment

16. Are you familiar with aspects of working in America such as:

- American attitudes towards work Benefits/security
 Welfare Employment assistance & services
 Employer expectations (timeliness, responsibility, respectfulness, appearance)
 Laws (including those on harassment, wage/age/gender discrimination)

17. What types of employment are you qualified for?

- Sewing Childcare provider
 Cook/restaurant worker Assembly line worker
 Domestic/cleaning services Craft work
 Health care provider Social services provider
 Teacher Bookkeeper/accountant
 Secretary/clerk Engineer

Other: _____

18. Are you interested in:

- Home-based employment Self-employment
 Small business creation Volunteer opportunities
 Women's professional organizations Mentoring programs

19. Have you ever completed a job application? Yes No

20. Have you ever prepared a resume? Yes No

21. Have you ever had a job interview? Yes No

22. If you are currently working, do you have any job-related concerns or problems?

23. If you are not employed, do you have any questions or concerns about working?

For Refugee Service Provider:

Section 4—Employment was administered

- Individually In a group

Section 5—Finances & Laws

24. Are you familiar with:

- | | |
|--|--|
| <input type="checkbox"/> Applying for a loan through a bank | <input type="checkbox"/> Establishing credit |
| <input type="checkbox"/> Setting up a savings/checking account | <input type="checkbox"/> Investing money |
| <input type="checkbox"/> Filing yearly taxes | <input type="checkbox"/> Creating a budget |

25. Will you be applying or have you applied for public assistance? Yes___ No___

If yes, which ones?

- | | |
|--|--|
| <input type="checkbox"/> Food stamps | <input type="checkbox"/> Medicare/Medicaid |
| <input type="checkbox"/> Unemployment compensation | <input type="checkbox"/> Supplementary Security Income |
| <input type="checkbox"/> Housing and energy assistance | <input type="checkbox"/> Disability insurance |
| <input type="checkbox"/> Temporary Assistance for Needy Families | |

Other: _____

26. Would you like assistance with budgeting? Yes___ No___

27. Are you familiar with current changes in welfare laws? Yes___ No___

28. Are you familiar with your rights and responsibilities as a refugee in the US?

- | | |
|--|---|
| <input type="checkbox"/> Rights of an immigrant/refugee | <input type="checkbox"/> Role of law enforcement |
| <input type="checkbox"/> Criminalization of FC/FGM | <input type="checkbox"/> Mandatory education for minors |
| <input type="checkbox"/> Regulations/conditions in workplace | <input type="checkbox"/> Voting/driving privileges |
| <input type="checkbox"/> Criminalization of spouse/child abuse | |
| <input type="checkbox"/> Role of the judicial system (including court-appointed lawyers & victim assistance) | |
| <input type="checkbox"/> Freedoms in marital separation/divorce & child custody | |

Other: _____

For Refugee Service Provider:

Section 5—Finances and Laws was administered

- Individually In a group

Section 6—Health

29. Did you receive a full medical evaluation before you arrived in the U.S.?
Yes___ No___

30. If yes, did you receive a second evaluation for follow-up on health problems identified in the first evaluation? Yes___ No___

31. Did you receive an evaluation of the following medical conditions?

- | | |
|--|--|
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Parasitic infections |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing problem/abnormality |
| <input type="checkbox"/> Vision problem/abnormality | <input type="checkbox"/> Dental problem/abnormality |
| <input type="checkbox"/> Reproductive system cancer | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Chronic condition (please identify) _____ | |
- Other: _____

32. Have you received any immunizations? Yes___ No___

If so, please list them: _____

33. Have your children received any immunizations? Yes___ No___

If so, please list them: _____

34. Do you have access to mental health services?

- | | |
|---|---|
| <input type="checkbox"/> anger management | <input type="checkbox"/> stress management |
| <input type="checkbox"/> depression | <input type="checkbox"/> individual/spousal/family counseling |
- Other: _____

35. Have you received instruction on nutritional issues?

- | | |
|--|---|
| <input type="checkbox"/> Meal planning | <input type="checkbox"/> Effects of alcohol |
| <input type="checkbox"/> Food preparation | <input type="checkbox"/> Effects of tobacco |
| <input type="checkbox"/> Cultural influences on food | <input type="checkbox"/> Effects of drugs |
- Other: _____

36. Why would you not have access to health care services?

- | | |
|---|---|
| <input type="checkbox"/> Not aware of existing services | <input type="checkbox"/> Transportation not available |
| <input type="checkbox"/> Child care not available | <input type="checkbox"/> No one available to accompany client |
| <input type="checkbox"/> Staff does not speak client's language | <input type="checkbox"/> Staff is/was rude or insensitive |
- Family commitments
 Female physician/midwife not available
 Clinic/hospital/physician's office too far from home
- Other: _____

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37. What services would you like more information on or better access to?

Prenatal/perinatal/postnatal care

Spouse/child abuse

Family planning/birth control

Female circumcision (FC/FGM)

Immunization

Nutrition

Cancer of the breasts or reproductive system

Sanitation

Other: _____

For Refugee Service Provider:

Section 6—Health was administered

Individually In a group

Section 7—Miscellaneous

38. Would you attend services, such as ESL classes, job-training, and support groups, offered at a neighborhood center? Yes_____ No_____

39. Why would you not be able to go to services at a neighborhood center?

____Cost _____Transportation not available

____Child care not available

____Day of week or time of day services offered (please note best day of week and/or time of day) _____

Other: _____

40. What is the best way to tell people in your community about services being offered?

____Physician _____Word of mouth

____Posters _____Newspapers

____TV/radio Other: _____

41. What do you think about life in America?

For Refugee Service Provider:

Section 7—Miscellaneous was administered

____Individually _____In a group

Confidential Refugee Service Provider Survey

Name (optional): _____

Profession: _____

Specialty: _____

City and State in which you work: _____

1. During the past year, what was the average number of women from the Middle East and/or the Horn of Africa (Ethiopia, Somalia, Sudan) that you saw per month?

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 10 to 15 |
| <input type="checkbox"/> Less than 5 | <input type="checkbox"/> 15 to 20 |
| <input type="checkbox"/> 5 to 10 | <input type="checkbox"/> More than 20 |

2. Describe the general purpose of your interaction with the women:

3. What was your overall perception of your interaction?

4. Which languages do you speak?

- | | |
|---------------------------------|----------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Somali |
| <input type="checkbox"/> Amhara | <input type="checkbox"/> Kurdish |
| <input type="checkbox"/> Tigray | Other (please list) _____ |

5. What is the general level of English-language skills among your female clients from the Middle East/Horn of Africa on a scale of 1 to 5 (1 being none and 5 being fluency)? _____

6. How would you find a translator if necessary?

Refugee Health Services Provider Survey

7. Do refugee women who come into your office see a physician?
___All ___Some ___None

8. If not, who do they see? _____

9. How many physicians are in your office? _____
How many of them are female? _____

10. Can a female physician be provided if requested? Yes___ No___

11. If a refugee woman comes to your office for service, will she be evaluated for the following? (check all that apply):

- | | |
|--------------------------|---------------------------|
| ___ Tuberculosis (TB) | ___ HIV/AIDS |
| ___ Hepatitis B | ___ Parasitic infections |
| ___ Anemia | ___ Chronic conditions |
| ___ Vision abnormalities | ___ Hearing abnormalities |
| ___ Dental abnormalities | Other _____ |

12. Have you administered any vaccines to clients? Yes___ No___

13. If so, which ones? _____

14. Have your clients raised any questions about or have any problems concerning:

- | | |
|------------------------------|-----------------------------------|
| ___ Her reproductive history | ___ Sexually transmitted diseases |
| ___ Birth control | ___ Reproductive cancers |
| ___ Family planning | ___ Breast cancer |

15. If so, how did you respond to the question(s)?

16. Could you explain to a refugee woman:

- | | |
|--------------------------------------|---------------------------------|
| ___ what an "HMO" is | ___ "informed consent" |
| ___ "doctor/patient confidentiality" | ___ how to read a hospital bill |

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17. If a client needs mental health services (including those for anger, depression, stress management, trauma counseling, individual/spousal/family counseling), what would you do?

18. If a client or her children have been abused by her husband/boyfriend/family member, how would you handle the situation?

19. What do you know about female circumcision/female genital mutilation (FC/FGM)?

20. Do you know about the possible effects of FC/FGM, including:

- | | |
|--|--|
| <input type="checkbox"/> Infection | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Pain as a result of no anesthetic | <input type="checkbox"/> Pain at childbirth |
| <input type="checkbox"/> Stress and shock | <input type="checkbox"/> Pain during sexual intercourse |
| <input type="checkbox"/> Psychological trauma | <input type="checkbox"/> Delayed urination/urine retention |

21. Have you ever addressed any of these problems (or other FC/FGM-related problems) with a client? Yes No

22. If yes, how often? OR If no, why? _____

23. In your opinion as a health services provider, do you think it is appropriate for providers to:

- Assist women who have undergone FC/FGM
- Explain the legal ramifications of FC/FGM in the U.S. to women and their families
- Advocate against FC/FGM
- Not get involved

Other _____

24. What topics would you like more information about?

25. Additional questions or comments:

Refugee Social Services Provider Survey

7. In general, do you know how children are viewed in Muslim societies?
Yes____ No____
8. If yes, please describe how:

9. What are the ages of your clients' children: _____
10. Assuming the mother is the primary caretaker, who watches the children when the mother is away from home or at work? _____
11. Is affordable daycare or home care available? Yes____ No____
12. Does the family generally get along well? Yes____ No____
13. Does intergenerational tension, adolescent rebellion, and/or communication problems between parents and children seem to exist? If so, please explain: _____

14. If a client or her children have been abused by her husband/boyfriend/family member, how would you handle the situation?

15. Could you direct an interested client to community services such as:
____ Self-help/support groups ____ Parent-child enrichment programs
____ Substance abuse prevention ____ Ethnic associations
____ Religious groups/services ____ Public library
____ Museums ____ Parks/zoo
____ Open markets ____ Women's leadership/grassroots organizations
16. Could you help a client enroll in:
____ ESL program ____ Basic reading/math classes
____ GED program ____ College
17. What percentage of your clients qualify for public assistance? _____
18. Which programs do they qualify for? (eg. TANIF, WIC, Medicaid, CHIP, Foodstamps, SSI, etc.)

19. Are you familiar with the current changes in welfare laws? Yes _____ No _____

20. How have the changes in welfare policy affected your clients?

21. Which types of income-generating tasks are your clients qualified for?

- | | |
|---|---|
| <input type="checkbox"/> Sewing | <input type="checkbox"/> Childcare |
| <input type="checkbox"/> Assembly-line work | <input type="checkbox"/> Domestic/cleaning services |
| <input type="checkbox"/> Craftwork | <input type="checkbox"/> Cook/restaurant |
| <input type="checkbox"/> Health care provider | <input type="checkbox"/> Social services provider |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Bookkeeper/accountant |
| <input type="checkbox"/> Secretary/clerk | <input type="checkbox"/> Engineer |
| <input type="checkbox"/> Translator | Other _____ |

22. Could you explain to a client how to:

- | | |
|--|--|
| <input type="checkbox"/> Open savings/checking account | <input type="checkbox"/> Create a budget |
| <input type="checkbox"/> Apply for a bank loan | <input type="checkbox"/> Establish credit |
| <input type="checkbox"/> Invest money | <input type="checkbox"/> File yearly taxes |

23. Could you explain the following nutritional issues?:

- | | |
|---|---|
| <input type="checkbox"/> Meal planning | <input type="checkbox"/> Cultural influences on food |
| <input type="checkbox"/> Food preparation | <input type="checkbox"/> Effects of alcohol/tobacco/drugs |

24. Could you explain to a client:

- | | |
|---|--|
| <input type="checkbox"/> what an "HMO" is | <input type="checkbox"/> "informed consent" |
| <input type="checkbox"/> "doctor/patient confidentiality" | <input type="checkbox"/> how to read a hospital bill |
| <input type="checkbox"/> how health insurance benefits work in the US | |

25. Are you familiar with the five basic tenets of Islam (daily prayer, pilgrimage to Mecca, giving to the poor, fasting at Ramadan, and accepting Mohammed as the Prophet)? Yes _____ No _____

26. Additionally, are you familiar with:

- | | |
|--|--|
| <input type="checkbox"/> Full-body covering | <input type="checkbox"/> Female seclusion |
| <input type="checkbox"/> Arranged marriage | <input type="checkbox"/> Relations between unrelated women & men |
| <input type="checkbox"/> Property rights of males | <input type="checkbox"/> Customs regarding marital relations/divorce |
| <input type="checkbox"/> Customs regarding sexual relations/harassment | |

GLOSSARY

1951 Refugee Convention	On July 28, 1951, world governments adopted this "convention" relating to the status of refugees. This agreement has served as the bases for defining refugees and refugee law and for granting refugees status ever since.
Adolescent	The period of life from puberty to maturity, approximately ages 12 to 20 (or terminating legally at the age of majority).
Aids	Acquired Immune Deficiency Syndrome. A disease of the immune system caused by the HIV (human immunodeficiency virus) virus.
Alcohol Abuse	A maladaptive pattern of alcohol use leading to clinically significant impairment or distress (evident in recurrent failures to fulfill obligations at work, school, or home, or in recurrent health or legal problems due to alcohol use).
Alcohol Dependency	Alcohol Abuse with the additional feature of physiological and psychosocial evidence of addiction.
Alcoholics Anonymous (AA)	This is a free service for people who are trying to stop drinking.
Alpha Blockers	These work on the nervous system to relax blood vessels, which allows blood to pass more easily.
Alpha-Beta Blockers	These work the same way as alpha blockers but also slow the heartbeat, as beta-blockers do. As a result, less blood is pumped through the vessels.
Alpha-fetoprotein (AFP)	A serum (blood) protein produced by the growing fetus (healthy, nonpregnant adults produce only very small quantities). Increased amounts of AFP in the mother's blood is the result of diffusion across the placenta and the amniotic membranes. The concentration of AFP in the fetus's (and thus the mother's) blood is at its maximum at the end of the first trimester of pregnancy.
Amniocentesis	A method used to determine the sex or any abnormality of the fetus by testing a sample of amniotic fluid (obtained by inserting a hollow needle into the women's uterus via the abdominal wall).

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Amniotic Fluid	The fluid within the uterus in which the fetus is suspended.
Anemia	A condition in which the blood is deficient in red blood cells, in hemoglobin, or in total volume.
Angina	Brief spasmodic attacks of chest pain caused by deficient oxygenation of the heart muscles.
Angiotensin Antagonists	These are a new type of high blood pressure drug. They shield blood vessels from a hormone called angiotensin II, which normally causes vessels to narrow. As a result, the vessels are wider and pressure lowers.
Angiotensin Converting Enzyme (ACE) Inhibitors	These prevent angiotensin II from being formed. They relax blood vessels and pressure goes down.
Arteriosclerosis	Literally, the hardening of the arteries.
Asylum Seeker	A person seeking refuge in a new country from these same threats. International law recognizes the right to seek asylum, but does not oblige states to provide it.
Ataxia	Lack of coordination and/or balance.
Autonomy	Self-directing freedom, especially moral independence.
Before School/After School Programs	Children receive care and supervision while parents are working either before or after formal school hours.
Behavior Management	A general term used to describe techniques used by parents to help their child learn appropriate and desired behaviors.
Benign	Non-cancerous, does not threaten health or life.
Beri beri	A deficiency disease marked by inflammatory or degenerative changes of the nerves, digestive system, and heart and caused by a lack of or inability to assimilate thiamine (vitamin B ₁).

Beta Blockers	These reduce nerve impulses to the heart and blood vessels. This makes the heart beat less often and with less force; as a result, blood pressure drops and the heart works less hard.
Biopsies	The removal and examination (for the presence of disease) of tissue, cells, or fluid from the living body.
Blood group	One of the four classes (A, B, AB, or O) into which individuals and/or their blood can be separated based on the presence or absence of specific antigens in the blood.
Calcium Channel Blockers (CCBs)	These keep calcium from entering the muscle cells of the heart and blood vessels. Blood vessels relax and pressure goes down. <i>(Note: One short-acting type of CCB has been found to increase the chance of a repeat heart attack. Short-acting CCBs are taken several times a day.)</i>
Cardiomyopathy	Enlarged Heart due to a non-inflammatory disease of the heart muscle.
Cataracts	Clouding of the lens of the eye.
Cerebrovascular Disease	Of or involving the brain and the blood vessels supplying it.
Chamber of Commerce	This is an office that has information about the city.
Child Abuse	Any physical, emotional, or sexual injury inflicted on a child, other than accidental, by those responsible for the care and custody of the child.
Child Neglect	Failure to provide the basic necessities of life by those responsible for the care and custody of the child.
Chorionic Villus Sampling (CVS)	An early surgical test (usually done between nine and twelve weeks into the pregnancy) in which a piece of the chorion (the outer tissue of the placental sac surrounding the fetus) is removed from the uterus in order to identify chromosome and biochemical conditions.
City Bus System	People use this public transportation system to go from place to place in their local community.

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Clitoridectomy	The partial or total removal of the clitoris.
Community College	This is an educational institution where you can study for two years in order to achieve two years worth of credits towards a college degree or obtain an associate degree.
Congenital	Present at birth.
Congenital Infection	An infection present at birth.
Day Care	This is a center that provides a safe environment for children while their parent(s) are working.
De-infibulation	Surgical procedure in which the genitalia of women who have undergone infibulation is reconstructed as best possible.
Department of Motor Vehicles (DMV)	Municipal authority where you can apply for a driver's license, register your car, or renew your driver's license.
Detrusor Dysynergia	A lack of appropriate coordination of bladder muscles which results in incontinence.
Diabetic Retinopathy	Damage the small blood vessels that supply the back of the eye, causing them to leak blood or other fluid into the eye.
Dialysis	The mechanical filtering of the blood via machine.
Diastolic Pressure	The dilation (expansion) of the cavities of the heart during which they fill with blood.
Discipline	The rules, guidelines, and standards for acceptable behavior that parents establish for their children. It forms boundaries within which children learn to behave and act in an acceptable manner.
Diuretics	These are sometimes called "water pills" because they work on the kidney and flush excess water and sodium from the body through urine; thus, reducing the amount of fluid in the blood. Since sodium is flushed out of blood vessel walls, the vessels open wider and pressure goes down. There are different types of diuretics. They are often used with other high blood pressure drugs.

Domestic Violence	Physical or sexual abuse of spouse or intimate partner.
Durable Solutions	There are three durable solutions to refugees' plight that are promoted by UNHCR. They are voluntary repatriation, integration into the country of asylum, or resettlement in a third country.
Early Childhood.	Children 3-4 years of age.
Ectopic Pregnancy	Pregnancy during which the fertilized egg develops outside of the uterus, usually in a fallopian tube.
Educational Neglect	All children under the age of 16 must attend school. It is the parents' responsibility to ensure that their child enrolls in and attends school. This type of neglect also includes failure on the parents' part to address special education needs.
Elder Abuse	Abuse or neglect of older persons.
Elementary School	Children receive their first eight years of education at this institution.
Emergency Room	This is a place in a hospital where you go if you have a health problem and you need immediate attention.
Emotional Abuse	Rejecting, belittling, or blaming a child; constantly treating siblings unequally, and/or a persistent lack of concern by the caretaker for the child's' welfare or well-being.
Employment Center	This center announces job openings and provides employment counseling.
Endometrial	Relating to the inner mucous membrane of the uterus.
Energy Assistance	Federal program that helps pay for heating.
Environmental Neglect	Includes not providing a child with a safe and healthy environment in which to live.
Ergonomic Techniques	Techniques for designing or arranging the things people use so that people and things interact safely and efficiently.

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Estrogen Replacement Therapy (ERT)	A prescribed regimen of estrogen-replacement drugs usually given to women after menopause.
Excision	A form of FC/FGM in which is characterized by the removal of clitoris and labia minora (inner lips).
Female Circumcision/ Female Genital Mutilation (FC/FGM)	An umbrella term that describes three discrete surgical procedures: clitoridectomy, excision, and infibulation. It is a custom involves the cutting of parts of the external genitals of girls and women to fulfill cultural and traditional beliefs.
Fetal Alcohol Syndrome (FAS)	A highly variable group of birth defects including mental retardation, deficient growth, and defects of the skull, face, and brain that tend to occur in the infants of women who consume large amounts of alcohol during pregnancy.
Fine Motor Skills	Manipulating objects, such as using a crayon or pencil, cutting with scissors.
Fire Department	This is a community service that you should call in case of fire.
Food Stamps	Federal program that provides coupons to purchase food (no cigarettes, alcohol, paper products).
Gestational Age	Age at which it is possible to become pregnant.
Gestational diabetes	Diabetes that occurs in women during pregnancy.
Glaucoma	Buildup of pressure from fluid inside the eye.
Goiter	An enlargement of the thyroid gland, caused by a lack of iodine in the diet, visible as a swelling of the front of the neck.
Gross Motor Skills	Pulling oneself up, standing, walking, picking up objects, throwing a ball.
Guidance	The process of helping a child learn how to behave towards people and things.
Hematocrit	A screening test and instrument that determines the ratio of the volume of red blood cells to the volume of whole blood.

Hematuria	Blood in urine. Is often a symptom of bladder infection.
Hemoglobin	The iron-containing, oxygen-carrying pigment of red blood cells.
Hemorrhagic Stroke	When very high pressure causes a break in a weakened blood vessel in the brain.
Homeless Shelter	A temporary place of refuge if you have lost your home.
Human Immunodeficiency Virus (HIV)	The retrovirus that causes AIDS in humans. It attacks the human immune system by infecting and destroying helper T-cells (a type of white blood cell).
Human Papilloma Virus (HPV)	This virus is the cause of genital warts. HPV-caused lesions on the cervix (determined via the pap smear) are associated with an increased risk of cervical cancer.
Hyperglycemia	A high concentration of glucose in the bloodstream. It is a hallmark of diabetes.
Hypertension	High blood pressure.
Ignoring	A form of behavior management used to eliminate or reduce behaviors that parents find irritating and annoying.
Impulse Control	The ability to rationally judge and make decisions with regards to spontaneous inclinations and desires.
Infants	Children from birth to 12 months of age.
Infibulation	A form of FC/FGM characterized by the removal of the clitoris, labia minora (inner lips and incision of the labia majora (outer lips), with stitching together of the remaining skin into a hood that covers the entrance to the vagina. Also known as pharonic circumcision.
Insulin	A hormone secreted by the Islets of Langerhans (in the pancreas) that is essential in the metabolism of carbohydrates.

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Integration	When it is not safe for refugees to return home for a prolonged period, this is the second durable solution that is sometimes applied. Often in an effort to avoid long-term relief for large groups of people, UNHCR helps refugees to integrate into the country to which they fled.
Internally Displaced Person (IDP)	<p>A person who has been forced from his/her home but remains within the borders of his/her nation. Because the person is still under the jurisdiction of a government that might not want international agencies to help him/her, an internally displaced person might still be vulnerable to persecution.</p> <p>There are six million more IDPs than refugees—20 million in all—and they are a growing concern to refugee advocates such as the U.S. Committee for Refugees.</p>
Invitrofertilization	Fertilization outside the living body and in an artificial environment.
Islet Cells	A cluster of cells or an isolated piece of tissue. Often used to refer to the Islets of Langerhans (<i>see insulin, above</i>).
Jigsaw Puzzles	A puzzle consisting of small irregularly cut pieces that are to be fitted together to form a picture.
Khat	Also known as Qat or Miraa. Consists of the fresh young leaves of the <i>Catha edulis</i> plant, which contain a psychoactive substance with a stimulant effect. It is widely used in Yemen and the Horn of Africa.
Labia Majora	Outer lips of a woman's genitalia.
Labia Minora	Inner lips of a woman's genitalia.
Legume	Beans, peas.
Logical Consequences	Planned or arranged consequences that are established by parents as a way of helping their child learn appropriate and desirable behaviors.

Match Grant Program	This program is an alternative to public welfare (cash assistance) programs. This is a four-month federal program funded to a member (but not all) local voluntary resettlement agencies for families who want to become employed and economically self-sufficient quickly.
Medical Neglect	Includes not providing a child with appropriate and necessary medical care when needed.
Menopause	The period of natural cessation of menstruation occurring usually between the ages of 45 and 50, after which a woman is no longer fertile.
Middle School/High School	Youth aged 12-18 continue their education at this institution.
Mutual Assistance Association (MAA)/Ethnic Community-Based Organization (ECBO)	An organization founded and run by an ethnic-specific community (usually made up of former refugees and immigrants) to meet their community's ongoing needs. They provide orientation programs, temporary transportation, assistance with clothing, furniture, ESL classes, etc.
Natural Consequences	These happen in the natural course of events.
Neonatal	Newborn to one month.
Nervous System Inhibitors	These relax blood vessels by controlling nerve impulses.
Neuropathies	Problems specific to the nervous system.
Non-Symptomatic	Without or not exhibiting symptoms.
Operant Thinking	The ability to think hypothetically and to take different perspectives into account.
Optic Neuropathy	Vision problems.
Osteoporosis	A condition that affects older women (often post-menopausal) and is characterized by a decrease in bone mass and density which makes the bones porous and fragile.

Journey of Hope

Pap Smear	A method for the early detection of cervical cancer that involves the testing of sample cells obtained from the cervix for abnormalities.
Pat-A-Cake	A game in which the two participants (such as mother and daughter) clap their hands together in rhythm to a rhyme.
Peek-A-Boo	A game for amusing a baby or young child in which the adult repeatedly hides their face/body and pops back into view exclaiming "Peekaboo!"
Peer Group	A societal group based on age, grade, or status.
Pelvic Inflammatory Disease (PID)	Inflammation of the female reproductive tract, especially the fallopian tubes. It is generally caused by a sexually transmitted disease and is a leading cause of female sterility.
Perceptual Motor Skills	Applying gross and fine motor skills to new situations.
Phenylketonuria (PKU)	Inherited condition consisting of an inability to metabolize the amino acid phenylalanine. A person with this problem may develop mental retardation either from eating foods high in phenylalanine as a young adult or if their mother ate foods high in phenylalanine while pregnant. A phenylalanine-restricted diet (avoiding meat, dairy, and other foods high in protein) should be observed until adolescence and before and during pregnancy.
Physical Abuse	It includes any non-accidental injury caused to a child by a caretaker. It includes beating, shaking, biting, burning, punching, or other such physical acts, which may cause injury to a child. A parent or caretaker might not intentionally hurt a child, but it can happen as a result of punishment or excessive discipline.
Physical Neglect	Includes not providing adequate food, clothing, or housing. Also includes a child not having adequate supervision.
Police	This department is responsible for helping citizens maintain a safe community.
Post Office	This is where you can go to mail a letter, send a package or to buy stamps.

Post Traumatic Stress Disorder (PTSD)	A psychological reaction that occurs after a highly stressful event. It is usually characterized by depression, anxiety, flashback, recurring nightmares, and avoidance of reminders of the event.
Preliterate	Lacking the use of writing.
Prenatal	Occurring, existing, or performed before birth.
Psychosomatic Illness	Relating to, involving or concerned with bodily symptoms caused by mental or emotional disturbance.
Punishment	It is a penalty administered by a parent to a child when the child has chosen to break a rule, guideline, or standards that have been set by the parents. It is not an abusive act. Appropriate types of punishment include Time Out, the loss of privilege, or having to replace a broken object.
Refugee	Someone who has left his/her country because of a well-founded fear of persecution for reasons of race, religion, nationality, social group, or political opinion.
Refugee Cash Assistance Program	This is an eight-month federal program for families without children. Also funds programs to help refugees prepare for jobs (ESL, job-training.).
Refugee Medical Assistance (RMA)	This is an eight-month federal program for families without children (if you are eligible for a state medical aid program) that compares with state by state Medicaid benefits. After June 2000, any refugee that loses Medicaid benefits during their first eight months in the United States will be eligible to rollover to RMA without a second eligibility interview.
Repatriation	When conditions in the home country have changed so much that refugees no longer believe their lives or liberty to be threatened, they return home voluntarily.
Resettlement	<p>Third country resettlement is always UNHCR's last choice of the three solutions. When repatriation is not an option, and the country of asylum—often citing social, ethnic, cultural, or economic factors—refuses integration, a third country must be found that will accept them.</p> <p>First-asylum countries sometimes get impatient and threaten to expel refugees before a durable solution is found.</p>

Journey of Hope

Resettlement Agency	This is another name for Voluntary Agency (Volag). It is responsible for assisting refugees in their first three months of resettlement.
Rh factor	Is a substance present in the blood. People who have this coating their red blood cells are Rh positive (Rh+) and those who don't are Rh negative (Rh-). If someone with Rh- blood is given (or otherwise exposed to, such as during pregnancy when small amounts of blood can be transferred between the mother and fetus through the placenta) Rh+ blood, their blood will develop antibodies against the Rh factor.
RhoGam	A brand name for Rh immunoglobulin. It is administered to pregnant Rh- women to prevent the creation of Rh antibodies.
Risk Factor	The likelihood of an individual becoming ill with a particular disease.
School-Aged	Children 5-years-old and older.
Scurvy	A disease caused by a lack of vitamin C. It is characterized by spongy gums, loosening of the teeth, and bleeding into the skin and mucous membranes.
Secondary Sex Characteristics	A physical characteristic that appears in members of one sex at puberty (i.e.: breast, facial hair, pubic hair, etc.).
Senior Citizen's Center	This center provides services to help the elderly meet their physical and social needs.
Sexual Abuse	Includes any inappropriate sexual contact between a child and an adult where the intention of the adult is sexual gratification.
Shari'a	Islamic law.
Sonogram	An image produced by an ultrasound.
Subdermal	Literally, "under/beneath the skin."
Supermarket	This is a store where you can buy food and toiletries.

Supplemental Security Income (SSI)	Federal program that provides cash benefits to low - income people who are over age 65 or who are seriously disabled. After receiving benefits for seven years, all recipients must become U.S. citizens before receiving further benefits.
Surah	A Chapter of the Koran.
Systolic Pressure	The contraction of the heart muscle by which the blood is forced onward and the circulation kept up.
Temporary Assistance to Needy Families (TANF)	Federal program with a maximum 5-year, life-time limitation, that provides assistance to low-income (or no income) families with children. Some states (9) have shorter life -time limitation. Some states limit aid to 24 months at any one time. Some states provide aid to mothers of newborn children so that they need not work during the first year of the child's life—some states provide aid for a shorter period of time.
Thrombotic Stroke	Stroke due to a blood clot in an artery.
Title XX	Federal program that pays for some child care programs and public health programs in which your family may participate.
Toddlers	Children 12-36 months of age.
Tricycle	A three-wheeled bike usually used by young children.
Tubal Ligation	Female sterilization.
United Nations High Commissioner For Refugees (UNHCR)	Established in 1951, UNHCR is that branch of the UN charged with the protection and assistance of refugees internationally. Mrs. Sadako Ogata currently holds the office of High Commissioner for Refugees.
Vasectomy	Male sterilization.
Vasodilators:	These open blood vessels by relaxing the muscle in the vessel walls.

Journey of Hope

Verbal Redirection	A means of managing your child's behavior by verbally expressing a command or request.
Vesico-Vaginal Fistula	A hole between the vagina and bladder.
Volag	Voluntary Agency. Another name for Refugee Resettlement Agency.
Welfare Office	The government department that processes documents for unemployed people who are seeking financial assistance.
Women's Shelter	This place provides temporary housing for women who are being abused in their homes.

ACRONYMS

ACOG	American College of Obstetricians and Gynecologists
ACPM	The American College of Preventive Medicine
ACS	American Cancer Society
ADA	American Dental Association
AFDC	Aid for Families with Dependent Children
AFP	alpha-fetoprotein
AMC	American Muslim Council
AUDIT	Alcohol Use Disorders Identification Test
BBA	Balanced Budget Act
BP	blood pressure
CBE	clinical breast exam
CHD	coronary heart disease
CHIP	Children's Health Insurance Program
CPR	Cardiopulmonary Resuscitation
CVS	Chorio Villionic Sampling
DFS	Department of Family Services
DHHS	Department of Health and Human Services
DM	diabetes mellitus
DMPA	depot-medroxyprogesterone acetate
DMV	Department of Motor Vehicles
DSS	Department of Social Services
EAP	Employee Assistant Program
ERT	Estrogen Replacement Therapy
ESL	English as a Second Language
FAS	fetal alcohol syndrome
FC/FGM	Female Circumcision/Female Genital Mutilation
FVP	family violence professionals
HIV	human immunodeficiency virus
HPV	human papillomavirus
IASC	Inter-Agency Standing Committee
IDUs	intravenous drug users
IOM	International Organization for Migration

Journey of Hope

IRSA	Immigration and Refugee Services of America
ISED	Institute for Social and Economic Development
LMP	last menstrual period
MAST	Michigan Alcoholism Screening Test
NAS-IOM	National Academy of Sciences—International Institute of Medicine
NHLBI	National Heart, Lung, and Blood Institute
NIDDM	non-insulin dependent diabetes mellitus
OC	Combination oral contraceptive
PID	pelvic inflammatory disease
PRWORA	Personal Responsibility and Work Opportunity Act
PTSD	Post-Traumatic Stress Disorder
SAPs	substance abuse professionals
SSA	Social Security Administration
SSD	Social Security Disability
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TB	tuberculosis
USPSTF	U.S. Preventive Services Task Force
USPTF	U.S. Preventive Task Force
VOLAG	voluntary agency
WHO	World Health Organization
WIC	Women, Infants and Children program
YMCA/YWCA	Young Men's Christian Association/Young Women's Christian Association

REFERENCES & RESOURCES

These resources have been divided into the following sections for ease of use with the corresponding modules of this manual.

- Section I:** Applied Life Skills
- Section II:** Parenting
- Section III:** Child Care
- Section IV:** Health & Wellness
- Section V:** Domestic Violence/Violence Against Women
- Section VI:** Public Benefits & Community Service
- Section VII:** Female Circumcision/Female Genital Mutilation

Section I: Applied Life Skills

Outline

- A. Cultural Orientation to the United States
- B. Independent Living Skills
- C. Islamic Issues
- D. For Women
- E. For Refugee Service Providers
- F. English as a Second Language, Employment, & Leadership

A. Cultural Orientation to the United States

Citizenship and Immigration, Canada Brian Coleman Communications Canada 300 Slater Street Ottawa, Ontario CANADA (613) 957-8014	<i>A Newcomer's Introduction to Canada</i>	FREE. This is written especially for newcomers, based on the experiences of former newcomers from many parts of the world. While not specific to any ethnic group or gender, this booklet offers valuable information on the environment, getting settled, and general rules for finding a job.
Indochinese Cultural and Service Center 3030 Southwest 2nd Ave. Portland, OR 97201	<i>Teaching Refugee Women</i>	FREE. Refugee women are often less visible than other refugee groups, as they are more likely to remain in the home while their husbands and children attend school, find jobs, and generally adjust to the new culture. Child care responsibilities may prevent them from attending ESL classes and they are usually timid about venturing out on their own. The curriculum guide is designed for general independent living: personal information, everyday activities, clothing, food, home maintenance and safety, transportation, money, and social courtesies.

<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>American Ways</i></p>	<p>\$14.95. A description of the basic characteristics of American culture (values, styles of communication, patterns of thinking, customary behaviors) that explains how they differ from the ways of other cultures. The author then demonstrates how these characteristics are reflected in the many aspects of American life that the foreigner encounters: politics, family life, education, the media, male-female relations, involvement in organizations, and behavior in public.</p>
<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>Living in the U.S.A.</i></p>	<p>\$15.95. <i>Living in the U.S.A.</i> is provided by multinational corporations to their foreign personnel in the U.S. It is also used by intercultural training firms, international organizations, and governmental and non-governmental agencies, especially those concerning refugees and immigrants. A partial listing of topics covered includes general first impressions, customary behaviors and dominant attitudes, business practices and work environment, social manners and courtesies, transportation and money management, medical care, food and dining services, shopping, communications, safety and emergencies, housing, care of young children, schools, teenage life, household help, and religion.</p>
<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>Moving Your Family Overseas</i></p>	<p>\$14.95. This is a special book on moving abroad, designed explicitly for use by the entire family. The authors discuss informing the children and assisting them in adapting, making the most of the trip and managing the living quarters, keeping the family functioning as an effective unit.</p>
<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>The Art of Crossing Cultures</i></p>	<p>\$14.95. A compelling analysis of the personal challenges inherent in the cross-cultural experience, based not only on psychological and communication theory, but on the vivid perceptions of an assortment of the world's greatest writers and the literature they have produced.</p>

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<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>The Mullah With No Legs (and other stories)</i></p>	<p>\$14.95. In these short stories, the author gives us a view of Iran through the lens of American culture. The stories, based on the author's experience, focus on the family and friends of a child growing up in Iran and on his later life as a student in the U.S. All the characters are buffeted by the clash of tradition and modernity, especially by the impact of Western technology and culture.</p>
<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>The Whole World Guide to Language Learning</i></p>	<p>\$14.95. The author offers a set of guidelines and instructions so clear and easy to follow that if they are used consistently, anyone will be able to pursue language learning successfully while abroad. The program is inexpensive, takes place at the learner's own speed, and involves a maximum use of and involvement with the whole community. Two core elements are the use of the mentor and the other is the daily learning cycle.</p>
<p>Intercultural Press P.O. Box 700 Yarmouth, ME 04096 (207) 846-5168</p>	<p><i>Women's Guide to Overseas Living</i></p>	<p>\$15.95. This perspective book was written by two women who have lived abroad for many years. They examine critical issues to women and their families who relocate: learning about culture shock and other adjustments, handling stress and loneliness, managing the household, helping children adjust, and staying healthy.</p>
<p>Melodija Books Raimonda Mikatavage P.O. Box 689 Hampstead, MD 21074 (410) 374-5106</p>	<p><i>Life in the U.S.A.</i></p>	<p>\$19.95 (\$12.95 if brought with Resource binder). Windows Software disk by Autonomy Publishing Corp. A useful guide to American life: the people, land, culture, making a living, starting and running a business, religion in America, public services, transportation, immigration and citizenship, and American government and law.</p>

<p>Melodija Books Raimonda Mikatavage P.O. Box 689 Hampstead, MD 21074 (410) 374-5106</p>	<p><i>Pioneer Living Series</i></p>	<p>\$39.95 (10% discount). Reproducible Resource binder by Raimonda Mikatavage. Topics include education, relationships, work, money, major purchases, health, and safety. Over 140 reproducible master pages, plus 10 pages of popular Internet web sites in the areas of immigration, ESL, car guides, job listings, consumer information, government resources, and travel. Teaches how to surpass language difficulties, save money and find a credit union, understand taxes and social security, cope with depression and other mental ailments, deal with emergencies, accidents and scams, build a credit history and obtain a credit card.</p>
<p>Melodija Books Raimonda Mikatavage P.O. Box 689 Hampstead, MD 21074 (410) 374-5106</p>	<p><i>Speaking of Survival</i></p>	<p>\$11.50. High-beginning/Low-intermediate ESL workbook by Daniel Freeman. Designed to provide the vocabulary newcomers need to cope in vital areas of life. Topics include medical care, emergencies, banking, shopping, transportation, and more.</p>
<p>Melodija Books Raimonda Mikatavage P.O. Box 689 Hampstead, MD 21074 (410) 374-5106</p>	<p><i>The Complete Guide to Immigration and Successful Living in the U.S.</i></p>	<p>\$39.95. By Access U.S.A., Inc. The Immigration Law section provides a comprehensive overview of regulations in easy-to-read words and charts. Contains copies of Immigration and Naturalization (INS) forms to fill out. A The Successful Living section covers banking, credit, investments, taxes, shopping, finding employment, and good schools, and improving English.</p>
<p>Refugee Transitions Deborah McSmith 942 Market Street Suite 412 San Francisco, CA 94102 (415) 989-2151</p>	<p><i>How to Mix and Meet With Americans and How to Understand Their Courtesies</i></p>	<p>FREE. Offers a chapter on learning to and understanding how to socialize with Americans. Though originally designed for newly arrived Asian immigrants, but applicable to any culture, the pamphlet is written in easy-to-comprehend text with pictures to accompany.</p>

<p>United Nations High Commission for Refugees Larry Yunk 1775 K St., NW Washington, DC 20006 (202) 296-5191</p>	<p><i>Cultural Orientation Program: Curriculum Lesson Guide</i></p>	<p>FREE. This cultural orientation curriculum guide contains outlines and activities/lessons plans as developed by representatives of the agencies currently implementing the UNHCR Intensive English as a Second Language and Cultural Orientation Program. This guide, though originally designed for refugees from Southeast Asia, is applicable to other ethnic groups.</p>
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B. Independent Living Skills

<p>Center for Development and Population Activities 1400 16th St., NW Suite 100 Washington, DC 20036 (202) 667-1142</p>	<p><i>Choose a Future! Issues and Options for Adolescent Girls</i></p>	<p>\$25.00. This training manual helps girls and young women examine issues and options in their lives, set goals, develop new skills in analysis and decision-making, and build self-esteem. Field-tested in South Asia, Africa, and Latin America, the manual contains 12 modules. Girls are actively involved in creating their own solutions to situations they encounter at home, in school, at work, and with male and female peers. Skits, stories and poems, games, crafts, posters and cartoons, field trips, and other activities stimulate learning and participation. Sessions on work, marriage, and motherhood help girls who are restricted by poverty and gender roles to explore positive options available to them, are complimented by sessions on reproductive issues: health, education, economic effects, abuse and violence, and harmful traditional practices.</p>
<p>City Family Arthur Shiff P.O. Box 748, Ansonia Station New York City, NY 10023 (212) 362-3052</p>	<p><i>City Family Magazine: Guide to Better Living</i></p>	<p>FREE. Life in the United States isn't always easy. Learning how laws affect you, about finding a job, about good medical care, and many other things, can be difficult. We bring information for better living directly to you. This magazine is a favorite of adult students, library patrons, union members, job trainees, clinic patients, service agency clients, newly arrived immigrants and refugees, and others working hard to improve their lives.</p>

<p>Consumer Information Center Catalog S. James/R. Woods P.O. Box 100 Pueblo, CO 81002 (719) 948-4000</p>		<p>Offers a variety of free booklets on cars, children, employment, the environment, federal programs and benefits, housing, money, and travel. Up to 25 booklets can be ordered for free. For over 25 booklets, prices range from \$0.50 to \$10.00.</p>
<p>Daniel Memorial Brenda Pausche 4203 Southpoint Blvd. Jacksonville, FL 32216 (800) 226-7612</p>	<p><i>Independent Living Skills System</i></p>	<p>\$1,195.00 ILS System. Topics include money management/consumer awareness, food management, health, housekeeping, housing, transportation, educational planning, job-seeking, emergency and safety skills, knowledge of community resources, religion, and leisure activities.</p>
<p>Daniel Memorial Brenda Pausche 4203 Southpoint Blvd. Jacksonville, FL 32216 (800) 226-7612</p>	<p><i>Skills, Training and Education for Pregnancy Prevention and Parenting</i></p>	<p>\$695.00 STEPPE System, \$10.00 additional Interview Assessments, \$12.00 additional Objective Assessments, and \$20.00 Generated Skill Plan Services. Topics include knowledge of sex education, family planning, childbirth preparation, nutrition and exercise, teen pregnancy, parenting infants, and parent/child development.</p>
<p>Daniel Memorial Brenda Pausche 4203 Southpoint Blvd. Jacksonville, FL 32216 (800) 226-7612</p>	<p><i>Yetunde</i></p>	<p>\$8.95 Instruction Manual and \$6.75 Workbook. By Linda Scope. Rites of Passage are structured programs by which women of the African-American community teach girls of that community how to grow into responsible women.</p>
<p>Department of Health and Human Services Ginger Hart 2525 Mount Vernon Ave. Alexandria, VA 22301 (703) 838-0700</p>	<p><i>100 Questions To Ask Yourself To Find Out Just How Ready You Are To Go Out On Your Own</i></p>	<p>FREE. Taking control of your life is a difficult task. The sooner you begin to prepare for independent living the better your chances will be of succeeding. The questions in this booklet are intended to help you think about the realities of living on your own.</p>
<p>Department of Health and Human Services Ginger Hart 2525 Mount Vernon Ave. Alexandria, VA 22301 (703) 838-0700</p>	<p><i>Start-Up Costs</i></p>	<p>FREE. Section of a workbook that introduces the reader to the costs associated with moving into a new place and other budgeting concerns.</p>

Journey of Hope

<p>Department of Health and Human Services Ginger Hart 2525 Mount Vernon Ave. Alexandria, VA 22301 (703) 838-0700</p>	<p><i>The Road to Independent Living: A Handbook for Adults</i></p>	<p>FREE. The purpose of this handbook is to provide resources for social workers, foster parents, and volunteers who are assisting teenagers and adults for a more self-sufficient independence. Topics include: identifying and planning goals, daily living skills, developing a career, searching for a job, maintaining employment, and building relationships with family and friends.</p>
<p>Department of Social and Health Services Division of Children and Family Services B37-4, 1720 Ellis St., P.O. Box 32090 Bellingham, WA 98228-4090 (360) 647-6100</p>	<p><i>The New Making it on Your Own</i></p>	<p>FREE. Created by the Virginia Commonwealth University's School of Social Work, this workbook is an easy-to-understand workbook for general independent living: job hunting, money management, apartment living, home management, and community resources.</p>
<p>Life Skills Education Center Jack Zeran 12114 SE 75th Place Newcastle, WA 98056 (206) 271-0502</p>	<p><i>It's Your Future: Survival Skills for the Real World</i></p>	<p>\$650.00 (\$250.00 for the Teacher's Manual only). A series of classroom simulations, designed through the cooperative efforts of teachers, students, business, and the community to explore the working world, personal finances, independent living, transportation, the consumer, leisure time, and health and wellness. Participants are engaged in the tasks of choosing a career, finding a job, renting an apartment, establishing a bank account, and budgeting earnings. Within each lesson participants are given the opportunity to field test what they have learned by possibly calling a business and requesting a tour of its daily operations or visiting a car dealership.</p>
<p>Metropolitan Life Insurance Company Life Advice New York City, NY</p>	<p><i>Life Advice About Doing Your Taxes</i></p> <p><i>Life Advice About Running a Small Business</i></p> <p><i>Life Advice About Starting a Business</i></p> <p><i>Life Advice About Taking Legal Action</i></p>	<p>FREE. All easy-to-understand pamphlets on various financial matters featuring the Peanuts characters.</p>

C. Islamic Issues

<p>Arab World and Islamic Services</p>	<p>http://www.dnai.com/~gui/awairproductinfo.html</p>	<p>The AWAIR (Berkley, CA) is a non-profit dedicated to the awareness of Arab and Islamic culture. We work primarily with schools, offering an exciting range of informative material. We feel it is vital to make these materials available so that both the curious and proud have a means of connecting to the heritage. Prices vary.</p>
<p>El Saadawi, N.</p>	<p><i>The Hidden Face of Eve: Women in the Arab World</i></p>	<p>1980. This is a personal account of growing up in the Islamic world. The author explores a host of topics that include sexual aggression against female children, the circumcision of young girls, prostitution, sexual relationships, and marriage and divorce.</p>
<p>Fernea, Elizabeth Warnock</p>	<p><i>In Search of Islamic Feminism: One Woman's Global Journey</i></p>	<p>1998 New York: Doubleday. This book explores the nature of feminism in the context of Muslim women's lives, Muslim women's organizations and Muslim women's struggles.</p>
<p>Haddad, Yvonne Yazbeck</p>	<p><i>Islamic Vales in the United States: A Comparative Study</i></p>	<p>New York City: Oxford University Press, 1987. \$14.95</p>
<p>Haddad, Yvonne Yazbeck</p>	<p><i>The Muslims of America</i></p>	<p>New York City: Oxford University Press, 1991. \$18.95</p>
<p>Islamic Information Service Sharaf N. Rehman, Ph.D. P.O. Box 6220 Altadena, CA 91003-6220 (818) 791-9818</p>		<p>This organization offers a large variety of television programs produced by IIS on Islam-related topics, including "Women in Islam," "Islam in America," and "Immigrant Muslims." \$39.00 (five videos), \$24.95 (two videos)</p>
<p>Yamani, Mai (ed.)</p>	<p><i>Feminism and Islam: Legal and Literary Perspectives</i></p>	<p>1996 NY: New York University Press. This book examines how women in Islamic societies have become more actively involved not only in learning their rights under the sharia, but in regarding this law to improve their status and gain increased equality and freedom.</p>

D. For Women

<p>Women Make Movies, Inc. Distribution Dept. 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Its Okay to Peek: Gynecological Self-Exam</i></p>	<p>Video. Rental \$60.00, VHS Sale \$175.00. This is a self-help tool for empowerment useful for detecting changes in the vaginal tract that could signal potential medical problems.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Acting Our Age: A Film About Women Growing Old</i></p>	<p>Video. Rental \$90.00, VHS Sale \$275.00. This film offers empowering insights about women and aging. Personal portraits of six ordinary women in their 60s and 70s share their lives. Topics include self-image, sexuality, financial concerns, dying, and changing family relationships.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>As Women See It</i></p>	<p>Video. Rental \$60.00, VHS Sale \$250.00. This is a unique collection of films by women about women in the Third World.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Calling the Ghosts: A Story About Rape, War and Women</i></p>	<p>Video. Rental \$90.00, VHS Sale \$325.00. This powerful documentary is a first-person account of two women caught in war in Bosnia-Herzegovina where rape was as much an everyday weapon as bullets and bombs.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Delirium</i></p>	<p>Video. Rental \$50.00, VHS Sale \$200.00. This film explores the historical relationship between women and madness with wit and sensitivity.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Hidden Faces</i></p>	<p>Video. Rental \$90.00, VHS Sale \$295.00. This film develops into a fascinating portrayal of Egyptian women's lives in Muslim society, highlighting the life of Nasal El Saadawi.</p>

<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Iraqi Women: Voices from Exile</i></p>	<p>Video. Rental \$75.00, VHS Sale \$250.00. This film provides a rare look at the recent history of Iraq through the eyes and experiences of Iraqi women living in exile. The Arab world usually speaks to the outside with a male voice and Arab women's voices are rarely heard. This documentary features moving interviews with women about life in Iraq before Saddam Hussein came to power, in the years of repression under his regime, and through the Gulf War in 1991.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Menopause: Our Shared Experience</i></p>	<p>Video. Rental \$60.00, VHS \$195.00. This film explores the physical and psychological experience of menopause.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>No Time to Stop: Women Immigrants</i></p>	<p>Video. Rental \$60.00, VHS Sale \$250.00. Three women who have different stories and different aspirations share a common bond: they are immigrants, women of color, and struggling to make a dignified life for themselves.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>On Becoming a Woman</i></p>	<p>Video. Rental \$80.00, VHS Sale \$195.00. This documentary provides rare insights into some important health issues for African American women (teen pregnancy, reproduction, birth control, and self-examination).</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Sidet: Forced Exile</i></p>	<p>Video. Rental \$75.00, VHS Sale \$295.00. During the past two decades, more than two million refugees have left Ethiopia. Famine, poverty, and political strife as well as religious persecution caused by Eritrea's annexation have already cost countless lives.</p>

<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Waking up to Rape</i></p>	<p>Video. Rental \$65.00, VHS Sale \$250.00. This is a powerful film that examines the personal trauma of rape, its long-term psychological effects, societal attitudes about sexual assault, and the problem of racism in the criminal justice system.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Why Women Stay</i></p>	<p>Video. Rental \$60.00, VHS Sale \$225.00. This documentary examines the complex reasons why women remain in violent homes and challenges the prevailing attitudes which accept domestic violence as well as the social structures which perpetuate it.</p>
<p>Women Make Movies, Inc. Distribution Dept. The 1997 Film and Video Catalog 462 Broadway, Suite 500E New York City, NY 10013 (212) 925-0606</p>	<p><i>Women: The New Poor</i></p>	<p>Video. Rental \$60.00, VHS Sale \$195.00. Divorced women and single mothers who lack skills and opportunities for economic self-sufficiency represent the alarming feminization of poverty in the U.S.</p>

E. For Refugee Service Providers

<p>Aswad, Barbara and Barbara Bilge (eds.)</p>	<p><i>Family & Gender among American Muslims: Issues Facing Middle Eastern Immigrants and Their Descendants</i></p>	<p>A collection of articles that explore the social and historical conditions of the Muslim migration, as well as the issues affecting Muslim-American life. This book provides information on topics such as intergenerational conflict about identity and values, intermarriage, religious and community involvement, gender and family structure, education, needs of the elderly, and physical and mental health problems.</p>
<p>Dirie, Waris and Cathleen Miller</p>	<p><i>Desert Flower: The Extraordinary Journey of a Desert Nomad</i></p>	<p>New York: William Morrow and Company, Inc., 1998. This autobiography tells the story of supermodel Waris Dirie, who was born in a traditional Somali family of nomads. The book explores her journey from exploitation, casual violence and attempted rape to her modeling career in Europe and the United States.</p>

<p>Fadiman, Anne</p>	<p><i>The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collusion of Two Cultures</i></p>	<p>New York: Noonday Press, 1997. This book explores the clash between a small country hospital in California and a refugee family from Laos over the care of Lia Lee, a Hmong child diagnosed with severe epilepsy. <i>Winner of the National Book Critics Circle Award for Nonfiction.</i></p>
<p>Gropper, Rena</p>	<p><i>Culture and the Clinical Encounter: An Intercultural Sensitizer for the Health Professions</i></p>	<p>Intercultural Press, Inc., 1996. This book utilizes critical incidents to educate health professionals about the importance of cultural differences in health care delivery. The reader is presented with conflicts and problems within the context of a clinical setting and are expected to choose the best of four explanations.</p>
<p>Institute for Cultural Partnerships Fouzia Musse</p>	<p><i>A Profile of New Refugee Arrivals: Tunni From Somalia, the Rer Brava and Shangamas</i></p>	<p>FREE. In early 1996, the UNHCR in Kenya recommended that the refugees living in the Hatimy camp to be resettled in the U.S. Interviews and processing began shortly after, and approx. 4,500 Somali refugees mostly from the Tunni clan (Rer Brava and Shangamas) who had lived in the Benadir region of Somalia, were approved for resettlement in the U.S. Prior to departure, each refugee will receive a medical screening and any required medical treatment, particularly for tropical and parasitic diseases. The article gives clan descriptions, geography and economy, a history of Tunni refugees in Kenya, Tunni society and family, language and education, religion, occupation, skills and employment, custom, traditions and arts, and medical issues.</p>
<p>International Catholic Migration Commission</p>	<p><i>U.S. Cultural Orientation Curriculum</i></p>	<p>Zagreb, Croatia: International Catholic Migration Commission, 1997.</p>
<p>International Center for Research for Women 1717 Mass., Ave., Suite 302 Washington, DC 20036</p>	<p><i>Taking Women into Account: Lessons Learned from NGO Project Experiences</i></p>	<p>ICRW, 1996. This book highlights the experiences of U.S. NGOs in integrating women and gender concerns into their development activities, as well as illustrating practical and replicable lessons learned from case studies.</p>
<p>Nichols, Jane</p>	<p><i>Refugee Guide to the United States of America</i></p>	<p>FREE. Pictures and text give a brief introduction to life in America. Translated into Arabic.</p>

<p>Nichols, Jane</p>	<p><i>Transition Strategies: Iraqi Refugee Cultural and Psychological Adaptation Issues</i></p>	<p>FREE. This paper is a preliminary investigation exploring some of the cultural and psychological adjustment issues of the Gulf War refugee population. The Gulf War refugee population consists of Kurds predominantly from Northern Iraq. The data gathered for this paper was from social service agency employees and the Iraqi refugees now residing in three cities in the U.S. Life transitions, particularly when induced by war or traumatic life events, often create significant emotional challenges. It has been suggested by various agencies that the Iraqi population is challenged in adapting to life in the U.S.</p>
<p>Nichols, Jane</p>	<p><i>Transitions</i></p>	<p>FREE. The three phases of change and adaptation are: an ending, followed by a period of confusion and distress, leading to a new beginning. These three parallel with the processes we experience as cross-cultural adventurers or are forced to experience as a refugee. This paper examines transition issues and processes in the context of the three phases and with other articles on culture shock. Secondly, this paper applies the theory to the issues of refugee resettlement and suggests some conclusions and observations.</p>
<p>Office of Pastoral Care for Immigrants and Refugees (UCSC/M.S.) U.S. Catholic Conference Publishing Department 3211 4th St., NE Washington, DC 20017 (301) 209-9020</p>	<p><i>Who Are My Brothers and Sisters? A Catholic Curriculum Guide for Understanding and Welcoming Immigrants and Refugees</i></p>	<p>\$14.95, \$6.95 (Order No. 5-006 and 5-057). This is a significant resource in combating the prevailing anti-immigrant feelings in the U.S. The document weaves the Catholic Church teachings of welcoming and supporting the stranger throughout the text. The completed curriculum guide will be available by early 1996.</p>

<p>Refugee Policy Group Center for Policy Analysis and Research on Refugee Issues 1424 16th Street, NW Suite 401 Washington, DC 20036 (202) 387-3015</p>	<p><i>Issues and Options for Refugee Women in Developing Countries</i></p>	<p>FREE. The Refugee Policy Group is a non-profit, private organization established in 1982. Its purpose is to serve as an independent center of policy analysis and research on refugee issues. This report is an initial effort to explore a variety of complex issues regarding refugee women and the impact that their refugee status has had on their lives. While not a definitive study, its purpose is to create an awareness of the needs of refugee women and to generate a commitment on the part of assistance agencies to respond accordingly.</p>
<p>Refugee Policy Group Center for Policy Analysis and Research on Refugee Issues 1424 16th Street, NW Suite 401 Washington, DC 20036 (202) 387-3015</p>	<p><i>Older Refugees in the United States: From Dignity to Despair</i></p>	<p>A paper on the experiences of elderly immigrants who relocate to the U.S. Topics include: financial security, English, health, housing, transportation, intergenerational tensions, community and religion, and death and dying. Though not specific to any ethnic group or gender, the booklet may be useful for older female clients.</p>
<p>Ryan, Angela Shen (ed.)</p>	<p><i>Social Work with Immigrants and Refugees</i></p>	<p>Haworth Press, 1992. This book provides service providers with valuable information on social work issues regarding delivery of services to new populations. The articles contained in the book promote a needed understanding of the realities of these groups' experiences.</p>

F. English As a Second Language, Employment, & Leadership

<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>A Guide to Resettlement in the United States</i></p>	<p>FREE. The 1985 resettlement guide gives fundamental aspects of life in the U.S., such as employment, education, government, law, and consumerism. Languages available: Amharic (a), Farsi (d), Kurdish (g), and Somali (k).</p>
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<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Fact Sheet Series</i></p>	<p>\$3.00 each (single copies complimentary). These are designed for service care providers and others assisting newcomers to America, containing a basic introduction to the people, history culture of different refugee groups and include topics such as geography, economy, history, social structure and gender roles, language and literacy, education, religion, art and song, food and dress, and festivities. Groups available: Ethiopians (#1), Somalis (#9), Iraqis (#11) and Iraqi Kurds (#13).</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Family as Resource</i></p>	<p>An Overseas Refugee Training Program Video Presentation. \$60.00. Video that draws from and builds upon existing networks of community resources describing intergenerational methods which stress age and gender perspectives, family content, supporting structures where cooperation and risk-taking are practiced. The principle assumption is that good education results from an integration of home, school and community.</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>From the Classroom to the Community: A 15-Year Experiment in Refugee Education</i></p>	<p>\$14.95. This book describes the unique educational program established in 1980 for U.S.- bound refugees in Southeast Asia, analyzing forces that led to the launching of the program and discusses some of its innovative practices which include language literacy, educating parent's involvement in their children's education, and integrating educational and social systems for young adults.</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Helping Refugees to Learn to Read and Write</i></p>	<p>An Overseas Refugee Training Program Video Presentation. \$60.00. Video about ESL literacy introduction, presenting the three fundamental principles of: reading and writing with a focus on meaning, second language literacy can develop at the same time as speaking and listening, students need a literacy-rich environment.</p>

<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>How to Integrate Language and Content Instruction: A Training Manual</i></p>	<p>\$10.00. A training manual to help language teachers and content area teachers integrate language learning and academic content for students of limited English proficiency.</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Native Language and Content Instruction for Adults: Patterns, Issues, Promises</i></p>	<p>\$5.00</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Opening the Word: Narrative Activities for ESL Students</i></p>	<p>An Overseas Refugee Training Program Video Presentation. \$60.00. Using narrative (any oral or written language event which involves a story line) in ESL classrooms, showing how to use story lines in a variety of contexts including story books, news reporting, round-robin writing about personal and group experiences. Lessons about story lines are explained and demonstrated through examples from actual classrooms.</p>
<p>Center for Applied Linguistics Refugee Service Center 1118 22nd St. Washington, DC 20037 (202) 429-9292</p>	<p><i>Phrase Books</i></p>	<p>\$5.00 each (cassette versions available). The English phrases in the books have been selected for their directness, brevity, and relevance to the needs of newly arrived residents of the U.S., including phrases and supplementary vocabulary for use in daily activities of American life (examples: giving information about yourself, recognizing signs, dealing with money, health, food, clothing, housing, and jobs). Languages available: English-Farsi.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>A Multi-cultural Focus on Career Education</i></p>	<p>\$5.25. By Don Locke and Larry Parker.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Complete Set</i></p>	<p>\$895.00. Contains 57 Occupations with math skills through 6th grade and reading skills through 4th-5th grade level.</p>

Journey of Hope

<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Creative Inclusive Adult Learning Environments: Insights from Multi-cultural Education and Feminist Pedagogy</i></p>	<p>\$9.75. By Elizabeth Tisdell.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Enhancing Diversity in Vocational Education</i></p>	<p>\$6.00. By Blannie Bowen and Gary Jackson.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Equity, Women and Literacy: Guide to Literature and Issues for Women-Positive Programs</i></p>	<p>\$9.75. By Susan Imel and Sandra Kerka.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Leadership in Entrepreneurship: Resources for Small Business Development and Enhancement</i></p>	<p>\$9.75. By Judy Balogh.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Life Skills Curriculum</i></p>	<p>\$495.00</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>Psychological Development of Women: Linkages to Teaching and Leadership in Adult Education.</i></p>	<p>\$7.00. By Rosemary Caffarella.</p>
<p>Center on Education and Training for Employment College of Education Ohio State University 1900 Kenny Road Columbus, OH 43210-1090 (614) 292-4353</p>	<p><i>The Vocational and Language Development of Limited English Proficient Adults</i></p>	<p>\$8.00. By Joan Friendenberg</p>

<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>What You Should Know About: Job Interview Skills</i></p>	<p>FREE. Fifteen page easy-to-understand pamphlet with pictures and charts on getting a job.</p>
<p>Deva Clothiers Lois Small Route #9 Ranson, WV 25438 (304) 728-6792</p>		<p>Cutting facility in West Virginia, ideal for home-based stitchers. Most groups are women, all self-employed, and put out between 50 and 300 garments per week. Heavy industrial sewing equipment are required purchases for anyone interested.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>A Field Guide for Literacy: Life Skills and Literacy for Adult Beginning Readers and ESL Students</i></p>	<p>\$1.34 MF, \$27.79 PC (173 pages). By Jane Ditmars. Life skills curricula that includes four sections: focus on language arts, focus on life skills and literacy, focus on holidays and observances, and focus on survival math.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>ABLE Curriculum Guide 1994. A Resource Listing for ABLE Practitioners</i></p>	<p>\$1.34 MF, \$11.91 PC (59 pages). By Sherry Royce. This bibliography lists 52 recently published resources for adult basic literacy education (ABLE) and ESL adult learners. The materials featured were selected from 350 books, videos, computer-assisted instruction programs on the topics of life skills, family literacy, vocational skills, etc.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Arlington Adult Learning System (AALS) Curriculum: A Transitional ESL Curriculum for Adults</i></p>	<p>\$1.34 MF, \$123.07 PC (751 pages). By Carol Molek and Barbara Woodruff. AALS is a consortium in which the adult education provider coordinates efforts between itself and a community-based organization, a vocational institute, and a university to transition limited English-proficient adults into college and vocational training. Descriptions of the scope, assessment system, and criteria for determining skill levels are supplied for participants in need of life skills training.</p>

<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Branches Out! A Language and Life Skills Competency- based Curriculum Integrated With MELT Competencies</i></p>	<p>\$1.34 MF, \$71.46 PC (450 pages). By Eleanora Bell and Twila Evans. An adult education curriculum combining life skills and language instruction for students of ESL, integrating communicative language skills of learning, interpreting non-verbal language, speaking, reading, and writing, and instructional material on these topics: personal information, housing, environment, health, shopping, money/banking, transportation and community services/responsibility.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Common Threads: A Whole Language Text for Intermediate ESL Readers. ESL: Reading in a Skills Curriculum</i></p>	<p>\$1.34 MF, \$19.85 PC (124 pages). By Beverly Martin. Ten chapters address a variety of topics relating to daily life in America, including: travel and transportation, the nuclear and extended family, holiday traditions and customs, the education system, the workplace and its rules, moving to a new community, buying on credit, making major purchases, health and hospital care, child care alternatives, and working parent concerns.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Everyday Basic Skills: Final Report and Product</i></p>	<p>By Carol Molek and Barbara Woodruff. \$1.34 MF, \$59.55 PC (361 pages). Curriculum for basic adult education, literacy skills, job skills learning, parenting instruction, employment, everyday mathematics and English, and social and reasoning skills. Modules include the following: learning activities, information sheets, self-assessment questionnaires, teaching strategies and techniques.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Personal Inventory: Market Yourself</i></p>	<p>FREE. Checklist will help you see how you might perform better in some occupations than others. The job needs checklist, the pre-application test, and the guidelines for filling out applications for employment also help a person looking for a job.</p>

<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Project Work English Competency-Based Curriculum: Survival Level One</i></p>	<p>\$1.34 MF, \$27.79 PC (159 pages). By Carol Molek and Barbara Woodruff. Curriculum for ESL and life skills geared towards actual classroom examples that include topics such as interviewing, safety, task performance (housekeeping, assembling), and social skills.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Successful Life Skills Curriculum: Single Parents and Home makers: A Facilitator's Guide</i></p>	<p>\$1.34 MD, \$95.28 PC (584 pages). By Carol Molek and Barbara Woodruff. A guide intended to aid service providers as they provide support services to single parents and displaced homemakers to help them achieve the goal of economic self-sufficiency. The handbook provides learning activities, divided into seven critical life skills areas: self-awareness, communication skills, health and wellness, resource management, parenting, relationships, and personal power.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Teaching Basic Skills in Life Skills Contexts: An Inservice Training Module for LVA-CT, English as a Second Language</i></p>	<p>\$1.34 MF, \$7.94 PC (50 pages). By Jill Baldwin and Gloria Kielbaso. A set of instructional materials designed as a training module for volunteer tutors in ESL for adults, with three main objectives: help tutors understand the distinction between basic skills and life skills ESL, develop skills in two teaching techniques useful for integrating the different kinds of skills, and prepare for classroom implementation through lesson planning. Small group exercises encouraged.</p>
<p>ERIC Personal Library Software Document Reproduction Service 7420 Fullerton Road, Suite 110 Springfield, VA 22153 (800) 443-ERIC</p>	<p><i>Working Together: A Sex Equity Training Manual</i></p>	<p>\$1.34 PC, \$39.70 MF (237 pages). By Jill Baldwin and Gloria Kielbaso. Curriculum provides learning activities that combat traditional sex role stereotypes and behaviors.</p>
<p>Ethiopian Community Development Council Seyoum Berhre 1038 S. Highland St. Arlington, VA 22204 (703) 685-0510</p>	<p><i>International Community Services: Pre-Employment Orientation Session</i></p>	<p>FREE. Covers various topics, including American work attitudes and welfare, American cultural values and work, establishing a work history, today's job market, where jobs will be, and other related topics.</p>

Journey of Hope

<p>Home-Based Working Moms (HBWM) http://www.hbwm.com/opp ort.html</p>	<p><i>HBWM: Helpful Books</i></p> <p><i>HBWM: Helpful Tips</i></p> <p><i>HBWM: Home-Based Opportunities</i></p>	<p>FREE. Lesley Spenser founded HBWM-Home-Based Working Moms in 1995 in the hopes of creating strong support and informational networking among parents who were working at home. She felt an organization like HBWM would be a perfect way to allow parents to share new ideas and ask questions to others who have met similar challenges. Suggested reading includes: "Raise a Family and a Career Under One Roof: A Parent's Guide to Home Business"; "Mompreneurs: A Mother's Practical Step-by-Step Guide to Work-at-Home Success"; and "Starting Your Own Home-Based Business." HBWM also has a Resume Service, ways to avoid scams, and membership information.</p>
<p>Massachusetts Office for Refugees and Immigrants Dorian Fliegel Cambridge, MA</p>	<p><i>Competence-Based Job Development</i></p>	<p>FREE. Job development can be a daunting task. Add in the complications of working with refugee and immigrant clients in a competitive economy and the task can seem overwhelming. This is a comprehensive approach to job development that can add to your professional skills and help you to place your clients.</p>

Section II: Parenting

Outline

A. Parenting Adolescents

A. Parenting Adolescents

Lutheran Immigration and Refugee Service New York, NY.	<i>Working with Refugee and Immigrant Children: Issues of Culture, Law, and Development</i>	New York, NY: Lutheran Immigration and Refugee Service, 1998
Palanca, Peter M., M.A. C.A.C. Deeffield, IL.	<i>What Do Adolescents Need?</i>	
Popkin, Michael H., Ph.D.	<i>Active Parenting of Teens</i>	Atlanta, Georgia: Active Parenting, Inc. 1990.
Virginia Coalition for Child Abuse Prevention Month, Richmond, VA.	<i>What to Expect From Your Teen</i>	

Section III: Child Care

Outline

- A. General Information
- B. Standards & Regulations

A. General Information

Herman, Doris	<i>Preschool Primer for Parents: A Question and Answer Guide to Your Child's First School Experience</i>	
Muscari, Ann and Wenda Wardell Morrone	<i>Child Care That Works: How Families Can Share Their Lives with Child Care and Thrive</i>	

B. Standards & Regulations

Berezin, Judith	<i>The Complete Guide to Choosing Child Care</i>	New York: Random House, 1990
Co-ordinated Access for Child Care (Canada) http://www.cafcc.on.ca/gst art.htm	Choosing Quality Child Care	
Texas Department of Protective and Regulatory Services	"Day-care Center Minimum Standards and Guidelines"	

Section IV: Health & Wellness

Outline

- A. General Information
- B. Access to Care Issues
- C. Mental Health Issues & Substance Abuse
- D. Cultural Issues
- E. Navigating the U.S. Health Care System
- F. Linguistic Issues & Barriers
- G. Sexual & Reproductive Health & Family Planning Issues
- H. Pre-, Peri-, & Post-Natal Care & Pediatric Care
- I. Issues Concerning Children
- J. Diabetes
- K. Immunizations & Medications
- L. Nutrition, Physical Exercise, & Hygiene
- M. For Health Providers
- N. Educational Materials & Resources

A. General Information

American Academy of Family Physicians	<i>Summary of Policy Recommendations for Periodic Health Examination</i>	Kansas City, MO: American Academy of Family Physicians; 1997.
American College of Obstetricians and Gynecologists	<i>Guidelines for Women's Health Care</i>	Washington, DC: American College of Obstetricians and Gynecologists; 1996.
American College of Physicians Common Screening Tests	"Guidelines"	Edited by D. M. Eddy. Philadelphia, Pa: American College of Physicians, 1991.
American Dental Association Department of Salable Material 211 E Chicago Ave Chicago, IL 60611 (800) 947-4746	<i>Diet and Dental Health</i>	
American Dental Association Department of Salable Material 211 E Chicago Ave Chicago, IL 60611 (800) 947-4746	<i>Oral Health Care Guidelines for Special Patients</i>	11 different guideline booklets

<p>American Dental Association Department of Salable Material 211 E Chicago Ave Chicago, IL 60611 (800) 947-4746</p>	<p><i>Smoking Can Really Do a Number on Your Health</i></p>	
<p>American Dental Association Department of Salable Materials 211 E Chicago Ave Chicago, IL 60611 (800) 947-4746</p>	<p><i>Dental Emergency Procedures</i></p>	
<p>American Dental Association Department of Salable Materials 211 E Chicago Ave Chicago, IL 60611 (800) 947-4746</p>	<p><i>Seal Out Decay; Smokeless Tobacco: Think Before You Chew</i></p>	
<p>American Red Cross</p>	<p><i>Giving and Receiving Blood</i></p>	<p>Series #329, 546.</p>
<p>Boston Women's Health Book Collective</p>	<p><i>Our Bodies, Ourselves for the New Century</i></p>	<p>1998. By and for women, this book is an enormous resource for women's health needs, concerns and questions. The book places emphasis on what women can do for themselves and for each other to stay healthy, heal themselves, and work for change.</p>
<p>Commission on Women's Health</p>	<p><i>Selected Facts on U.S. Women's Health</i></p>	<p>March 1997. This is a chart book that includes the following types of information: 1/ Gender differences in the leading cause of death, i.e., heart disease; 2/ age differences in major health problems; 3/ racial differences in leading health problems; 4/ chronic physical and mental conditions; 5/ violence against women; 6/ risky personal health behaviors; 7/ utilization of clinical preventive services; 8/ How women feel about their doctors; and 9/ health care coverage.</p>

<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>Prevention and Women's Health: A Shared Responsibility</i></p>	<p>September 1996. This Policy Report reviews the major health risks that women face over their lifetimes, the prevention opportunities that are available to reduce those risks, and the major barriers that impede women from taking advantage of these opportunities. The Report identifies policies and programs that have proven successful in promoting prevention, and suggests that prevention needs to be viewed as a shared responsibility; one that requires commitments and self-help on the part of women, but also the support of families, health professionals, policy makers, and employers.</p>
<p>Commonwealth Fund Johns Hopkins University</p>	<p><i>Case Studies of Women's Health Centers: Innovations and Issues in Women-Centered Care</i></p>	<p>March 1997. The case studies identify some commonalities across various centers in their women-centered missions, support for women providers, and strong leadership. The outcome of this study is in the form of policy recommendations for the preferred model of health care.</p>
<p>Commonwealth Fund Survey of Women's Health</p>	<p><i>Survey of Women's Health</i></p>	<p>July 1993. This survey was conducted with more than 2,500 women and 1,000 men nationwide between February and March 1993. The results of this survey lay the groundwork of the Commonwealth Fund's established Commission on Women's Health. This survey represents the first comprehensive national health survey of American women, which ultimately found them at significantly higher risks in terms of lack of medical care, underuse of preventive services, depression, abuse and poor physician communication.</p>
<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>In Their Own Words: Adolescent Girls Discuss Health and Health Care Issues</i></p>	<p>This report examines a series of focus groups of adolescent girls ages 10 to 19. The discussion explores what adolescent girls are facing and how they are coping with health care issues. The groups uncovered serious shortcomings and misunderstandings in what girls know and understand about their own health and about women's health and health care.</p>

<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>The Health of College Women: A Rationale for Preventive Health Interventions</i></p>	<p>December 1995. This paper addresses the importance of health issues of younger women and adolescent girls. The behavior of girls and young women, who are still developing physically and emotionally, can determine the quality of the health they will experience as adults and older women.</p>
<p>Commonwealth Fund Commission on Women's Health UCLA Center for Health Policy Research</p>	<p><i>Women's Health- Related Behaviors and Use of Clinical Preventive Services</i></p>	<p>October 1995. This report adds significantly to an understanding of knowledge about two major problems in women's health: women who are not taking preventive measures to protect themselves against serious illness, and women who are not getting screened for detectable, treatable disease. In both instances the numbers of women at risk are large and unacceptable.</p>
<p>Commonwealth Fund Program on Women's Health</p>	<p><i>Program on Women's Health</i></p>	<p>November 1996. This booklet provides a summary of the program on women's health at the Commonwealth Fund. The booklet is a good resource for a general overview of the working completed through the Commonwealth Fund, as well as work in progress. A publications listing, general fund publications, and directors and staff are also listed.</p>
<p>Frymoyer J. W. <i>Bailliere's Clin Rheumatol</i></p>	<p>"Can Low Back Pain Disability be Prevented?"</p>	<p>1992. Vol. 6, pp. 595-606.</p>
<p>Frymoyer J. W. <i>Engl J Med</i></p>	<p>"Back Pain and Sciatica"</p>	<p>1988. Vol. 318, pp. 291-300.</p>
<p>Jacobs Institute of Women's Health</p>	<p><i>The National Survey of Women's Health Centers: Current Models of Women- Centered Care</i></p>	<p><i>WHI</i>. Vol. 5, No. 3. Fall 1995. This article presents results from the first national survey of women's health centers in the United States. The article acknowledges that although there is growing interest in women's health and recognition of the need for new models of care delivery for women, relatively little is known about the women's health centers currently operating.</p>

<p>Liebenson C. S. <i>J Manipulative Physiol Ther</i></p>	<p>"Pathogenesis of Chronic Back Pain"</p>	<p>1992. Vol. 15, pp. 299-308.</p>
<p>McElligott J, Miscovich S. J., Fielding L. P. Conn. Med.</p>	<p>"Low Back Injury in Industry: The Value of a Recovery Program"</p>	<p>1989. Vol. 53, pp. 711-715.</p>
<p>Nachemson A. L. <i>Bull Hosp. Joint Dis. Orthop. Inst.</i></p>	<p>"Prevention of Chronic Back Pain: The Orthopedic Challenge for the 80's."</p>	<p>1984. Vol. 44, pp. 1-15.</p>
<p>Schwartz M. K. <i>Clin Chem.</i></p>	<p>"The Role of the Laboratory in the Prevention and Detection of Chronic Disease"</p>	<p>1992. Vol. 38, pp. 1539-1546.</p>
<p>Shephard, Bruce D., M.D. and Carroll A. Shephard, R.N.</p>	<p><i>The Complete Guide to Women's Health</i></p>	<p>3rd Edition. Plume Book. \$21.95. The most comprehensive, up-to-date resource available for making vital health decisions. This book is for all women who wish to participate more actively and more knowledgeably in their own health care. The emergence of women's health in the 1990s has made health information ever more accessible. But a second megatrend—the rise of managed health care—has made it even more critical for women to be able to use that information widely. Contains chapters on health strategies, birth control, planning pregnancy, pregnancy and childbirth, sexual issues, diseases of the female reproductive system, a healthy lifestyle, and what your symptoms mean.</p>
<p>U.S. and Human Services.</p>	<p><i>Clinicians Handbook of Preventive Services</i></p>	<p>1994.</p>
<p>U.S. Preventive Services Task Force</p>	<p><i>Guide to Clinical Preventive Services</i></p>	<p>2nd edition. 1995.</p>

<p>United Nations High Commission on Refugees General Legal Advice Section (HQPR02) Case Postale 2500 CH-1211 Geneva 2 Depot Switzerland</p>	<p><i>The World's Women: Trends and Statistics</i></p>	<p>\$15.95. In addition to being an official document for the Fourth World Conference on Women, this edition is an independent UN publication. Its six chapters cover and update areas previously analyzed on education, population, and public life. It also expands the sections on health, childbearing and work, as well as media, violence against women, poverty, the environment, and refugees and displaced persons.</p>
<p>World Health Organization.</p>	<p><i>International Classification of Diseases</i></p>	<p>10th revision. Geneva: World Health Organization, 1992.</p>

B. Access to Care Issues

<p>Adams, Diane L., M.D.</p>	<p><i>Health Issues for Women of Color: A Cultural Diversity Perspective</i></p>	<p>London: Sage Publications, 1995. Focusing on African-American, Hispanic/Latina, Asian/Pacific Islander, Middle Eastern, and American Indian/Alaskan Native women, <i>Health Issues for Women of Color</i> presents a multi-disciplinary and multi-factual approach to the major health concerns of today's women of color. The chapters address topics such as domestic violence, anxiety, drug abuse, mental health, sexism, and racism, as well as the unique problems of the growing population of women of color who are homeless. This valuable resource not only demonstrates how much needs to be done to bring parity to health care for women of color, but also provides eliminating barriers to access to health care. Students, health care professionals, researchers, and policy makers who desire to see equity in health care access and delivery will find the book an important addition to their libraries.</p>
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<p>American Journal of Public Health</p>	<p>"Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans"</p>	<p>Vol. 86, No. 12. December 1996. This article explores the impact of duration of physician-patient ties on the processes and costs of medical care. The study uses a nationally representative sample of Americans 65 old or older who participated in Medicare Current Beneficiary Survey in 1991.</p>
<p>Commonwealth Fund</p>	<p><i>Briefing Note: Medicaid: The Health Care Safety Net for the Nation's Poor</i></p>	<p>June 1996. This article includes testimony presented by Karen Davis before the Committee on Finance and The United States Senate during the hearing on Welfare and Medicaid Reform. The testimony addresses the importance of Medicaid benefits and the implications for low-income women and children in terms of welfare and medicaid reform.</p>
<p>Commonwealth Fund</p>	<p><i>Improving the Delivery of Clinical Preventive Services to Women in Managed Care Organizations: A Case Study</i></p>	<p>January 1997. This study attempts to provide useful, practical information to managed care plans on the types of preventive programs available for women and the potential contributions to their health, and to share experiences and knowledge in the design and implementation of prevention programs in six managed care plans located across the United States and one medical group practice.</p>
<p>Commonwealth Fund</p>	<p><i>Medicaid's Role in Insuring Low-Income</i></p>	<p>May 1996. This study describes the role that Medicaid currently plays in insuring low-income women. Due to the eligibility for Aid to Families with Dependent Children (AFDC) automatically qualifies welfare recipients for Medicaid, the health insurance of low-income women will be affected by modifications to either AFDC or Medicaid.</p>
<p>Commonwealth Fund</p>	<p><i>Minority Americans Do Not Have Equal Health Opportunities. A Briefing Note from the Commonwealth.</i></p>	<p>This report details the results of a national survey that clearly show that Minority Americans do not enjoy equal health opportunities. This survey addresses the serious health problems and overall shorter life span and higher rates of infant mortality that Minority Americans face compared with white Americans.</p>

<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>Health Care Reform: What is at Stake for Women?</i></p>	<p>July 1994. This report reviews how women currently obtain health insurance, how their coverage affects their access to health care services, the extent to which women are covered for services important to their health, what they currently spend from their personal resources for health care, and the non-financial barriers they face in obtaining needed care.</p>
<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>Health Insurance and Access to Care: Issues for Women</i></p>	<p>January 1995. This paper serves as a background for a policy paper addressing health care reform from the perspective of women's health. The paper describes how women and men differ in the economic and social circumstances, largely related to employment and family, that determine access to insurance and health care at the present time.</p>
<p>Geriatrics</p>	<p>"Older Women's Health: 'Taking the Pulse' Reveals Gender Gap in Medical Care"</p>	<p>May 1995. A roundtable discussion where five panelists assess the status of medical education and the need to include older women in research and drug trials. The paper explores issues of gender bias in health insurance and quality of treatment; ways to improve the use of preventive health services—such as mammography and Pap smears—by older women; as well as the role of office physicians in identifying and helping victims of domestic violence.</p>
<p>Jacobs Institute Women's Health Issues</p>	<p>"Women's Health and Managed Care: Promises and Challenges"</p>	<p>Vol. 6, No. 1. January/February 1996. This article examines women's health and managed care within the context of the rapid growth of managed care in today's health care delivery system and the increasing role of managed care organizations in the health care of women.</p>
<p>Journal for Minority Medical Students</p>	<p>"Education"</p>	<p>Fall 1996. This journal details the opportunities, as well as barriers facing minority medical students in health care delivery and medical training systems.</p>

<p>Refugee Policy Group 1424 16th St. Suite 401 Washington, DC 20036</p>	<p><i>Issues and Options for Refugee Women in Developing Counties</i></p>	
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C. Mental Health Issues & Substance Abuse

<p>American Psychiatric Association</p>	<p><i>Diagnostic and Statistical Manual of Mental Disorders</i></p>	<p>4th ed. Washington, DC: American Psychiatric Association, 1994.</p>
<p>Center for Applied Linguistics, Refugee Service Center, Health Educational Materials, 1118 22nd St., NW, Washington, DC (202) 429-9292</p>	<p><i>Issues of War Trauma and Working With Refugees: A Compilation of Resources</i></p>	<p>Summer 1995. \$5.00 copying fee. The materials include background information on how trauma and post-traumatic stress disorder affect both children and adults (as well as specific information on the effects on refugees) and such implications for ESL teaching, helping to guide refugee service providers and classroom teachers in their work with refugees from war-torn countries.</p>
<p>Center for Victims of Torture Evelyn Lennon (Mental Health Issues)</p>	<p><i>Proposed Community-Based Intervention for Newly-Arrived Torture and War Traumatized Refugee Community in Minnesota</i></p>	<p>This handout discusses an intervention program for primary and secondary survivors of war trauma and torture in an identified refugee community by discerning and initiating use of appropriate resources from within the refugee community and from the greater Minnesota community.</p>
<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>Women and Mental Health: Issues for Health Reform</i></p>	<p>Depression, a source of considerable morbidity and disability in women, often goes unrecognized and untreated even though it is highly treatable. This paper identifies, explores, and addresses this important issue in women's health. The paper includes discussion of available data on the incidence and prevalence of mental disorder in women, the use women make of mental health services, and the treatment they receive.</p>
<p>Flay B. R. , et al. Chest</p>	<p>"Smoking: Epidemiology, Cessation, and Prevention"</p>	<p>Sept 1992. Vol. 102, pp. 277 (Supplement).</p>

Grant B.F., Harford T. C., Chou P., et al. <i>Alcohol Health Res World</i>	"Prevalence of DSM-III-R Alcohol Abuse and Dependence: United States, 1988"	1991. No. 15, pp. 91-96. Epidemiologic Bulletin no. 27:
Hales, Robert and Stuart Yudofsky, eds.	<i>The American Psychiatric Press Synopsis of Psychiatry</i>	Washington, DC: American Psychiatric Press, 1996
Helzer J. E., Burnam A, McEvoy L. T.	Alcohol Abuse and Dependence	
Institute of Medicine, Division of Mental Health and Behavioral Medicine	<i>Broadening the Base of Treatment for Alcohol Problems: Report of a Study by a Committee of the Institute of Medicine</i>	Washington, DC: National Academy Press, 1990.
Kessler RC, McGonagle KA, Zhao S, et al. <i>Arch Gen Psychiatry.</i>	"Lifetime and 12- Month Prevalence of DSM-III-R Psychiatric Disorders in the United States: Results from the National Comorbidity Survey"	1994. Vol. 51, pp. 8-19
Lebowitz, Leslie, Mary Harvey and Judith Lewis Herman <i>Journal of Interpersonal Violence</i>	<i>A Stage-by- Dimension Model of Recovery From Sexual Trauma</i>	Vol. 8, No. 3. September 1993. This article offers a conceptual model of recovery from sexual trauma in the context of treatment. The model constitutes some useful ways of thinking about trauma, treatment and recovery.
Lee, Serge, Ph Department of Social Work Education	<i>Hmong Shamanism and Psychotherapy: A Perspective for Mental Health and Social Work Practitioners</i>	Presented at 1998 NIMH. This paper describes one of the traditional health practices—shamanism, as one of the oldest practices that continues to be practiced by Hmong individuals and families in the U.S. and throughout the world. The paper includes recommendations for health, mental health, and social work practitioners in working with Hmong refugees.

<p>Lincoln Medical Education Foundation Behavioral Health Center (Mental Health Issues) (402) 483-4593</p>	<p><i>Stress Physiology and the Response to Refugee Adaptation and Trauma</i></p>	<p>This handout discusses the 'Stress Diathesis Model' and its impact on the mental health of refugees, adaptation/acclulturation and the recovery from trauma. This paper identifies what direct line staff can look for, how symptoms may present themselves, co-occurring disorders, the impact of culture, emotion and somatization, coping and resiliency and when to refer.</p>
<p>National Cancer Institute 1-800-4-CANCER</p>	<p><i>How to Help Your Patients Stop Smoking</i></p>	<p>1990. FREE.</p>
<p>National Institute on Drug Abuse</p>	<p><i>Epidemiologic Trends in Drug Abuse</i></p>	<p>Vol. I-II. Rockville, MD: National Institute on Drug Abuse, National Institutes of Health, 1994. (NIH Publication Nos. 94-3745, 3746.)</p>
<p>National Institute on Drug Abuse</p>	<p><i>The National High School Senior Drug Abuse Survey. NIDA Capsules</i></p>	<p>Rockville, MD: National Institute on Drug Abuse, 1994.</p>
<p>Roth, Susan and Leslie Lebowitz <i>Journal of Traumatic Stress</i></p>	<p><i>The Experience of Sexual Trauma</i></p>	<p>Vol. 1, No. 1. June 29, 1988. This article describes women's experience of sexual trauma and its aftermath as it relates to difficulties in coping with the trauma. A sample of survivors were interviewed in an unstructured format and encouraged to present their story of what had happened and what it had meant to them.</p>
<p>Substance Abuse and Mental Health Administration</p>	<p><i>National Household Survey on Drug Abuse: Population Estimates, 1993</i></p>	<p>Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 1994. Publication No. (SMA) 94-3017.</p>
<p>Substance Abuse and Mental Health Services Administration</p>	<p><i>Preliminary Estimates from the 1992 National Household Survey on Drug Abuse</i></p>	<p>Advance Report no. 3. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1993.</p>
<p>U.S. Dept of Health and Human Services</p>	<p><i>Reducing the Health Consequences of Smoking. A Report of the Surgeon General</i></p>	<p>1989.</p>

D. Cultural Issues

<p>Center for Applied Linguistics Refugee Service Center Health Education Materials 1118 22nd Street, NW Washington, DC 20037 (202) 429-9292</p>	<p><i>A Guide to Resettlement in the United States</i></p>	<p>FREE. Translated into Somali, Arabic, and Amharic. This booklet provides refugees being resettled in the United States with general information about what they will encounter and the services they will need during their first months in the country. It aims to help these US bound refugees develop realistic expectations about employment, education, health, and other aspects of life in the U.S.</p>
<p>Center for Cross-Cultural Health, Patricia Ohmans 410 Church St., SE Minneapolis, MN 55455 (612) 624-4668</p>	<p><i>Six Steps Towards Cultural Competence: How to Meet the Needs of Immigrants and Refugees</i></p>	<p>FREE. This is a Minnesota-based clearinghouse of information, training, and research on the relationship between culture and health from the perspective of health care providers. The six steps include: involving immigrants in their own health care, learning more about culture (starting with our own), speaking the language or using a trained interpreter, asking the right questions and looking for answers, paying attention to financial issues, and finding resources and forming partnerships.</p>
<p>Cross-Cultural Health Care Program Pacific Medical Care Center Beacon Hill 1200 12th Ave South, 5th Floor Seattle, WA 98144 (206) 326-4161</p>	<p><i>Individual Community Profiles</i></p>	<p>\$1.00 each (6 pages). Individual descriptions of the culture and beliefs of a variety of communities (Arab, Somali and Ethiopian) written by community members.</p>
<p>EthnoMed Harborview Medical Center University of Washington Community House Calls Program Dept. of Pediatrics 325 9th Ave. Seattle, WA 98104-9959 (206) 521-1916 http://www.hslib.washington.edu/clinical/ethnomed</p>	<p><i>Clinical Pearls in Cross-Cultural Medicine</i></p>	<p>A description of ethnic groups included in EthnoMed: Ethiopian, Eritrean, Somali (East Africa).</p>

<p>Kavanagh, Kathryn Hopkins and Patricia Kennedy</p>	<p><i>Promoting Cultural Diversity: Strategies For Health Care Professionals</i></p>	<p>London: Sage Publications 1992. While we abhor bias, bigotry and prejudice such perspectives can and do influence our work. As today's health care professionals practice in settings composed of ethnically, socially and economically disparate populations, they often encounter such attitudes in themselves and others. The book is an essential resource that offers techniques for understanding and appreciating differences in others. Kavanagh and Kennedy analyze the issues surrounding cultural, gender, ideological and experiential diversity focusing on effective communication skills and intervention strategies. They also offer a repertoire of experiential strategies and aids for learning about diversity, and present a variety of scenarios, collages, and extensive case studies to illustrate and encourage the analysis of real life situations.</p>
<p>Maloof., Dr. Patricia The Catholic University of America <i>Anthropology Studies</i></p>	<p><i>Medical Beliefs and Practices of Palestinian-Americans</i></p>	<p>No. 45. This is a dissertation submitted to Catholic University of America. The purpose of the study is to explore the pattern of medical beliefs and practices of Arab Palestinian-Americans. Consideration is given to the retention of traditional preventive and curative beliefs and practices and their integration with professional health services in the Washington, D.C. metropolitan area.</p>
<p>Nichols, Jane</p>	<p><i>Iraqi Refugee Cultural and Psychological Adoption Issues: Transition Strategies</i></p>	<p>FREE. This paper is a preliminary investigation exploring some of the cultural and psychological adjustment issues of the Gulf War refugee population. Life transitions particularly when induced by war or traumatic life events often create significant emotional challenges. It is suggested by various agencies that the Iraqi refugee population is particularly challenged in adapting to life in the U.S.</p>

<p>Resources for Cross-Cultural Health Care Julia Puebla Fortier 8915 Sudbury Road Silver Spring, MD 20901-3832, (301) 588-6051</p>	<p><i>Cross Currents Newsletter</i></p>	<p>FREE. RCCHC is a national network of individuals and organizations working to improve access to health care services for linguistically and culturally diverse populations.</p>
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E. Navigating the U.S. Health Care System

<p>Chicago Institute on Urban Poverty Heartland Alliance for Human Needs and Human Rights 208 South LaSalle Street Suite 818 Chicago, IL 60604 (312) 629-4500 x4178</p>	<p><i>Impact of Medicaid Managed Care on Immigrants and Refugees: A Best Practices Review With Policy Recommendations</i></p>	<p>FREE. The Chicago Institute on Urban Poverty undertook a qualitative study and policy analysis to look at Medicaid managed care and its impact of refugee and immigrant communities. Answers were sought from a study of Medicaid managed care transitions in four states, with the intention of drawing out 'best practices:' those state policies, managed care program features and advocacy strategies which have worked well in addressing the needs of this population. The needs of newcomers represent broader issues relevant to the development of language and cultural competence within health care and in managed care organizations in particular.</p>
<p>Jewish Federation of Chicago Wina Glenn Ben Gurion Way 1S. Franklin St. Chicago, IL 60606 (312) 357-4765</p>	<p><i>Health the American Way</i></p>	<p>FREE. Working in collaboration with the Mount Sinai Hospital Medical Center of Chicago and NYANA, JFC has created a publication for Jews from the Soviet Union, applicable to the general health care needs of refugees. Specific topics include Diabetes Mellitus, breast cancer, and birth control. Handbook is in both English and Russian.</p>

<p>Newcomers to America Lisa Baldasar Pacific Standard Television Products and Custom Production P.O. Box 339 Portland, OR 97207-0339 (503) 224-9821</p>	<p><i>Using Health Care Services</i></p>	<p>Video. \$52.00 plus \$5.00 shipping (17 min). Many refugees are understandably wary, fearful, and confused about some Western medical practices and are reluctant to seek needed treatment. This program aims to reduce this anxiety by exploring some of the features and common practices of American medicine from the availability of free or low-cost health care, how to find a doctor, how to make an appointment, what to expect during a physical exam, how to use prescription medications safely, the safety of American surgery and mental health treatment, the difference between clinics, hospitals, private doctor's offices, and emergency clinics.</p>
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F. Linguistic Issues & Barriers

<p>Center for Applied Linguistics Refugee Service Center Health Educational Materials 1118 22nd Street, NW Washington, DC 20037 (202) 429-9292</p>	<p><i>Multilingual Health Education Resource Guide</i></p>	<p>1995. FREE. The Multilingual Health Education Resource Guide (MHER) provides listings of health education available in Arabic and Somali. The materials address the areas of TB, Hepatitis B, parasites, dental care, immunization, breast health, and prenatal care. Each item listed is described with respect to content, length, language, and the source/year of its development. The information and listing serve as a point of reference for health care providers and agencies that work with limited-English speaking patients, primarily refugees. (We have short educational information in Arabic, Somali and Tigray, requested from the above guide, on various medical concerns).</p>
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<p>Center for Human and Molecular Genetics Genetic Service Outreach Programs 90 Bergen Street Suite 5400 Newark, NJ 07103-2499 (201) 982-3300</p>	<p><i>Catalog of Multilingual Patient Education Materials on Genetic and Related Maternal/Child Health Topics</i></p>	<p>FREE. This catalog is intended for use by health professionals working in a variety of settings, particularly in the areas of genetics, family planning, prenatal and pediatric services, and the service providers of non-English speaking people. Although the materials listed are primarily for patients (clients), the catalog will hopefully assist in "educating the educators" who are the professionals responsible for health education and service delivery. Selective materials can be found in Arabic.</p>
<p>Cross-Cultural Health Care Program Pacific Medical Care Center Beacon Hill 1200 12th Avenue South 5th Floor Seattle, WA 98144, (206) 326-4161</p>	<p><i>An Interpreter's Guide to Common Medications</i></p>	<p>\$10.00. Answers the most basic questions about how medications work, how they are administered and what they do. This is meant to be basic and easily understandable.</p>
<p>Cross-Cultural Health Care Program Pacific Medical Care Center Beacon Hill 1200 12th Avenue South 5th Floor Seattle, WA 98144 (206) 326-4161</p>	<p><i>Bridging the Gap</i></p>	<p>\$50.00. A basic training handbook for medical interpreters.</p>
<p>Ethnomed Harborview Medical Center University of Washington Community House Calls Program Dept. of Pediatrics 325 9th Avenue Seattle, WA 98104-9959 (206) 521-1916 http://www.hslib.washington.edu/clinical/ethnomed/intprpt.html</p>	<p><i>Guidelines for Interpreted Visits</i></p>	<p>Six guidelines for medical professionals: introduce yourself to the family and to the interpreter, write down the interpreter's name and the interview language on the progress note, do a pre-visit conference with the interpreter, direct questions to the patient not to the interpreter unless they are meant for the interpreter, do a post-visit conference with the interpreter outside the room if you have concerns about the interview, and gender and age of the interpreter may be very important.</p>

New York Times	"Language Barriers are Hindering Health Care"	November 23, 1997, An article outlining barriers to providing linguistically appropriate health care in New York City hospitals. This article describes some of the needs associated with medical interpreters and providing health care services to patients speaking a language other than the service provider's.
Women Boston Area Health Education Center Boston City Hospital Roberta Washington 818 Harrison Ave. Boston, MA 02118 (617) 534-5258	<i>The Bilingual Medical Interview</i>	Video \$50.00. Training video for health professionals created by doctors at the Boston City Hospital addressing the problem of communication in the health care setting for the non-English speaking patient and physician.

G. Sexual & Reproductive Health & Family Planning Issues

Alan Guttmacher Institute	<i>Sex and America's Teenagers</i>	New York: Alan Guttmacher Institute, 1994.
American Academy of Family Physicians 8880 Ward Pkwy. Kansas City, MO 64114-2797 (800) 944-0000 http://www.aafp.org	<i>Birth Control: Choosing the Method That's Right for You</i>	.
American Cancer Society Donald George Fox 2265 Como Ave. Suite 10 St. Paul, MN 55108-1700 (612) 925-6330 x1094	<i>How to Examine Your Breasts</i>	FREE. The Minnesota-based chapter of the ACA and Dr. Zahra Niccu Tifarodi (assisted by Dr. Edis Sahar from the University of MN) are currently at work on a program for Persian-speaking women to aid in their awareness of breast cancer. Project is in its beginning stages. Pamphlet is easy to understand and translated into Arabic.
American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com	<i>Barrier Methods of Contraception</i>	

<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Contraception</i></p>	<p>In English and Spanish.</p>
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Family Planning by Periodic Abstinence</i></p>	
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Oral Contraceptives</i></p>	
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Postpartum Sterilization</i></p>	
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Sterilization by Laparoscopy</i></p>	
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Sterilization for Women and Men</i></p>	
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>The Intrauterine Device</i></p>	

<p>American College of Obstetricians and Gynecologists 409 12th St, SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>HIV Infection and Women</i></p>	<p>ACOG Patient Education Pamphlet AP082.</p>
<p>American College of Obstetricians and Gynecologists 409 12th St, SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>How to Prevent Sexually Transmitted Diseases, Genital Herpes, Gonorrhea and Chlamydia, Pelvic Inflammatory Disease.</i></p>	
<p>American College of Physicians <i>Ann Intern Med.</i></p>	<p>"Acquired Immunodeficiency Syndrome"</p>	<p>1986. Vol. 104, pp. 575-581.</p>
<p>American Medical Association <i>JAMA</i></p>	<p>"Prevention and Control of Acquired Immunodeficiency Syndrome: An Interim Report"</p>	<p>1987. Vol. 258, pp. 2097-2103.</p>
<p>American Red Cross</p>	<p><i>HIV Infections and AIDS</i></p>	<p>Series #329, 560.</p>
<p>American Red Cross</p>	<p><i>Testing for HIV Infection</i></p>	<p>Series #329, 547.</p>
<p>American Red Cross</p>	<p><i>Women, Sex, and HIV</i></p>	<p>Series #329, 537.</p>
<p>Brown, S. S., Eisenberg, L., eds. Committee on Unintended Pregnancy Institute of Medicine</p>	<p><i>The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families</i></p>	<p>Washington DC: National Academy Press, 1995.</p>
<p>Canadian Task Force on the Periodic Health Examination <i>The Canadian Guide to Clinical Preventive Health Care</i></p>	<p>"Prevention of Gonorrhea"</p>	<p>Ottawa, Canada: Minister of Supply and Services; 1994, chap 59.</p>
<p>CDC National AIDS Information Hot Line</p>	<p><i>Condoms and Sexually Transmitted Diseases... Especially AIDS</i></p>	<p>(800) 342-AIDS (English speaking) (800) 344-SIDA (Spanish speaking) (800) AIDS-TTY (hearing impaired) All phone calls are confidential.</p>

<p>CDC National AIDS Information Hot Line</p>	<p><i>Surgeon General's Report to the American Public on HIV Infection and AIDS</i></p>	<p>(800) 342-AIDS (English speaking) (800) 344-SIDA (Spanish speaking) (800) AIDS-TTY (hearing impaired) All phone calls are confidential.</p>
<p>Center for Multi-cultural Human Services Washington AIDS Partnership & Northern Virginia Planning District Commission 701 W. Broad Street Suite 305 Falls Church, VA 22046</p>	<p><i>HIV/AIDS Cross-Reference Directory</i></p>	<p>March 1997. FREE. CMHS is a non-profit organization that has been serving new Americans in Fairfax County, VA. by providing mental health and social services to the international community. It is staffed by social workers, psychologists, family therapists, substance abuse counselors, education specialists and art therapists, providing services in both Arab and Amharic. The Directory has been designed to assist the reader in obtaining information on specific HIV/AIDS educational topics. The material has been received from the U.S. Health and Human Services Centers for Disease Control and Prevention, National AIDS Clearinghouse, Food and Nutrition Information Center, National and International Health Departments from around the world, various National Health Clearinghouses, Pan American Health Organization, various embassies, and other community health centers.</p>
<p>Centers for Disease Control and Prevention MMWR</p>	<p>"Youth Risk Behavior Surveillance, United States, 1993"</p>	<p>1995. Vol. 44, SS-1, pp. 1-56.</p>

<p>Centers for Disease Control National AIDS Clearinghouse U.S. Department of Health and Human Services P.O. Box 6003 Rockville, MD 20849-6003</p>	<p><i>Catalog of HIV and AIDS Education and Prevention Materials</i></p>	<p>FREE. Prevention of HIV infection is a challenge shared by all Americans. It involves improving Americans' knowledge of the behaviors that increase the risk of infection and motivating people to avoid or change unsafe behaviors. Effective prevention also includes use of epidemiological, surveillance and social and behavioral science research to learn about the disease, how people respond to it, and how to combat it. The CDC has created a multi-phrase public educational campaign and an organized information delivery system consisting of the CDC national AIDS Hotline and the CDC National AIDS Clearinghouse. Staff from these two programs respond to questions from the public and professionals on all aspects of HIV infection, from prevention and research to health care and support services. The HOTLINE is toll free (800) 342-AIDS.</p>
<p>Columbia School of Public Health Center for Population and Family Health Therese McGinn 60 Haven Ave. New York, NY 10032 (212) 304-5224</p>	<p><i>Setting Priorities in International Reproductive Health Programs: A Practical Framework</i></p>	<p>FREE. This booklet helps policy makers and planners choose among many options available as they expand their reproductive health programs for women. Issues include unwanted pregnancy, maternal mortality, reproductive diseases and cancers, HIV/AIDS, FC/FGM, sexual and gender-based violence, and infertility. The CPFH involve teaching, applied research, and service delivery to improve reproductive health both in the United States and the developing world.</p>
<p>Commonwealth Fund</p>	<p><i>Briefing Paper: Routine Mammography Screening for Women Ages 40-49 and Considerations Regarding Breast Cancer Screening in Women Under 50</i></p>	<p>March 1994. These materials provide some points that need emphasis in the wake of the NCI decision including 1/ the continuing importance of clinical breast examination and self-examination for women 40-48; 2/ the continuing importance of screening mammograms for women over 50; 3/ the need for research focused on the biology of breast cancer in younger women; and 4/ the need for further research on the efficacy of mammography for African-American women under 50.</p>

<p>Ethiopian Community Development Council (ECDC) Seyoum Berhre 1038 S. Highland Arlington, VA 22204 (703) 685-0510</p>	<p><i>ECDC AIDS Awareness and Prevention Education Program</i></p>	<p>FREE. A quick fact sheet on HIV/AIDS. Translated into Tigray.</p>
<p>Family Health International</p>	<p><i>Women's Lives and Family Planning : An International Perspective</i></p>	<p>Folder of information put together by the AIDSCAP Division of Family Health International. The information includes statements about this organization, as well as fact sheets on family planning issues affecting women all over the world. (Bolivia, Philippines, Egypt, Indonesia, Zimbabwe, Brazil, Korea, Mali, Jamaica, Bangladesh)</p>
<p>FDA Office of Consumer Affairs HFE 88 Room 1675 5600 Fishers Ln. Rockville, MD 20857 (800) 532-4440</p>	<p><i>Choosing a Contraceptive</i></p>	
<p>FDA Office of Consumer Affairs HFE 88 Room 1675 5600 Fishers Ln. Rockville, MD 20857 (800) 532-4440</p>	<p><i>Drugs and Pregnancy: Often the Two Don't Mix</i></p>	
<p>Forrest JD, and S. Singh <i>Fam. Plann. Perspect</i></p>	<p>"The Sexual and Reproductive Behavior of American Women, 1982-1988"</p>	<p>1990, Vol. 22, pp. 206-214.</p>
<p>Forrest, J. D. <i>Am J Obstet Gynecol</i></p>	<p>"Epidemiology of Unintended Pregnancy and Contraceptive Use"</p>	<p>1994; 170 (Suppl. 2) 1485</p>
<p>Institute for Reproductive Health Georgetown University Medical Center</p>	<p><i>Expanding Options, Improving Access: Natural Family Planning and Reproductive Health Awareness</i></p>	<p>This pamphlet details the Institute's assistance to organizations around the world, primarily in developing countries, in translating research into usable tools for communities, programs and policy makers.</p>

<p>Institute for Reproductive Health, Georgetown University Medical Center</p>	<p><i>Natural Family Planning: Expanding Options</i></p>	<p>This pamphlet details the Natural Family Planning (NFP) program and its role in improving reproductive health. The expansion of family planning programs to include other reproductive health services has highlighted the contribution NFP can make to the health of women and their families.</p>
<p>Jacobs Institute of Women's Health <i>Women's Health Issues</i></p>	<p>"Delivering Breast and Cervical Cancer Screening Services to Underserved Women: Part I. Literature Review and Telephone Survey"</p>	<p>Vol. 6, No. 4. July/August 1996. This study identifies several strategies utilized in breast and cervical cancer screening programs to increase use. This study found that not all strategies work for all women and discuss possible strategies best suited to particular target populations.</p>
<p>Jacobs Institute of Women's Health <i>Women's Health Issues</i></p>	<p>"Delivering Breast and Cervical Cancer Screening Services to Under-served Women: Part II. Implications for Policy"</p>	<p>Vol. 6, No. 4. July/August 1996. This study reports on intensive on-site interviewing of programs identified during Part I. These case studies provide insights and a platform from which comments on policies can be made when talking about programs that provide BCCS services to under-served women.</p>
<p>National AIDS Information Hotline Centers for Disease Control and Prevention (800) 342-AIDS</p>		
<p>National Association of People Living with AIDS 1413 K St, NW Washington, DC 20005 (202) 898-0435</p>	<p><i>HIV in America: A Profile of the Challenges Facing Americans Living With HIV</i></p>	
<p>National STD Hot Line</p>		<p>(800) 227-8922 English. (809) 765-1010 Spanish (call collect).</p>
<p>Network for the Dissemination of Information 110 Green St. New York, NY 10012 (800) 424-2634.</p>	<p><i>Information on Hemophilia and HIV: Hemophilia and AIDS</i></p>	

NOVA Research Co 4600 East-West Hwy Suite 700 Bethesda, MD 20814 (301) 986-1891	<i>Women, AIDS, and Drug Use Annotated Client Education Directory</i>	
Office of Population Research Princeton University	http://opr.princeton.edu/ec/hotline.html	Emergency Contraception Website
Office of Population Research Princeton University.	Emergency Contraception Hotline	(800) 584-9911
Planned Parenthood 810 7th Ave. New York, NY 10019 (212) 541-7800 http://www.igc.org/ppfa	<i>Facts About Birth Control</i>	
<i>Reproductive Health Matters</i>	"Fundamentalism, Women's Empowerment and Reproductive Rights"	No. 8. November 1996. This issue of the journal focuses on the influence and dangers of many faces of fundamentalism for women and women's rights. This journal places emphasis on the increasing influence of politically motivated fundamentalism internationally.
Ventura S. J., Martin J. A., Taffel S. M., et al. <i>Monthly Vital Statistics Report</i> U.S. Department Of Health And Human Services	"Advance Report of Final Natality Statistics, 1992"	Hyattsville, MD: National Center for Health Statistics, 1994. Vol. 43, No. 5 (suppl). Chapter 61: Unintended Pregnancy.
Ventura S. J.; Taffel SM, Mosher W. D., et al. <i>Monthly Vital Statistics Report</i>	"Trends in Pregnancies and Pregnancy Rates: Estimates for the United, States 1980- 92"	Hyattsville, MD: National Center for Health Statistics, 1995. Vol. 43, No. 11 (suppl).
Wilcox, L. S., Marks, J. S., eds. <i>Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children</i>	"Unintended Pregnancy and Childbearing"	By L. J. Piccinino. Washington, DC: U.S. Department of Health and Human Services, 1994. 73-82.

<p>Women's Studies Project Family Health International</p>	<p><i>Women's Voices, Women's Lives: The Impact of Family Planning</i></p>	<p>This booklet contains a synthesis of findings from the Women's Studies Project. Some articles include research findings from Asia, Latin America, and the Middle East and Africa.</p>
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H. Pre-, Peri-, and Post-Natal Care and Pediatric Care

<p>American Academy of Pediatrics/American College of Obstetrics and Gynecology</p>	<p><i>Guidelines for Perinatal Care</i></p>	<p>3rd edition. Elks Grove, Illinois: American College of Pediatrics,. 1992.</p>
<p>American College of Obstetricians and Gynecologists and American Academy of Pediatrics</p>	<p><i>Guidelines for Perinatal Care</i></p>	<p>4th edition. Washington, DC and Elk Grove Village, Ill: American College of Obstetricians and Gynecologists and American Academy of Pediatrics; 1997.</p>
<p>Commonwealth Fund</p>	<p><i>Healthy Steps for Young Children: Helping Children Take Healthy Steps: Abstracts of Selected Articles on Early Childhood Interventions</i></p>	<p>February 1997, This volume of articles contains detailed abstracts of articles that describe and evaluate intervention programs for families with young children. The interventions described represent a wide range of programs designed to promote positive child development.</p>
<p>Commonwealth Fund</p>	<p><i>Innovative Approaches For the Delivery and Financing of Parent Education Programs in Health Care Settings</i></p>	<p>September 1995. This report reviews the 1/ range and scope of parent education services offered in health care settings, 2/ example of innovative parent education initiatives, and 3/ private health insurance and Medicaid options for financing parent education services.</p>
<p>EthnoMed Harborview Medical Center University of Washington Community House Calls Program Dept. of Pediatrics (206) 521-1916 http://www.hslib.washington.edu/clinical/ethnomed</p>	<p><i>Asthma and Preventing Rickets in Breastfed Babies</i></p>	<p>Translated into Amharic and Tigrinya.</p>

<p>International Institute of New Jersey 880 Bergen Ave. Jersey City, NJ 07306 (201) 653-3888</p>		<p>Provide translated materials in Arabic for newly arrived immigrants and refugees on the following topics: perinatal care and warning signs of pre-term labor, preventing birth defects, and how to care for yourself and your baby.</p>
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I. Issues Concerning Children

<p>Cohen, Lucy M. The Commonwealth Fund <i>Illegal Immigration in America: A Reference Handbook</i></p>	<p>"Young Immigrants Views on Caretaking and Family Reunification"</p>	<p>By Lucy M. Cohen/Catholic University. Edited by David Haines and Karen Rosenblum. Greenwood Publishing. This article draws on the author's experience among immigrants and refugees from Latin America in Washington, D.C. The author presents two brief cases on the circumstances of separation and reunification of parents from El Salvador followed by comments regarding the concepts of caretaking and childgiving, from the perspectives of young people.</p>
<p>Commonwealth Fund</p>	<p><i>The Health of Adolescent Boys: Commonwealth Fund Survey Findings</i></p>	<p>June 1998. This booklet contains the results from a survey of boys and girls in grades five through twelve in nearly 300 schools across the country. This report focuses on boys' reports on their experiences, health, and behavior that emphasize abuse, access to care, and emotional support to be key concerns.</p>
<p>Schuyler, Kinza</p>	<p><i>Summary of Response to Caucus Challenge 3: "Refugee Children, their adaptation and their problems, will be handled by some other program"</i></p>	<p>November 11, 1998. Presentation at National ORR Conference. This article addresses the need to pay more attention to refugee children and the process through which refugee children get lost in the system. The author offers viable solutions and methods to work towards comprehensive care and assistance for refugee children.</p>

<p>United Nations Children's Fund</p>	<p><i>The Progress of Nations 1998</i></p>	<p>August 1998. This report is an assessment of every nations' development in achieving the goals set at the 1990 World Summit for Children. This report ranks countries according to the well-being of their children, providing scorecards on how effectively nations are improving the status of their children.</p>
<p>United Nations High Commissioner for Refugees</p>	<p><i>Refugee Children: Guidelines on Protection and Care</i></p>	<p>1994. This book details the policy adopted by UNHCR in October 1993 that explores the special care and assistance that refugee children need. Each chapter takes a subject, such as legal status or psychological well-being and discusses it from the point of view of children's needs and rights. The book contains a quick index that helps field workers find quick guidance on specific problems without having to read entire chapters.</p>
<p>United Nations High Commissioner for Refugees</p>	<p><i>This Guidelines on Policies in dealing with Unaccompanied Children Seeking Asylum</i></p>	<p>February 1997. This booklet details the guiding principles of child care and protection in that effective protection and assistance should be delivered to unaccompanied children in a systematic, comprehensive and integrated manner.</p>

J. Diabetes

<p>American Diabetes Assoc. 1660 Duke St. Alexandria, VA 22314 (800) 232-3472</p>	<p><i>Diagnosis Diabetes</i></p>	
<p>Canadian Task Force on the Periodic Health Examination <i>The Canadian Guide to Clinical Preventive Health Care</i></p>	<p>"Screening for Diabetes Mellitus in the Non-Pregnant Adult"</p>	<p>Ottawa, Canada: Minister of Supply and Services, 1994. Chap. 50.</p>
<p>Engelgau M. M., Aubert R. E., Thompson T. H., Herman W. H. <i>Diabetes Care.</i></p>	<p>"Screening for NIDDM in Nonpregnant Adults"</p>	<p>1995. Vol. 18, pp. 1606-1618.</p>

Eriksson K. F., Lindgarde F. <i>Diabetologia</i>	"Prevention of Type 2 (Noninsulin-Dependent) Diabetes Mellitus by Diet and Physical Exercise"	1991. Vol. 34, pp. 891-898.
Expert Committee on the Diagnosis and Classification of Diabetes Mellitus <i>Diabetes Care</i>	"Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus"	1997. Vol. 20, No. 7, pp. 1183-1197.
Gerken KM, Van Lente E. <i>Arch Pathol. Lab. Med.</i>	"Effectiveness of Screening for Diabetes"	1990. Vol. 114, pp. 201-203.
Harris, M. I., Eastman, R. C. <i>JAMA</i>	"Early Detection of Undiagnosed Non-Insulin-Dependent Diabetes Mellitus"	1996. Vol. 276, pp. 1261-2.
Howard B. V., Abbott W. G. H., Swinburn B.A. <i>Diabetes Care</i>	"Evaluation of Metabolic Effects of Substitution of Complex Carbohydrates for Saturated Fat in Individuals with Obesity and NIDDM"	1991. Vol. 14, pp. 786-795.
Manson J. E., Nathan D. M., Krolewski A. S., Stampfer M. J., Willett W. C., Hennekens C. H. <i>JAMA.</i>	A Prospective Study of Exercise and Incidence of Diabetes Among U.S. Male Physicians	1992. Vol. 268, pp. 63-67.
Manson JE, Rimm E. B., Stampfer MJ, et al. <i>Lancet.</i>	"Physical Activity and Incidence of Non-Insulin-Dependent Diabetes Mellitus in Women"	1991. Vol. 338, pp. 774-778.
Marshall J. A., Hamman R. F., Baxter J. <i>Am J Epidemiol.</i>	"High-fat, Low-Carbohydrate Diet and the Etiology of Noninsulin-Dependent Diabetes Mellitus: The San Luis Valley Diabetes Study"	1991. Vol. 134, pp. 590-603.

National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes Control and Complications Trial</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes in African Americans</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes in Hispanics</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes Overview</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes Research and Training Centers</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetes Statistics</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Diabetic Neuropathy: The Nerve Damage of Diabetes</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Directory of Diabetes Resources</i>	Available in Spanish.
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>End-Stage Renal Disease: Choosing a Treatment That's Right for You</i>	

National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Hypoglycemia</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Insulin-Dependent Diabetes</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Kidney Disease of Diabetes</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>Noninsulin-Dependent Diabetes</i>	
National Diabetes Information Clearinghouse 1 Information Way Bethesda, MD 20892-3560 (301) 654-3327	<i>The Diabetes Dictionary</i>	Available in Spanish.
Singer D. E., Samet J. H., Coley C. M., Nathan D. M. <i>Ann Intern Med.</i> US Preventive Services Task Force	"Screening for Diabetes Mellitus"	1988. Vol. 109, pp. 639-649.
U.S. Department of Health and Human Services <i>Guide to Clinical Preventive Services</i>	"Screening for Diabetes Mellitus"	2nd edition. Washington, DC: US Department of Health and Human Services; 1996: chap 19.
World Health Organization <i>Third Report on Diabetes Mellitus</i>	"World Health Organization Expert Committee on Diabetes Mellitus"	Geneva, Switzerland: World Health Organization; 1985. WHO Technical Report Series 727.

K. Immunizations & Medications

<p>Erie County Dept. of Health 606 West 2nd Street Erie, PA 16507</p>	<p><i>Childhood Immunization</i></p>	<p>FREE. General information on childhood diseases, vaccine reactions, and local laws regarding school immunizations.</p>
<p>Seattle-King County Department of Public Health Kristen Korolak 110 Prefontaine Place So., #500 Seattle, WA 98104 (206) 296-4377</p>	<p><i>Immunization Fact Sheet</i></p>	<p>\$0.15 each. Easy-to-understand pictorials and text available in Amharic, Tigray, and Somali on child immunizations.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm. 840 Albany, NY 12237-0669</p>	<p><i>Fact Sheet for Ethambutol</i></p>	<p>Translated into Tigrinya.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>Fact Sheet for INH</i></p>	<p>Translated into Tigrinya.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>Fact Sheet for Pyrazinamide</i></p>	<p>Translated into Tigrinya.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>Fact Sheet for Rifampin</i></p>	<p>Translated into Tigrinya.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>Instructions for Collecting Sputum</i></p>	<p>Translated into Tigrinya and Amharic.</p>

<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>Pediatric Vaccine Administration Record</i></p>	<p>Translated into Somali and Amharic.</p>
<p>State of New York Dept. of Health Leo Bolaski Health Program for Refugees Tower Building, Rm 840 Albany, NY 12237-0669</p>	<p><i>What Does a Positive Skin Test Mean?</i></p>	<p>Translated into Ethiopian/Eritrean.</p>
<p>State of New York Dept. of Health Leo Bolaski, Health Program for Refugees Tower Building Rm 840 Albany, NY 12237-0669</p>	<p><i>You've Had Your Tuberculin Test</i></p>	<p>Translated into Tigrinya and Amharic.</p>
<p>Texas Preventable Disease News Texas Department of Health Bureau of Disease Control and Epidemiology 1100 W. 49th Street Austin, TX 78756 (512) 458-7455</p>	<p><i>Texas Preventable Disease News: Refugee Health Problems in Texas</i></p>	<p>FREE Newsletter talks briefly on TB, Hepatitis B, Parasites, and other medical problems refugees face upon resettlement.</p>

L. Nutrition, Physical Exercise, & Hygiene

<p>American College of Sports Medicine</p>	<p><i>Guidelines for Exercise Testing and Prescription</i></p>	<p>Philadelphia: Lea & Febiger, 1991.</p>
<p>Blair S. N., Kohl H. W., Gordon N. F. <i>Annu Rev Public Health</i></p>	<p>"How Much Physical Activity is Good for Health?"</p>	<p>1992. Vol. 13, pp. 99-126.</p>
<p>Blair S. N., Kohl H. W., Paffenbarger R. S. Jr., et al. <i>JAMA</i></p>	<p>"Physical Fitness and All-Cause Mortality: A Prospective Study of Healthy Men and Women."</p>	<p>1989. Vol. 262, pp. 2395-2401.</p>
<p>Bouchard C., Shepard R. J., Stephens T., eds. <i>Human Kinetics</i></p>	<p>"Physical Activity, Fitness, and Health"</p>	<p>Champaign, IL: 1994</p>

Caspersen C. J., Christenson G. M., Pollard RA <i>Public Health Rep.</i>	"Status of 1990 Physical Fitness and Exercise Objectives Evidence from NHIS 1985."	1986. Vol. 101, pp. 587-592.
Centers for Disease Control and Prevention <i>MMWR</i>	"Public Health Focus: Physical Activity and the Prevention of Coronary Heart Disease"	1993. Vol. 42, pp. 669-672
Centers for Disease Control and Prevention. United States <i>MMWR</i>	"Prevalence of Sedentary Lifestyle/Behavioral Risk Factor Surveillance System"	1993. Vol. 42, pp. 576-579.
Department of Agriculture	<i>Food Guide Pyramid</i>	1992
Food and Nutrition Board of the National Research Council	<i>Recommended Dietary Allowances (RDAs)</i>	For specific nutrients. An extensive report on diet and chronic disease risk is also available.
Food safety information.	http://www.agen.ufl.edu/foodsaf/foodsaf.html http://www.usda.gov/agency/ffsis/homepage.html http://www.vm.cfsan.fda.gov/mow/foodborne.html http://www.nal.usda.gov/fnic/foodborne/wais.html	Websites with a variety of information on food safety.
Hahn RA, Teutsch SM, et al. <i>JAMA</i>	"Excess Deaths from Nine Chronic Diseases in the U.S"	1990. Vol. 264, pp. 2654-2659.
Kochanek K. D., Hudson B. L. <i>Monthly Vital Statistics Report;</i>	"Advance report of Final Mortality Statistics"	Hyattsville, MD: National Center for Health Statistics, 1994. Vol. 43, No. 6 (suppl).

Lee I. M. In: Bouchard C, Shepard RJ, Stephens T, eds. <i>Human Kinetics</i>	"Physical Activity, Fitness, and Cancer"	Champaign, IL: 1994.
Lee I. M. In: Bouchard C, Shepard RJ, Stephens T, eds. <i>Human Kinetics</i>	"Physical Activity, Fitness, and Health"	Champaign, IL: 1994.
Pennsylvania State University, College of Agricultural Sciences Cooperative Extension 201 Willard Building University Park, PA 16802-2801 (814) 863-0471	<i>Managing Resources: Keeping Homes Safe and Families Healthy</i>	FREE. Pictorial guide to the proper procedure for cleaning dishes, cleaning a gas and an electric stove, and cleaning the bathroom.
USDA/FDA Foodborne Illness Education Information Center National Agricultural Library Cindy Roberts 10301 Baltimore Blvd. Rm. #304 Beltsville, MD 20705-2351 (301) 504-6365	<i>Sources of Free or Low-Cost Food and Nutrition Materials</i>	January 1997. FREE. This publication is a list of organizations that provide free or low-cost food and nutrition materials for consumers. The Food and Nutrition Information Center (FNIC) receives many requests for materials to distribute at health fairs, classes physicians' offices, wellness programs, and other locations. The list is alphabetical and divided into three sections: Nutrition, Medical and Health Organizations (1), Food-Related Associations (2), and Food Companies (3). Some publications are available in Arabic.

M. For Health Providers

American Academy of Family Physicians 8880 Ward Pkwy Kansas City, MO 64114-2797 (800) 944-0000 http://www.aafp.org	<i>Clinical and Psychosocial Aspects of Caring for HIV Patients</i>	Audiotape.
American Academy of Family Physicians 8880 Ward Pkwy Kansas City, MO 64114-2797 (800) 944-0000 http://www.aafp.org	<i>HIV Infection and AIDS</i>	Monograph.

<p>American Academy of Family Physicians 8880 Ward Pkwy Kansas City, MO 64114-2797 (800) 944-0000 http://www.aafp.org</p>	<p><i>HIV Infection and Physician Emotions</i></p>	<p>Videotape and discussion guide.</p>
<p>American Academy of Family Physicians 8880 Ward Pkwy Kansas City, MO 64114-2797 (800) 944-0000 http://www.aafp.org</p>	<p><i>HIV Infection in the Family Physician's Office</i></p>	<p>Brochure.</p>
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Emergency Contraception.</i></p>	<p>ACOG Practice Pattern #3</p>
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Hormonal Contraception</i></p>	<p>ACOG Educational Bulletin #198.</p>
<p>American College of Obstetricians and Gynecologists 409 12th St SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>The Intrauterine Device</i></p>	<p>Technical bulletin 164.</p>
<p>American College of Obstetricians and Gynecologists 409 12th St. SW Washington, DC 20024 (800) 762-2264 http://www.acog.com</p>	<p><i>Gynecologic Herpes Simplex Virus Infection</i></p>	<p>Technical bulletin 119.</p>
<p>Food and Drug Administration. Prescription Drug Products</p>	<p><i>Certain Combined Oral contraceptives for Use as Postcoital Emergency Contraception</i></p>	<p>Notice. Federal Register. 1997; Vol. 62, No. 37, pp. 8610-8612.</p>

N. Educational Materials & Resources

<p>Alliance for Aging Research 2021 K Street, NW Suite 305 Washington, DC 20006-1003</p>		
<p>American Dietetic Association, The 216 W. Jackson Blvd. Suite 800 Chicago, IL 60606-6995 1-800-366-1655</p>		
<p>American Heart Association (AHA) National Center 7272 Greenville Avenue Dallas, TX 75231 1-800-AHA-USA1 (214) 373-6300</p>		
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>All Babies Need Shots—One Parent's Story About Immunizations</i></p>	<p>Series of easy-to-understand pamphlets on a variety of medical concerns, social and gender issues. All prices range between \$1.25 (quantity 1-24) and \$0.89 (quantity 25-99) for each.</p>
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Breast Cancer—How You Can Help Protect Yourself</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Career Opportunities for Women</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Cervical Cancer—What Every Women Should Know</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Condoms—What Women Need to Know</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Drugs—Bad for You, Worse for Your Baby</i></p>	

<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Fetal Alcohol Effects</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Girls and Self-Esteem, What You Should Know About Hate Crimes</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Good Health for Women</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>How to Have a Healthy Pregnancy</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Infant Nutrition</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Lead and Pregnancy</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Nutrition and Pregnancy</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Partner Abuse—What Women Should Know</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Self-Care for Moms—After the Baby Comes</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Setting Goals to Reach Your Potential</i></p>	

Journey of Hope

<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Single Parenting</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Smoking and Pregnancy</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Understanding Pap Smears—What They Mean, What to Do</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Who to Call for Health Care</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Women and STDs—The Facts</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>Women in America—Their Experiences and Contributions</i></p>	
<p>Channing Bete Co., Inc. 200 State Road South Deerfield, MA 01373 (800) 628-7733</p>	<p><i>You, Your Baby and HIV</i></p>	
<p>Department of Social and Health Services Division of Children and Family Services B37-4, 1720 Ellis St. P.O. Box 32090 Bellingham, WA 98228-4090 (360) 647-6100</p>	<p><i>The New Making it on Your Own</i></p>	<p>FREE. Created by the Virginia Commonwealth University's School of Social Work, this booklet is an easy-to-understand workbook for to general independent living skills, as well as health issues: medical and dental resources, nutrition, exercise, drugs/alcohol/tobacco, stress, depression, HIV/AIDS, STDs, and teen pregnancy.</p>

<p>Indochinese Cultural and Service Center 3030 Southwest 2nd Ave Portland, OR 97201</p>	<p><i>Teaching Refugee Women</i></p>	<p>FREE. Refugee women are often less visible than other refugee groups, as they are more likely to remain in the home while their husbands and children attend school, find jobs, and generally adjust to the new culture. Child care responsibilities may prevent them from attending ESL classes and they are usually timid about venturing out on their own. The curriculum guide is designed for general independent living, but especially medical concerns: making appointments, getting a physical examination, types of examinations, common illnesses and treatment, personal hygiene, reproductive infections, and nutritional needs.</p>
<p>International Catholic Child Bureau/North America, Inc. Meg Gardinier 866 U.N. Plaza, Suite 529 New York, NY 10017 (212) 355-3992</p>	<p><i>New Beginnings: A Guide to Designing a Parenting Program for Refugee and Immigrant Parents</i></p>	<p>This booklet is designed to aid parents in understanding, disciplining, and educating their children. Service providers and parents sought a compromise: survival and adaption in America, with retention of traditional values and ways of life. The purpose of the guide is to create a curriculum for refugee and immigrant parents, especially those who are having problems in relation with their children.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>After Pregnancy: A New Start</i></p>	<p>\$14.95, video 34 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Birth Control</i></p>	<p>\$79.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Breast Cancer: Replacing Fear With Facts</i></p>	<p>\$14.95, video 37min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Common Child Illnesses</i></p>	<p>\$79.95, video 45 min.</p>

Journey of Hope

<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Contraception: Know Your Options</i></p>	<p>\$14.95 video 39 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Depression and Suicide</i></p>	<p>\$39.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Home Economics Careers</i></p>	<p>\$79.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Immunizations</i></p>	<p>\$59.95, video 20min</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Men, Sex and Rape</i></p>	<p>\$24.95, video 75min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Menstruation: Understanding Your Body</i></p>	<p>\$14.95, video 28 min</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>No Monolith: A Guide to African Diversity in America</i></p>	<p>\$74.95, video 107 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Nutrition for Children and Infants Under Six</i></p>	<p>\$79.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Pregnancy: Nine Special Months</i></p>	<p>\$14.95, video 40 mi.</p>

<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Sexually Transmitted Diseases: The Keys to Prevention</i></p>	<p>\$14.95, video 39 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Single Parenting</i></p>	<p>\$34.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>The Expectant Father</i></p>	<p>\$19.95, video 45 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>The Food Guide Pyramid: Contemporary Nutrition</i></p>	<p>\$79.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Who is an American?</i></p>	<p>\$74.95, video 26min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>Wholesaling</i></p>	<p>\$69.95, video 30 min.</p>
<p>Karol Media 350 N. Penn Ave. Box 7600, Wilkes-Barre, PA 18773-7600 (800) 884-0555</p>	<p><i>You Can be a Better Parent in 30 Minutes</i></p>	<p>\$39.95, video 30 min.</p>
<p>National AIDS Information Clearinghouse PO Box 6003 Rockville, MD 20850 (800) 458-5231</p>		<p>General information (in both English and Spanish) on STDS, HIV, AIDS and AIDS-related diseases (seven brochures) and fact sheet packet (10 brochures).</p>
<p>National AIDS Information Hotline Centers for Disease Control and Prevention (800) 342-AIDS</p>		

<p>National Association for Maternal and Child Health Clearinghouse Department of Health and Human Services 2070 Chain Bridge Road Suite 450 Vienna, VA 22182-2536 (703) 821-8955 x254 and National Center for Education in Maternal and Child Health 2000 15th St. North Suite 701 Arlington, VA 22201-2617 (703) 524-7802</p>	<p><i>Foreign Language Materials: Selected Bibliography</i></p>	<p>April 1996. FREE. The booklets provides information about materials published in languages other than English and Spanish, including Amharic and Arabic.</p>
<p>National Association for Maternal and Child Health Clearinghouse Department of Health and Human Services 2070 Chain Bridge Road Suite 450 Vienna, VA 22182-2536 (703) 821-8955 x254 and National Center for Education in Maternal and Child Health 2000 15th St. North Suite 701 Arlington, VA 22201-2617 (703) 524-7802</p>	<p><i>Maternal and Child Health: 1996 Publications Catalog</i></p>	<p>1996. FREE. Offers a variety of free pamphlets, publications, and videos on the health concerns of women and children, including adolescent care, reproductive care, perinatal care, newborn screening, HIV, nutrition, oral health, child safety, violence and injury prevention, immunological and genetic disorders, family-centered care, social work, and public health programs and services.</p>
<p>National Heart, Lung, and Blood Institute Information Center P.O. Box 30105 Bethesda, MD 20824-0105 (301) 251-1222</p>		<p>Information Line at 1-800-575-WELL.</p>
<p>National HIV Telephone Consultation Service</p>		<p>A clinical consultation service of health care providers: (800) 933-3413.</p>
<p>New York Task Force on Immigrant Health NYU School of Medicine Division of Primary Care Millageos Murcia 550 First Ave. New York City, NY 10016 (212) 263-8783</p>	<p><i>Epidemiologic Information on Immigrant and Minority Groups in NYC (1980-1993)</i></p> <p><i>Immigrant Health Bibliography</i></p>	<p>1980. FREE. Maternal and Child Health Country Factsheets.</p>

<p>Office of Minority Health U.S. Department of Health and Human Services Public Health Service P.O. Box 37337 Washington, DC 20013-7337 (800) 444-6472</p>	<p><i>Minority Health Database Search:</i> <i>Non-English Language Health Materials</i></p>	<p>FREE. The Office of Minority Health Resource Center's main resources database contains information on minority health topics in various forms, including audiotapes, books, community programs, documents, health service providers, manuals, organizations, pamphlets, and reports.</p>
<p>Office of Minority Health U.S. Department of Health and Human Services Public Health Service P.O. Box 37337 Washington, DC 20013-7337 (800) 444-6472</p>	<p><i>Pocket Guide to Minority Health Resources</i></p>	<p>FREE. Provides phone numbers on the Office of Minority Health, Public Health Service liaisons, State contacts, clearinghouses, organizations, health materials, and colleges.</p>
<p>St. Josephs Hospital and Medical Center Attn: Hanan S. Matari Arabic Community Liaison 703 Main Street Paterson, NJ 07503 (201) 754-2000</p>	<p><i>For Your Health</i></p>	<p>\$1.50 each. This pamphlet, translated into Arabic, contains information on domestic violence, tobacco, breast cancer, STDs, drugs, and alcohol.</p>
<p>State of California Alameda County Ambulatory Services Avril Anderson, RN, MS Refugee Health Program Coordinator, 1900 Embarcadero Ste 400 Oakland, CA 94606</p>	<p><i>Hepatitis B Information Sheet for Ethiopians</i></p> <p><i>TB and INH Pills to Prevent TB</i></p> <p><i>The Pap Test</i></p> <p><i>The Tuberculin Test</i></p>	<p>FREE. Four pamphlets, all translated into Amharic, on the Pap Smear test, TB and Hepatitis B.</p>
<p>State of California Department of Health Services Communicable Diseases Refugee Health Section 714 P St., MS 508 P.O. Box 942732, Sacramento, CA 94234-7320</p>	<p><i>Health Education Materials Listing (by county)</i></p>	<p>FREE. This is a useful list of free health care materials on TB, Hepatitis, immunizations, parasites, AIDS, STDs, cancer, heart disease, hypertension, smoking, diabetes, nutrition, injury prevention, mental health, newborn care, female examinations, family planning, and prenatal and postpartum care, cataloged according to language (Arabic, Ethiopian, Amharic, and Somali included).</p>
<p>State of Vermont Office of Minority Health Vermont Refugee Resettlement Program</p>	<p><i>Lead, Asbestos, Radon, Mercury</i></p>	<p>FREE. Guide to household safety translated into Arabic.</p>

Section V: Domestic Violence/

Violence against Women

Outline

- A. General Information
- B. Issues Concerning Children
- C. Issues Concerning Adolescents
- D. For Health Care Providers

A. General Information

<p>Commission on Women's Health</p>	<p><i>Violence Against Women in the United States: A Comprehensive Background Paper</i></p>	<p>November 1994. This report identifies violence as a condition that threatens the health of large numbers of women that are risk for sexual and domestic violence. The paper covers 1/ the dimensions of the problem, the numbers of women in American society; 2/ the effects of violence on women's physical and psychological health; 3/ strategies that have been developed to help individual women and their known effectiveness; and 4/ effective models of prevention.</p>
<p>Commonwealth Fund Commission on Women's Health</p>	<p><i>Addressing Domestic Violence and Its Consequences</i></p>	<p>February 1998. This policy report shares the information that the Commission has learned about the prevalence and incidence of domestic violence, as well as recommends a set of goals to help mount a more effective response to the problem.</p>
<p>Equality NOW Women's Action 15.1</p>	<p><i>Trinidad and Tobago: The Imminent Execution of a Battered Woman and Her Defenders</i></p>	<p>October 1998. The handout details the circumstances surrounding a murder and pending execution of a woman from Trinidad who killed her husband after years of physical and emotional abuse. This paper calls for a response from individuals to stop her execution.</p>
<p>New York Times</p>	<p>"The Tribulations of Afghanistan: Half a Nation, Condemned"</p>	<p>Saturday, August 15, 1998, and Thursday October 8, 1998.</p>

<p>Osawa, Yoshiko</p>	<p><i>Response of Nonprofit Organizations for Battered Women to Laws</i></p>	<p>This paper examines the present situation of domestic violence and the roles of nonprofit organizations for battered women. This examination includes the history of the laws towards domestic violence, as well as the possible responses of nonprofit organizations to the changing laws.</p>
<p>Physicians for Human Rights Boston/Washington, D.C.</p>	<p><i>The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan</i></p>	<p>This report contains compelling evidence of how a society in which women played a prominent role in the health professions, in government, and in teaching, has been replaced by one where: women are regularly and brutally beaten for walking on the street without a male chaperone or without a garment that covers their bodies from head to toe. This book contains the results of a human rights survey of 160 Afghan women and in-depth interviews of 40 women. The women represent a wide range, diverse educational and occupational backgrounds, and all levels of income.</p>
<p>United Nations High Commission on Refugees General Legal Advice Section (HQPR02) Case Postale 2500 CH-1211 Geneva 2 Depot, Switzerland</p>	<p><i>Guidelines on the Protection of Refugee Women</i></p>	<p>FREE. Protection is at the heart of the responsibility that the international community bears towards refugees. Refugees as a group are doubly disadvantaged and thus vulnerable to actions that threaten their protection. First, refugees are victims of human rights abuses, conflicts and other acts of aggression. Second, they are outside their own countries and unable access the protection their own governments should provide. The paper is broken down into five parts: the general introduction, assessment and planning, protection needs and responses, addressing protection through assistance, and follow-up and reporting of protection problems.</p>

<p>United Nations High Commission on Refugees General Legal Advice Section (HQPR02) Case Postale 2500 CH-1211 Geneva 2 Depot, Switzerland</p>	<p><i>Sexual Violence Against Refugees: Guidelines on Prevention and Response</i></p>	<p>FREE. Sexual violence against refugees is widespread. Women and girls and, less frequently, men and boys—are vulnerable to attack, both during their flight and while in exile. UNHCR is acutely aware of the dimensions of the problem and offers the following guidelines for preventing and responding to sexual violence against refugees intended to promote more effective ways for all concerned parties to act and react. The intention is to provide UNHCR, non-governmental organizations and other field workers with basic practical advice in areas of medical treatment, psychological support and legal intervention.</p>
<p>Van Hasselt VB, Morrison RL, Bellack AS, et al., eds.</p>	<p><i>Handbook of Family Violence</i></p>	<p>New York: Plenum Press, 1988.</p>

B. Issues Concerning Children

<p>Berkowitz C. D. <i>Adv Pediatr</i></p>	<p>"Sexual Abuse of Children and Adolescents."</p>	<p>1987. Vol. 34, pp. 275- 312.</p>
<p>Finkelhor D, Baron L. <i>Sourcebook on Child Sexual Abuse</i></p>	<p>"High-Risk Children"</p>	<p>Beverly Hills, CA: Sage, 1986</p>
<p>National Committee for Prevention of Child Abuse</p>	<p>"National Incidence and Prevalence of Child Abuse and Neglect."</p>	<p>Washington, DC: American Humane Association, 1987.</p>
<p>Reece RM, ed.</p>	<p><i>Child Abuse: Medical Diagnosis and Management</i></p>	<p>Philadelphia: Lea & Febiger, 1994.</p>
<p>U.S. Department of Health and Human Services National Center on Child Abuse and Neglect Washington, DC</p>	<p><i>Child Maltreatment 1993: Reports from the States to the National Center on Child Abuse and Neglect</i></p>	<p>Government Printing Office, 1995.</p>

Waller AE, Baker SP, Szocka A. <i>Am. J. Public Health</i>	"Childhood Injury Deaths: National Analysis and Geographic Variations."	1989. Vol. 79, pp. 310-315.
Wissow L.S. <i>N. Engl. J. Med.</i>	"Child Abuse and Neglect."	1995. Vol. 332, pp. 1425-1431.

C. Issues Concerning Adolescents

Riggs S, Alario AJ, McHorney <i>J Pediatr</i>	"Health Risk Behaviors and Attempted Suicide in Adolescents Who Report Prior Maltreatment."	1990. Vol. 116, pp. 815-821.
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D. For Health Care Providers

<i>Journal of the American Medical Association (JAMA)</i>	<i>Women's Health and Human Rights in Afghanistan</i>	Volume 280. August 5, 1998. A report detailing the assessment of health and human rights concerns and conditions of women living in Kabul under the Taliban regime.
McAfee R.E. <i>JAMA</i>	"Physicians and Domestic Violence: Can We Make a Difference?"	1995. Vol. 273, pp. 1790-1791.
Reece RM, ed.	<i>Child Abuse: Medical Diagnosis and Management.</i>	Philadelphia: Lea & Febiger, 1994.

Section VI: Public Benefits & Community Service

Outline

A. General Information

A. General Information

International Catholic Migration Commission Zagreb, Croatia	<i>U.S. Cultural Orientation Curriculum</i>	Zagreb, Croatia: International Catholic Migration Commission, 1997.
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Section VII: Female Circumcision/ Female Genital Mutilation

Outline

- A. General Information
- B. For Health Care Providers
- C. Legal Issues

A. General Information

<p>Abdalla Raqiya Haji Dualeh</p>	<p><i>Sisters in Affliction: Circumcision and Infibulation of Women in Africa</i></p>	<p>Zed Press, 1982. This book provides a basic record of female genital mutilation, utilizing a multi-dimensional view of the problems. The information is based on many sources which include: previous literature on the subject, the authors own experiences and observations of the practice, as well as information and statements gathered through empirical investigations with other Somali women.</p>
<p>Abu-Sahlieh, Aldeeb and A.Sami Swiss Institute of Comparative Law, Dorigny, 1015 Lausanne, Switzerland, (021) 692-4912</p>	<p><i>To Mutilate in the Name of Jehovah or Allah: Legitimization of Male and Female Circumcision</i></p>	
<p>Australian Medical Association</p>	<p>http://www.ama.com.au/policies/femgen.html</p>	<p>March 1994. Position statement condemning the practice of FC/FGM in any form. Available on website</p>

<p>Center for Applied Linguistics, Refugee Service Center, Health Educational Materials, 1118 22nd St., NW, Washington, DC (202) 429-9292</p>	<p><i>Female Circumcision/ Female Genital Mutilation: Resource Packet</i></p>	<p>1996. \$5.00 copying fee. The resources include background information about the various procedures of FC/FGM: where it is practiced, beliefs and misconceptions among groups who engage in the ritual and the resulting physical and psychological harm to women and children. A legislative update on the status of the federal and state prohibitions on FC/FGM is also included. The materials are intended to educate refugee service providers about FC/FGM and begin to understand the challenge of trying to change cultural traditions of refugees from communities that practice it.</p>
<p>El Dareer, Asma</p>	<p><i>Woman, Why Do You Weep? Circumcision and its Consequences</i></p>	<p>1982. London Zed Press</p>
<p>Eyega, Zeinab and Eileen Conneely MPH JAMWA</p>	<p>"Facts and Fiction Regarding Female Circumcision/Female Genital Mutilation: A Pilot Study in New York City."</p>	<p>1998. Vol. 52, No. 4.</p>
<p>Gynecology Ob.Gyn.</p>	<p><i>Complications Seen in Circumcised Women</i></p>	<p>July 15, 1998 This article discusses the cultural practice of FC/FGM and some of the implications to health care and status of women's health in the United States. The article also discusses the projected immigrant patterns in the United States that are fueling the need for ob.gyns. nationwide to become educated on the basics of FC/FGM.</p>
<p>Hosken, Fran P.</p>	<p><i>The Hosken Report</i></p>	<p>Lexington: Women's International Network 1994. Fourth revised edition.</p>
<p>Hosken's Report</p>	<p>http://www.hollyfeld.org/xastur/world.html</p>	<p>A listing by population group of Africans who practice FC/FGM.</p>
<p>Kassindja, Fauziya and Layli Miller Bashir</p>	<p><i>Do They Hear You When You Cry?</i></p>	<p>New York: Delacorte Press. This book chronicles the life of Fauziya Kassindja, who fled her African homeland to escape female genital mutilation only to be locked up in American prisons for sixteen months. The book also looks at the struggles of Layli Miller Bashir who as a law student fought for Fauziya's freedom.</p>

<p>Lightfoot-Klein, Hanny</p>	<p><i>Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa</i></p>	<p>Harrington Park Press. This book includes an examination of the methods, medical and psychological ramifications, and cultural context of female circumcision in Sudan and other parts of Africa. The author pulls from personal interviews and her own considerations to illustrate the ways in which culture and custom can dictate the most severe assault on women.</p>
<p>Musalo, Karen International Human Rights Law Clinic The American University Washington College of Law</p>	<p><i>In Re Kasinga: A Big Step Forward for Gender-based Asylum Claims</i></p>	
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>		<p>Audio Visual Materials. Training kit for health professionals and educators, includes 26 color slides describing the types of FC/FGM, health consequences and the social, cultural, religious, and legal issues surrounding the practice. The slides are accompanied with speaker's notes written by Dr. Toubia.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318 (212) 477-3318</p>		<p>Audio Visual Materials. \$150.00 (plus S & H). A selection of video tapes on FC/FGM from different countries is available on loan basis for educational purposes. Refundable security deposit.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Caring for Circumcised Women</i></p>	<p>New Publication from RAINBO.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Female Circumcision as a Public Health Issue</i></p>	<p>\$5.00 (plus \$1.50 S & H) Published by the <i>New England Journal of Medicine</i>.</p>

<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Female Circumcision in the United States: A Declaration of Violence</i></p>	<p>This handout outlines a declaration of values in relation to FC/FGM due to the growing attention this issue continues to receive in the United States. This organization maintains that FC/FGM violates the bodily integrity and human rights of a non-consenting child and, if not undertaken voluntarily, of women.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Female Genital Mutilation and the Responsibility of Reproductive Health Professionals</i></p>	<p>\$5.00 (plus \$1.50 S & H) Published by the <i>International Journal of Gynecology and Obstetrics</i>.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Female Genital Mutilation: A Call for Global Action</i></p>	<p>\$9.95 (plus \$1.50 s & h). Discusses FC/FGM in a cultural, health, and rights context with illustrations describing types of female circumcision.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Intersections Between Health and Human Rights: A Case of Female Genital Mutilation</i></p>	<p>\$6.95 (plus \$1.50 S & H) Report based on one-day workshop held at the National Council on International Health in 1995, which brought together an international panel of legal professionals, academics, social scientists and activists.</p>
<p>RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318</p>	<p><i>Second Inter-Agency Working Group on FGM Report (1995)</i></p>	<p>\$5.00 (plus \$1.50 S & H) A report from a meeting of international agencies, donors and representatives of African organizations on current research, programs, funding and future strategies related to the eradication of FC/FGM.</p>
<p>Raqiya Haji Abdalla</p>	<p><i>Sisters in Affliction: Circumcision and Infibulation of Women in Africa.</i></p>	<p>1982. London: Zed Press, 122 pgs.</p>
<p>Somach, Susan Refugee Service Center Center for Applied Linguistics</p>	<p><i>Female Genital Mutilation: Resource Packet</i></p>	<p>1996</p>

Toppozada, Nadine	<i>Female Genital Mutilation: Women at the Border</i>	FREE. Includes an introduction, reactions of the international community, history/types/effects of the practice, and a legal analysis of international human rights instruments.
Toubia, Nahid	<i>Female Genital Mutilation: A Call for Global Action</i>	1995. 2nd edition.
Toubia, Nahid <i>Women and the Family in the Middle East</i>	"The Social and Political Implications of Female Circumcision: The Case of Sudan."	Austin: University of Texas Press, 1994
Walker, Alice and Pratibha Parmar	<i>Warrior Marks: Female Genital Mutilation and the Sexual Binding of Women</i>	New York: Harcourt Brace & Company. The authors traveled from England to Africa to interview people concerned with and affected by the practice of female genital mutilation. The book chronicles their journey and adds insights to the politics of film making, feminism and the harmful and sometimes deadly process of female genital mutilation.
Warsame, A. SWDO	<i>Female Circumcision, Strategies to Bring About Change</i>	1988. Social and cultural implications of infibulation in Somalia.
World Health Organization.	<i>Female Genital Mutilation: An Overview.</i>	Geneva, 1998.

B. For Health Care Providers

<i>International Journal of Gynecologists and Obstetricians</i>	"Female Genital Mutilation and the Responsibility of Reproductive Health Professionals."	
RAINBO Nahid Toubia, President Zeinab Eyega, Program Officer 915 Broadway, Suite 1603 New York, NY 10010-7108 (212) 477-3318	<i>Caring for Women with Circumcision: A Technical Manual for Health Care Providers</i>	By Nahid Toubia. February, 1999.

Toubia, Nahid <i>The New England Journal of Medicine</i>	"Female Circumcision As a Public Health Issue."	1994.
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C. Legal Issues

An-Na'im, Abdullahi	<i>Toward an Islamic Reformation: Civil Liberties, Human Rights, and International Law</i>	Syracuse University Press, 1990.
Bashir, Layli Miller <i>The American University Journal of Gender and the Law</i>	"Female Genital Mutilation in the United States: "An Examination of Criminal and Asylum Law"	Spring 1996.
Center for Reproductive Law and Policy		Videos and audio-visual materials, as well as special publications and extensive bibliographies.
Center for Reproductive Law and Policy	<i>Female Circumcision/Female Genital Mutilation (FC/FGM): Global Laws and Policies Towards Elimination</i>	January 1999.
Center for Reproductive Law and Policy	<i>Reproductive Freedom in Focus: Legislation on Female Genital Mutilation in the United States</i>	July 1998.

Bibliography

This Bibliography has been divided into the following sections for ease of use with the corresponding modules of this manual.

- Section I:** Applied Life Skills
- Section II:** Parenting
- Section III:** Child Care
- Section IV:** Health & Wellness
- Section V:** Women's Issues
- Section VI:** Public Benefits & Community Service
- Section VII:** Culture, Language, & Immigration Issues
- Section VIII:** Education

Category	Title	Publisher	Date	Type
	<i>New Beginnings</i>	International Catholic Child Bureau Series		Booklet
	<i>Satisfaction in the Land of Opportunity: Answers for U.S. Immigrants and Refugees</i>	Pioneer Living Series		Booklet
	<i>Teaching Refugee Women</i>	Indochinese Cultural & Service Center		Booklet
	<i>The HUD Home Buying Guide</i>	HUD		Booklet
	<i>The New Making it on Your Own</i>	Virginia Commonwealth U		Booklet
	<i>Summary Report</i>	Temple U: The Center for Intergenerational Learning Temple U Institute on Aging	1998 (Jun. 8)	Brochure
	<i>Refugee Guide to the United States of America</i>		1994 (Jun.)	Brochure
	<i>The Road to Independent Living: A Handbook for Adults</i>	Linda Bayless, NOVA University: Institute for Social Services to Families	1986	Brochure
	<i>Conference on Refugee Orientation</i>	U.S. Department of State	1998 (Apr. 20-22)	Conference Proceedings
	<i>U.S. Cultural Orientation for Bosnian Refugees</i>	International Catholic Migration Commission	1998	Curriculum
	<i>Cultural Orientation Workshop Preliminary Proposal</i>	IRC-USRRO/Sudan		Draft
	<i>Cleaning Dishes</i>	Penn State		Flier
	<i>Cleaning the Bathroom</i>	Penn State		Flier
	<i>Cleaning Your Electric Stove</i>	Penn State		Flier
	<i>Cleaning Your Gas Stove</i>	Penn State		Flier
	<i>Cleaning Your Refrigerator</i>	Penn State		Flier
	<i>Welcome to the United States: A Guidebook for Refugees</i>	Center for Applied Linguistics Refugee Service Center	1996	Guidebook (Available in 10 languages.)

Category	Title	Publisher	Date	Type
	<i>Landlord-Tenant Rights</i>	Pennsylvania Bureau of Consumer Protection		Sheet
	<i>Survey</i>	Ethiopian Community Development Council		Sheet
	<i>How to Develop Your Decision-Making Skills</i>	Channing L. Bete Co. Inc.	1997	Small Booklet
	<i>138 Ways to Beat the High Cost of Living</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>About American Indians—The First People of America</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>About Understanding Diversity</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Asian and Pacific Islander Americans—An introduction to Their American Experience</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Hispanic Americans—A Diverse People</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>How to Enjoy a Balanced Diet on a Balanced Budget</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>How to Finance a Home</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>Learn About Diversity</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Medicare and You 1998 Edition</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>What Everyone Should Know About Checking Accounts</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>What You Should Know About Family Budgeting</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>What You Should Know About Pre-Retirement Planning</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Women in America—Their Experiences and Contributions</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Cultural Orientation Program Curriculum Lesson Guide</i>	UNHCR Intensive Cultural Programs in South Asia		Thick Booklet
	<i>Welcome: Refugee Guide to Resettlement, Refugee Orientation Video</i>	Center for Applied Linguistics Refugee Service Center	1997	Video (Available in 9 languages.)

Section II: Parenting

Outline

- A. Child Development
- B. Child Discipline
- C. Neglect & Abuse
- D. Teenagers

Category	Title	Publisher	Date	Type
A. Child Development				
	<i>Helping Children Take Healthy Steps: Abstracts of Selected Articles on Early Childhood Interventions</i>	The Commonwealth Fund	1997 (Feb.)	Booklet
	<i>Innovative Approaches for the Delivery and Financing of Parent Education Programs in Health Care Setting</i>	The Commonwealth Fund	1995 (Sept.)	Booklet
	<i>Child Health Needs Assessment: A Review of Data Sources to Measure Child Health Status</i>	CAHPC (Child and Adolescent Health Policy Center)	1995	Booklet
	<i>Essential Allies: Families as Advisors</i>	Institute for Family-centered Care	1995	Booklet
	<i>Biblio Alert! Focus on Infection Control in Child Care</i>	Children's Safety Network	1994	Booklet
	<i>Project Spoon: Special Program of Oral Nutrition for Children with Special Needs</i>	MCHB (Maternal and Child Health Bureau)	1991	Booklet
	<i>Palliative Pain and Symptom Management for Children and Adolescents</i>	Children's Hospice International	1989	Booklet
	<i>Genetic Family History: An Aid to Better Health in Adoptive Children</i>	Wisconsin Clinical Genetics Center	1984	Booklet
	<i>About Your Child's Emotional Health</i>	Channing L. Bete Co. Inc.		Booklet
	<i>Emergency Medical Services for Children: Summary</i>	Institute of Medicine		Booklet

Category	Title	Publisher	Date	Type
	<i>Ten Commandments for Teaching Parenting to School-Age Parents (You Can Help, Book 2: Curriculum Guide for Teens Parenting Series)</i>			Handouts
	<i>Temper Tantrums: A Normal Part of Growing UP</i>	American Academy of Pediatrics		Pamphlet
	<i>Discipline: A Parent's Guide</i>	The National PTA		Sheet
C. Neglect & Abuse				
	<i>About Adults Abused As Children</i>	Channing L. Bete Co. Inc.		Booklet
	<i>About Child Sexual Abuse</i>	Channing L. Bete Co. Inc.		Booklet
	<i>About Preventing Child Abuse</i>	Channing L. Bete Co. Inc.		Booklet
	<i>How Family Violence Affects Children</i>	Channing L. Bete Co. Inc.		Booklet
	<i>Recognizing & Reporting Child Abuse & Neglect</i>	Oregon Children's Services Division		Booklet
	<i>What Everyone Should Know About Child Neglect</i>	Channing L. Bete Co. Inc.		Booklet
	<i>Child Abuse Alert: A Desk Reference</i>	Council of Family and Child Caring Agencies		Handouts
D. Teenagers				
	<i>Understanding Youth Development: Promoting Positive Pathways of Growth</i>	The Family and Youth Services Bureau Update	1997 (Jun.)	Article
	<i>Peer Pressure and Your Child</i>	Channing L. Bete Co. Inc.	1999	Booklet
	<i>Refugee Teenagers: Escape and Protection from Persecution and War</i>	UNHCR	1999	Booklet
	<i>Talking to Adolescents About Sex</i>	Channing L. Bete Co. Inc.	1999	Booklet
	<i>Understanding Adolescence</i>	Channing L. Bete Co. Inc.	1999	Booklet
	<i>What Parents Should Know About Teen Behavior</i>	Channing L. Bete Co. Inc.	1999	Booklet
	<i>The Health of Adolescent Boys: Survey Findings</i>	Commonwealth Fund	1998 (Jun.)	Booklet

Section III: Child Care

Outline

- A. In-home
- B. School

Category	Title	Publisher	Date	Type
A. In-home				
	<i>Home-Based Child Care: Assessing the Self-Sufficiency Potential (With special reference to refugees.)</i>	Institute for Social and Economic Development	1999 (Jun.)	Booklet
B. School				
	<i>How to Help Your Child Succeed in School/National Association of School Psychologists</i>	Channing L. Bete Co. Inc.	1999	Booklet
	<i>Homework Survival Guide: Parent Handout</i>	Multi-Health Systems	1998	Booklet
	<i>15 Questions Parents Should Ask Teachers: Parent-Teacher Conference</i>	DC Public Schools		Handout
	<i>Parenting Your Elementary School Child</i>	Harriet Lurensky		Handout
	<i>About Your Child's Report Card</i>	Xogogaal, IRC (Vol. 1; Issue 5)	1997 (June)	Newsletter
	<i>School System</i>	Don Bosco Centers, NSC		Orientation Manual

Category	Title	Publisher	Date	Type
	<i>Family Planning Birth Control</i>	NY Association for New Americans, Inc.		Handouts
	<i>What's New—Flipcharts for Family Planning</i>	Media/Materials Clearing-house (Feb.)	1996	Materials List
	<i>Ann Rose's Ultimate Birth Control Links</i> < http://www.gynpages.com/ultimate >			WWW
	Condomania < http://www.condomania.com >			WWW
	<i>Contraceptive Methods</i> < http://www.avsc.org/contraception/index.html >	AVSC		WWW
	Directory of Providers of Emergency Contraception < http://opr.princeton.edu/ec/clinics/html >			WWW
	Oral Contraceptives < http://www.sex-ed101.com/oral.html >			WWW
C. General Health				
	"FDA's Tips for Taking Medicines: How to Get the Most Benefits with the Fewest Risks"	<i>FDA Consumer Magazine</i>	1996 (Feb.)	Article
	"An FDA Guide to Choosing: Medical Treatments"	<i>FDA Consumer Magazine</i>	1995 (Jul.)	Article
	"Making It easier To Read Prescriptions"	<i>FDA Consumer Magazine</i>	1995 (Jun.)	Article
	<i>Where Women Have No Doctors: A Health Guide for Women</i>	A. August Burns, Ronnie Lorch, Jane Maxwell, Katharine Shapiro, Hesperian Foundation	1997	Book
	<i>Smoke-Free Child Care</i>	Massachusetts Department of Public Health	1992	Booklet
	<i>The Surgeon General's Workshop on Self-Help and Public Health</i>	U.S. Department of Health and Human Services	1987	Booklet

Category	Title	Publisher	Date	Type
	<i>About Food And Drugs Interactions</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>About Keeping Your Child Healthy</i>	Channing L. Bete Co., Inc		Small Booklet
	<i>About Multiple Substance Abuse</i>	Channing L. Bete Co., Inc.		Small Booklet
	<i>Drugs & You</i>	Channing L. Bete, & Co, Inc		Small Booklet
	<i>Give Your Child a Healthy Start—Medicaid Services for Children</i>	Channing L. Bete Co., Inc		Small Booklet
	<i>Good Hygiene—How to Look and Feel Your Best</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>How to Manage Your Medications</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Keeping Your Baby Safe—Tips for Inside and Outside Your Home</i>	Channing L. Bete Co., Inc		Small Booklet
	<i>Overcoming Addiction—Building New Lives</i>	Channing L. Bete Co., Inc.		Small Booklet
	<i>Understanding Your Prescription</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Helping Health Workers Learn</i>	David Werner and Bill Bower, Hesperian Foundation	1982	Training Manual
	<i>"Good Health at the Heart of Development"</i> < www.dfid.gov.uk >	ODA (Overseas Development Administration)	1995	WWW
	Canadian Women's Health Network < http://www.cwhn.ca >			WWW
	<i>Diversity RX</i> < www.diversityrx.org >	Resources for Cross-Cultural Healthcare		WWW
	<i>Healthfinder, Just for You</i> < http://www.healthfinder.gov/justforyou/women/default.htm >	U.S. Dept. of Health & Human Services		WWW
	Immigration/Refugee Health < www.ppfca.ca >	Planned Parenthood, Manitoba, Canada		WWW
	Osteoporosis < http://www.pslgoup.com/osteoporosis.htm >	Doctor's Guide to the Internet		WWW
	Planned Parenthood < http://www.plannedparenthood.org >			WWW

Category	Title	Publisher	Date	Type
	<i>Patient Teaching Guide: Breast Self-Examination</i>	Mosby's Clinical Nursing Series	1996	Sheet
	<i>Breast Cancer: What Every Woman Should Know</i>	NY Association for New Americans, Inc.		Sheet
	<i>Patient Teaching Guide: Discovery of Breast Cancer</i>	Mosby's Clinical Nursing Series		Sheet
	<i>Patient Teaching Guide: Menopause and Osteoporosis</i>	Mosby's Clinical Nursing Series		Sheet
	<i>Patient Teaching Guide: Premenstrual Syndrome</i>	Mosby's Clinical Nursing Series		Sheet
	<i>Patient Teaching Guide: Signs and Symptoms of Sexually Transmitted Diseases</i>	Mosby's Clinical Nursing Series		Sheet
	<i>Patient Teaching Guide: Urinary Tract Infections</i>	Mosby's Clinical Nursing Series		Sheet
	<i>Cervical Cancer—What Every Woman Should Know</i>	Channing L. Bete Co. Inc.	1994	Small Booklet
	<i>Breast Cancer Awareness Crusade</i> < http://www.avoncrusade.com >	Avon		WWW
	Breast Cancer Information Clearinghouse < http://www.acor.org >			WWW
	Community Breast Health Project < http://www-med.stanford.edu/cbhp >			WWW
	Onlink < http://www.oncolink.org/disease/breast >			WWW

E. Illnesses

	<i>What is Cholesterol-Lowering Medicine?</i>		1994	
	"Guide to Holistic Health"	<i>New Age</i>	1994	Article
	"Newborn Screening for Sickle Cell Disease and Other Hemoglobinopathies"	National Institutes of Health	1987	Article
	<i>A Parents' Handbook for Sickle Cell Disease: Part II, 6-18 Years of Age</i>	Children's Hospital-Oakland Sickle Cell Center	1993	Booklet
	<i>Education in Genetics: Nurses and Social Workers</i>	U.S. Dept. of Health and Human Services	1980	Booklet
	<i>Diabetes—Facts for Everyone</i>	Channing L. Bete Co. Inc.		Booklet

Category	Title	Publisher	Date	Type
	<i>Overcoming Barriers to Immunization: A Workshop Summary</i>	Institute of Medicine	1994	Booklet
	<i>Immunization?</i>	IRC (International Rescue Committee)	1997 (June)	Newsletter (Vol. 1, Issue 5,)
	<i>"For Your Health": Measles</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>"For Your Health": Well Child Care/Immunizations</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>Childhood Immunization</i>	Commonwealth of Pennsylvania		Sheet
	<i>Fact Sheet: Your Child's Health: Immunization</i>	NYANA Department of Health and Safety Promotion Services		Sheet
	<i>Why Older Children Need Shots</i>	Channing L. Bete Co., Inc	1998	Small Booklet
	<i>Give Your Child a Shot—At Good Health</i>	Channing L. Bete Co., Inc	1994	Small Booklet
G. Lead Poisoning				
	<i>Project Lead-Safe 2000</i>	City of Kansas City, Missouri Health Dept		Application Form
	"Poisonous Paint?"	<i>The Kansas City Star</i>	1996 (Aug. 14)	Article
	"Anemia and Elevated Lead Levels in Underimmunized Inner-city Children"	<i>Pediatrics</i> (Vol. 101:No. 3)	1998	Article
	"Low-Level Lead Exposure and Behavior in Early Childhood"	<i>Pediatrics</i> (Vol. 101:No. 3)	1998	Article
	"Lead Alert!"	<i>Parent Report</i>	1997 (Mar.)	Article
	"Preventing Childhood Poisoning"	<i>FDA Consumer Magazine</i>	1996	Article
	"Lead Poisoning: From Screening to Primary Prevention"	<i>Pediatrics</i> (Vol. 92:No. 1)	1993 (July)	Article
	"The Children's Safety Network: A Resource for Child and Adolescent Injury and Violence Prevention"	Children's Safety Network		Article

Category	Title	Publisher	Date	Type
	<i>About Grief</i>	Channing L. Bete Co. Inc.		Small Booklet
I. Nutrition				
	<i>Good Health and Nutrition for You and Your Family</i>	NY Association for New Americans, Inc.		
	<i>About Good Nutrition</i>	Channing L. Bete Co. Inc.		Activity Book
	"Food Label Close-Up"	FDA Consumer Magazine	1994	Article
	"Can Your Kitchen Pass the Food Safety Test?"	<i>FDA Consumer Magazine</i>		Article
	<i>Nutrition Services in Perinatal Care</i>	Institute of Medicine	1992	Book
	<i>A Quick Consumer Guide to Safe Food Handling</i>	U.S. Department of Agriculture		Booklet
	<i>Action Guide for Healthy Eating</i>	National Institutes of Health		Booklet
	<i>Nutrition During Lactation</i>	Institute of Medicine		Booklet
	<i>Eat 5 Fruits and Vegetables every Day</i>	National Institutes of Health	1996	Brochure
	<i>Sources of Free or Low-Cost Food and Nutrition Materials</i>	Food and Nutrition Information Center		Catalog
	<i>Nutrition Resources for Early Childhood: A Resource Guide</i>	MCHB (Maternal and Child Health Bureau)		Pamphlet
	<i>How Do I Follow a Low-Fat Diet?</i>	American Heart Association		Sheet
	<i>How Do I Read Food Labels?</i>	American Heart Association		Sheet
	<i>Our Family's Growth Chart!</i>	Scriptographic Product; Channing L. Bete Co. Inc.		Sheet
	<i>What About Eating Out?</i>	American Heart Association		Sheet
	<i>About Good Nutrition</i>	Channing L. Bete Co. Inc.		Small Booklet

Category	Title	Publisher	Date	Type
	<i>"For Your Health" Prenatal Care</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>Help Your Baby to a Healthy Start</i>	California Department of Health Services		Sheet
	<i>Low Birthweight</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>Pregnancy Over 35</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>A Customized Bibliography</i>	National Center for Education in Maternal and Child Health		Sheet (Catalog)
	<i>Source List</i>	National Maternal and Child Health Clearinghouse		Sheet (Includes order form.)
	<i>Babyworld</i> < http://www.babyworld.com >			WWW
	Online Birth Center < http://www.efn.org/~djz/birth/birthindex.html >			WWW
	Pregnancy < http://www.noah.cuny.edu/pregnancy/pregnancy.html >	Ask NOAH About		WWW
	<i>Pregnancy and Related Care</i> < http://www.avsc.org/pregnancy/index.html >	AVSC		WWW
	Pregnancy Signs < http://www.usoft.com/pregnancy >			WWW
	Prenatal and Postnatal Care < http://www.familyweb.com/pregnancy/natal/natoe.html >	Family Web		WWW
	Prenatal Care < http://www.parentzone.com/parents >	Parentzone		WWW
	Teen Pregnancy/Maternal & Neonatal Care < http://www.software2.bu.edu/cohis/teenpreg/postcare/immune.htm >			WWW

K. Reproductive Health

	<i>The Universal Childbirth Picture Book</i>	Fran P. Hosken; WIN News	1995	Book
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Category	Title	Publisher	Date	Type
L. Safety				
	"Firearm Facts: Information on Gun Violence and Its Prevention"	Children's Safety Network		Article
	<i>Powerful Partnerships Twenty Crime Prevention Strategies That Work for Refugees, Law Enforcement and Communities</i>	National Crime Prevention Council, WDC	1998	Book
	<i>Lengthening the Stride: Employing Peace Officers from Newly-Arrived Ethnic Groups</i>	National Crime Prevention Council, WDC	1995	Book
	<i>Building and Crossing Bridges: Refugees and Law Enforcement Working Together</i>	National Crime Prevention Council, WDC	1994	Book
	<i>About Personal Safety</i>	Channing Bete	1999	Booklet
	<i>Know the Facts About Rape</i>	Channing Bete	1999	Booklet
	<i>Women and Safety</i>	Channing Bete	1999	Booklet
	<i>Biblio Alert! Focus on Firearms</i>	Children's Safety Network	1993	Booklet
M. Sexually Transmitted Diseases (STDs)				
	<i>Caring for Families with HIV: Case Studies of Pediatric HIV/AIDS Demonstration Projects</i>	Department of Health and Human Services	1991	Booklet
	<i>HIV/AIDS Cross-Reference Directory</i>	Center for Multicultural Human Services	1997	Catalog
	<i>Supplement—Catalog of HIV and AIDS Education and Prevention Materials</i>	Centers for Disease Control and Prevention	1997	Catalog
	<i>HIV/AIDS Surveillance Report</i>	Centers for Disease Control and Prevention	1996	Catalog
	<i>Catalog of HIV and AIDS Education and Prevention Materials</i>	Centers for Disease Control and Prevention	1994	Catalog
	<i>When Law and Culture Collide: Handling Conflicts Between U.S. Laws and Refugee Cultures</i>	National Crime Prevention Council	1999	Handbook
	<i>What's New—Family Planning Wallcharts</i>	Media/Materials Clearinghouse	1998 (Feb.)	Materials List
	<i>Get the Facts About AIDS</i>	ECDC AIDS Awareness and Prevention Education Program		Sheet

Section V: Women's Issues

Outline

- A. Domestic Violence
- B. Employment
- C. Female Circumcision/Female Genital Mutilation
- D. Women's Rights

Category	Title	Publisher	Date	Type
A. Domestic Violence				
	"Marriage or Rape?"	<i>Newsweek</i>	1996 (Dec. 16)	Article
	"Rape and Domestic Violence: The Experience of Refugee Women"	<i>Women & Therapy</i> , 13 (1- 2)		Article
	<i>Family Violence in Cross-cultural Perspective</i>	SAGE Publications		Book
	<i>About Collecting Child Support</i>	Channing L. Bete, Inc.		Booklet
	<i>Sexual Violence Against Refugees</i>	UNHCR		Booklet
	<i>You Don't Have to be Alone</i>	Middle Way House		Booklet
	<i>Dialogue for Asians in Portland</i>			Brochure
	<i>Personal Safety and Crime Prevention Orientation Materials for Refugees and Immigrants</i>	Bridging the GAP Project		Brochure
	<i>Power and Control</i>	Dr. Patricia Maloof		Handout
	<i>Recognizing Violence</i>	Book Lists		Handout
	<i>Domestic Violence Awareness Quiz</i>	Dr. Patricia Maloof		Handouts
	<i>IMPROVING Accessibility of Your Program's Services to Battered Immigrant Women</i>	Ayuda		Handouts
	<i>Overcoming Cultural Barriers in Working with Immigrant Battered Women</i>	Ayuda		Handouts

Category	Title	Publisher	Date	Type
	<i>Continuum of Family Violence</i>	Indiana Coalition Against Domestic Violence, Inc.		Sheet
	<i>What a Battered Woman Should Do If She Is Arrested by INS</i>	Ayuda		Sheet
	<i>Why Women Stay: Cycle of Violence</i>	Indiana Coalition Against Domestic Violence, Inc.		Sheet
	<i>Why Women Stay: Power and Control</i>	Indiana Coalition Against Domestic Violence, Inc.		Sheet
	<i>About Partner Abuse</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Handbook for Abused Women</i>	NY State Department of Social Services		Small Booklet
	<i>Partner Abuse—What Women Should Know</i>	Channing L. Bete Co. Inc.		Small Booklet
	<i>Violence against Women is a Crime: Your Rights and Sources of Help</i>	Renewal House		Small Booklet
	<i>What Every Woman Should Know About Protection Orders</i>	Channing L. Bete Co. Inc.		Small Booklet
B. Employment				
	<i>New! Employment Authorization Document</i>	U.S. Department of Justice		
	"How Do You Map Out Your Small Business Planning?"	<i>Working Woman:</i>	1996 (Oct.)	Article
	"The Insider's Guide to the SBA"	<i>Working Woman</i>	1996 (Oct.)	Article
	"Foundation Grants"	<i>Youth Today</i>	1993 (Mar./April)	Article
	"Resources for Discovering Self-Employment Opportunities"	Commission Comments	1989 (Fall)	Article
	<i>The Women's Guide to the Wired World</i>	Shan Penn; The Feminist Press	1997	Book
	<i>101 Best Home-Based Businesses for Women</i>	Priscilla Huff, Prima Publishing	1995	Book

Category	Title	Publisher	Date	Type
	<i>BNAC Communicator: Safety</i>	BNA Communications, Inc. (Spring)	1997	News-paper
	<i>Employment and Welfare</i>	Don Bosco Centers		Orientation Manual
	<i>An Employer's Guide to Islamic Religious Practices</i>	CAIR (Council on American-Islamic Relations)	1997	Pamphlet
	<i>Facts on Working Women: 20 Facts on Women Workers</i>	U.S. Department of Labor	1996 (Sept.)	Pamphlet
	<i>Life Advice: About Doing Your Taxes</i>	MetLife	1996	Pamphlet
	<i>Life Advice: About Starting a Business</i>	MetLife	1996	Pamphlet
	<i>Life Advice: About Taking Legal Action</i>	MetLife	1996	Pamphlet
	<i>Assertiveness Skills for Managers & Supervisors</i>	National Seminars Group		Pamphlet
	<i>Facts on Working Women; Domestic Violence: A Workplace Issue</i>	U.S. Department of Labor		Pamphlet
	<i>Facts on Working Women; What Women Need to Know About Downsizing</i>	U.S. Department of Labor		Pamphlet
	<i>Women-owned Businesses Employ More Workers Than the Fortune 500</i>	U.S. Small Business Administration (SBA)		Pamphlet
	<i>Refugee Microenterprise Development</i>	ISED (Institute for Social and Economic Development), John Eise and Carmel Clay-Thompson	1997 (April)	Paper
	<i>Matching Grant Program</i>	LIRS	1999	Reference Material
	<i>Access to Employee Exposure and Medical Records</i>	U.S. Department of Labor		Sheet
	<i>Back Injuries—Nation's Number One Workplace Safety Problem</i>	U.S. Department of Labor		Sheet
	<i>Improving Workplace Protection for New Workers</i>	U.S. Department of Labor		Sheet

Category	Title	Publisher	Date	Type
	<i>Facts on Working Women; Child Care Workers</i> <www.dol.gov>	U.S. Department of Labor	1997 (Nov.)	WWW
	Home-Based Workers <www.hbwm.com>	HBWM Opportunities & More	1997	WWW
	Home-Based Working Moms <www.hbwm.com>	HBWM Opportunities & More	1997	WWW
	"Facts on Working Women; Women Who Maintain Families" <www.dol.gov>	U.S. Department of Labor	1993 (Jun.)	WWW
	"How to Raise Money for a Small Business, etc." <www.sbaonline.sba.gov>	U.S. Small Business Administration (SBA)		WWW
	About US <www.online.wbc>	Women's Business Center		WWW
	Frequently Asked Questions <www.online.wbc>	Women's Business Center		WWW
	OSHA Statistics & Data <www.dol.gov>	U.S. Department of Labor		WWW
	OSHA Strategic Plan FY97-2002 <www.dol.gov>	U.S. Department of Labor		WWW
	Small Business Regulatory Compliance Assistance <www.dol.gov>	U.S. Department of Labor		WWW
	US Department of Labor; Women's Bureau <www.dol.gov>	U.S. Department of Labor		WWW
	<i>Women's Bureau Strategic Plan FY1997-2002</i> <www.dol.gov>	U.S. Department of Labor		WWW
	<i>Women's Business Center</i> <www.online.wbc>	Women's Business Center		WWW
	<i>Wage Discrimination</i> <www.dol.gov>	U.S. Department of Labor	1998	WWW & Pamphlet
	<i>Age Discrimination</i> <www.dol.gov>	U.S. Department of Labor	1995	WWW & Pamphlet
	<i>Disability Discrimination</i> <www.dol.gov>	U.S. Department of Labor		WWW & Pamphlet

Category	Title	Publisher	Date	Type
	<i>Female Genital Mutilation: A Call for Global Action</i>	RAINBO, Nahid Toubia	1995	Booklet
	<i>FGM Resource Packet</i>	Refugee Service Center, Center for Applied Linguistics	1996	Booklet
	<i>The FACTS on FGM</i>	PATH		Brochure
	<i>Female Genital Mutilation</i>	<i>Legislative Review</i>	1996 (May 23)	Document
	<i>Helping Adolescents Make Healthy Choices</i>	PATH		Handout
	<i>RAINBO Information Kit</i>	RAINBO		Handout
	<i>RAINBO Publication List and Video Library</i>	RAINBO		Handout
	<i>Awaken</i>	Equality Now	1999 (Mar.)	Journal
	<i>Awaken</i>	Equality Now	1999 (Jun.)	Journal
	<i>WIN NEWS: Vol. 24, Autumn, No. 4</i>	Fran Hosken	1998	Magazine
	<i>WIN NEWS: Vol. 24, Winter, No. 1</i>	Fran Hosken	1998	Magazine
	<i>What's New-FCIFGM</i>	Media/Materials Clearinghouse	1998 (Oct.)	Materials List
	<i>Awaken</i>	Equality Now	1997 (Dec.)	Newsletter
	Newsletter No. 21	InterAfrican Committee on Traditional Practices Affecting the Health of Women & Children	1997 (Sept.)	Newsletter
	Information Leaflet	InterAfrican Committee on Traditional Practices Affecting the Health of Women & Children	1996 (Jun.)	Pamphlet
	<i>The Dangers of Female Circumcision</i>	Maendeleo Ya Wanawake Organization		Pamphlet

Category	Title	Publisher	Date	Type
	"Rights—Senegal: FGM Losing Ground?"	David Hecht, Interpress Service Kit	1998	WWW
	<i>Female Circumcision: A Religions and Cultural Discussion</i>	RAINBO	2000	WWW
	<i>Female Circumcision: Federal and New York State Laws: What the African Immigrant Community Needs to Know</i>	RAINBO	2000	WWW
	<i>Female Circumcison and Women's Health</i>	RAINBO	2000	WWW
	<i>FGM—Position Statement</i>	American Medical Association	1994 (Mar.)	WWW
	Forward Foundation for Women's Health < http://www.tggh.net/forward >			WWW
	<i>Publication List and Order Form</i> < www.rainbo.org >	RAINBO		WWW
	<i>The Global Action Against Female Genital Mutilation</i> < www.rainbo.org >	RAINBO	1998	WWW

D. Women's Rights

	"A Manual on Rights of Women Under Islam"	<i>The NY Times International</i>	1996 (Dec. 29)	Article
	<i>Women's Rights versus Women's Rites (A Study of Circumcision)</i>	Emmanuel Babatunde, Africa World Press	1998	Book
	<i>Women in Exile</i>	Mahnaz Afkami, University Press of Virginia	1994	Book
	<i>Arab Women: a Profile of Diversity & Change</i>	Population Council		Book
	< www.womenink.org >	Women, Ink.	1999-2000	Book Catalogue
	<i>Rebuilding a Future Together</i>	UNHCR and Refugee Women	1995	Booklet
	<i>Women: Between Yesterday and Tomorrow</i>	UNESCO Sources, No 71	1995 (July/Aug.)	Booklet
	<i>Finding the Ties That Bind: Beyond Headship and Household</i>	J. Bruce & CB Lloyd	1992 (Oct.)	Booklet

Category	Title	Publisher	Date	Type
	GenderAction	U.S.AID; Office of Women in Development	1996/1997 (Vol. 1, No 2, Winter)	Newsletter
	<i>Conference Program Immigrant Women's Health: Current Issues and Concepts</i>	New York Task Force On Immigrant Health	1996, (June 4)	Packet
	<i>Women Vision</i>	Women Vision International		Packet
	<i>Amnesty International Center for Justice & Accountability</i>	Amnesty International	1998 (Oct.)	Press Release
	<i>Guidelines on the Protection of Refugee Women</i>	UNHCR		Printout
	<i>Women—Bible versus Quran?!</i>	ICNA Book Service		Printout
	<i>Wasichana na Wanawake wana Haki! (Women and Girls Have Rights!)</i>	Center for Sexual Health, Tanzania	1998	Small Booklet
	<i>Best Practices for Gender Integration in Organizations and Programs from the InterAction Community</i>	InterAction	1996 (Mar.)	Survey Summary

Category	Title	Publisher	Date	Type
	<i>Health Care Reform: What is at Stake for Women?</i>	The Commonwealth Fund Commission on Women's Health	1994 (July)	Policy Report
	<i>About Home Health Care Under Medicare</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>About the Americans with Disabilities Act</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>Medicaid and You</i>	Channing Bete L. Co. Inc.		Small Booklet
	<i>Who to Call for Health Care—Getting Care Under Your Medicaid Health Plan</i>	Channing Bete L. Co. Inc.		Small Booklet

Category	Title	Publisher	Date	Type
<i>Bosnian</i>				
	"Women Refugees from Bosnia-Herzegovina: Developing a Culturally Sensitive Counseling Framework"	<i>International Journal of Refugee Law</i> (Vol. 6, No. 2)	1994	Article
	<i>Bosnian Refugees: Information Sheet</i>	Texas Department of Health		Handout
<i>General</i>				
	Intercultural Press	Intercultural Press	1999 (Aug.)	Booklist
	Cross-cultural health issues < http://www.crosshealth.com > < http://www.diversityrx.org >			WWW
	Ethnic Medicine Guide (Amharic, Eritrean, Oromo, Somali, Tigrean). < http://www.hslib.washington.edu/clinical/ethnomed >			WWW
	Multi-cultural links. < http://www.isomedia.com/omes/imele/mcultlink.html > < http://medicine.wcsf.edu/divisions/dqim/pods >			WWW
<i>Iraqi</i>				
	"A Timeline of Common Life Events in Iraq for Iraqi Shia Refugees"	Melendez, Christina	1996	Article
	"Iraqi Cultural Information"	Lutheran Immigration and Refugee Services	1994	Article
	"The Meaning of Marriage and Status in Exile: The Experience of Iraqi Women"	<i>Journal of Refugee Studies</i> , Madawi Al-Rasheed (Vol. 6, No. 2)	1993	Article
	<i>Iraqi Packet</i>	IRSA	1994	Collection of Materials
	The Iraq Foundation	ICOP	1998	Handouts
	<i>Iraqi Refugee Cultural and Psychological Adaptation Issues: Transition Strategies</i>	Jane Nichols: Antioch University		Research Project
	Daily Press Briefing < www.reliefweb.int >	<i>ReliefWeb</i>	1996	WWW

Category	Title	Publisher	Date	Type
	<i>The Problem of the North</i>	Dr. John Garang de Mabior; Institute of International and Strategic Studies	1995 (Dec.)	Speech
	"Nuer Culture: A Profile in Minnesota"	www.umn.edu		WWW
B. Language				
<i>Amharic</i>				
	<i>Instructions for Collections: Sputum</i>	State of NY, Department of Health Albany		
	"Asthma"	Harborview	1995	Article
	"Pediatric Vaccine Administration Record"	State of NY, Department of Health, Albany		Article
	<i>Immunization</i>	Ethiopian Community Association of Chicago		Brochure
	<i>A Guide to Resettlement in the United States</i>	Center for Applied Linguistics		Guidebook
	<i>Hepatitis B Information Sheet</i>	Santa Clara County Refugee Health Services Program		Pamphlet
	<i>TB and INH Pills to Prevent TB</i>	American Lung Association of San Diego and Imperial Counties		Pamphlet
	<i>The PAP Test</i>	Department of Health Services, County of San Diego		Pamphlet
	<i>The Tuberculin Test</i>	Department of Health Services, County of San Diego		Pamphlet
	<i>Get the Facts about AIDS</i>	ECDC AIDS Awareness and Prevention Education Program	1994	Sheet
	<i>Is Your Baby Protected?</i>	Seattle-King County Dept of Public Health		Sheet

Category	Title	Publisher	Date	Type
	<i>Banking</i>	Don Bosco Centers		Orientation Manual
	<i>Employment and Welfare</i>	Don Bosco Centers		Orientation Manual
	<i>Housing</i>	Don Bosco Centers		Orientation Manual
	<i>Rights and Laws</i>	Don Bosco Centers		Orientation Manual
	<i>School System</i>	Don Bosco Centers		Orientation Manual
	<i>Standards of Personal and Public Hygiene/Health</i>	Don Bosco Centers		Orientation Manual
	<i>AIDS</i>	ACCESS		Pamphlet
	<i>AIDS, Questions and Answers</i>	Michigan Department of Public Health		Pamphlet
	<i>Chlamydia</i>	ACCESS		Pamphlet
	<i>Cholesterol</i>	Michigan Department of Public Health		Pamphlet
	<i>Diabetes</i>	Michigan Department of Public Health		Pamphlet
	<i>Genital Herpes</i>	ACCESS		Pamphlet
	<i>Genital Warts</i>	ACCESS		Pamphlet
	<i>Gonorrhea</i>	ACCESS		Pamphlet
	<i>HIV/AIDS</i>	ACCESS		Pamphlet
	<i>Immigration Help</i>	ECDC Multicultural Community Services		Pamphlet
	<i>Syphilis</i>	ACCESS		Pamphlet
	<i>TB Vaccine (BCG): What You Should Know</i>	State of NY; Dept. of Health		Pamphlet
	<i>Trichomoniasis</i>	ACCESS		Pamphlet
	<i>Tuberculosis</i>	State of NY; Dept. of Health		Pamphlet
	<i>You Can Beat TB!: Information for TB Patients</i>	State of NY; Dept. of Health		Pamphlet
	<i>How to Care for Yourself and Your Baby</i>	Ross Laboratories, Columbus, Ohio	1969	Sheet
	<i>"For Your Health" Alcohol: You and Your Baby</i>	CAL (Center for Applied Linguistics)		Sheet

Category	Title	Publisher	Date	Type
	<i>Preventing Birth Defects</i>	International Institute of New Jersey		Sheet
	<i>The Basic Facts: Smoking, Alcohol, Prescription drugs</i>	CAL (Center for Applied Linguistics)		Sheet
	<i>The Tuberculin Test</i>	American Lung Association		Sheet
	<i>Tuberculosis</i>	CAL (Center for Applied Linguistics)		Sheet
<i>Dari</i>				
	<i>TB and INH Pills to Prevent TB</i>	American Lung Association of San Diego and Imperial Counties		Pamphlet
	<i>The Tuberculin Test</i>	American Lung Association of San Diego and Imperial Counties		Pamphlet
<i>Eritrean</i>				
	<i>What Does "Positive" Skin Test Mean?</i>	State of NY, Department of Health, Albany		Sheet
	<i>Preventing Rickets in Breastfed Babies</i>	EthnoMed < http://healthlinks.washington.edu/clinical/ethnomed >	1995	WWW
<i>Farsi</i>				
	<i>POLIO</i>	CAL (Center for Applied Linguistics)		
	<i>Family Planning Birth Control</i>	NY Association for New Americans, Inc.		Brochure
	<i>How to Examine Your Breasts</i>	American Cancer Society	1992	Pamphlet
	<i>The Tuberculin Test</i>	American Lung Association of San Diego and Imperial Counties		Pamphlet

Category	Title	Publisher	Date	Type
	<i>A Guide to Resettlement in the United States</i>	Center for Applied Linguistics	1996	Guidebook
	<i>Xogogaal: About Your Child's Report Card etc.</i>	International Rescue Committee (IRC); (Vol. 1, Issue 5)	1997 (Jun.)	Newsletter
	<i>Xogogaal; U.S. Citizenship etc.</i>	International Rescue Committee (IRC); (Vol. 1, Issue 2.)	1997 (Feb.)	Newsletter
	<i>Banking</i>	Don Bosco Centers		Orientation Manual
	<i>Employment and Welfare</i>	Don Bosco Centers		Orientation Manual
	<i>Health System</i>	Don Bosco Centers		Orientation Manual
	<i>Housing</i>	Don Bosco Centers		Orientation Manual
	<i>School System</i>	Don Bosco Centers		Orientation Manual
	<i>Standards of Personal and Public Hygiene/Health</i>	Don Bosco Centers		Orientation Manual
	<i>Get the Facts About AIDS</i>	ECDC AIDS Awareness and Prevention Education Program	1994	Sheet
	<i>Is Your Baby Protected?</i>	Seattle-King County Dept of Public Health		Sheet
	<i>Pediatric Vaccine Administration Record—Somali</i>	State of NY, Department of Health, Albany		Sheet
	<i>Preventing Rickets in Breastfed Babies</i>	<i>EthnoMed</i> < http://healthlinks.washington.edu/clinical/ethnomed >	1996	WWW
Spanish				
	<i>Welcome to the U.S.</i>	Refugee Service Center: CAL (Center for Applied Linguistics)	1996	Guidebook
	<i>High Blood Pressure—Risk Factors</i>	The Hope Heart Institute		Pamphlet

Category	Title	Publisher	Date	Type
	Asthma < http://www.hslib.washington.edu/clinical/ethnmed/asthmaed.html >	<i>EthnoMed</i>		WWW
	<i>Pediatric Vaccine Administration Record</i>	State of NY, Department of Health, Albany		WWW
C. Islam				
	<i>In Search of Islamic Feminism</i>	Elizabeth Warnock Femea	1998	Book
	<i>Family and Gender Among American Muslims</i>	Barbara Aswad and Barbara Bilge	1996	Book
	<i>Islam</i>	Ismail Al Faruqi, Phd.—Amana Publications	1995	Book
	<i>Strategies & Structures for Presenting World History Using Islam & Muslim History As a Case Study</i>	Susan L. Douglas	1994	Book
	<i>Muslim Legal Directory & Guide to Your Legal Rights</i>	American Muslim Foundation		Book
	<i>Understanding Islam</i>	CAIR (Council on American- Islamic Relations)		Booklet
	<i>Muslim Legal Directory with Educational Addendum: Understanding your Rights</i>	American Muslim Foundation Legal Fund		Copy of Pamphlet
	<i>Al Nur</i>	Islamic Center	1997	Magazine, Quarterly, Winter 97- 98
	<i>Safe and Secure" Eliminating Violence Against Women and Girls in Muslim Societies</i>	SIGI (Sisterhood is Global Institute)	1998	Manual
	<i>Claiming our Rights: A Manual of Women's Human Rights Education in Muslim Societies</i>	SIGI (Sisterhood is Global Institute) Mahnz Afkhanmi Haleh Vaziri	1996	Manual
	<i>An Educator's Guide to Islamic Religious Practices</i>	CAIR (Council on American- Islamic Relations)	1997	Pamphlet

Category	Title	Publisher	Date	Type
	<i>What They Say about Muhammad</i>	The Islamic Center, WDC; WAMY series on Islam No. 4		Pamphlet
	<i>What They Say about the Quran</i>	The Islamic Center, WDC; WAMY series on Islam No. 2		Pamphlet
	<i>Islam and Child Rearing Quotations from the Holy Qura'n on Child Rearing and Breast-feeding</i>	Dr. Ahmed Moen		Paper
	<i>Arab Women: A Profile of Diversity and Change</i>	Nahid Toubia (ed.), The Population Council	1994	Publication
	<i>Islamic Medicine: History and Current Practice;</i> < www.iim.org >	Nagamia, Hasain F., M.D.	1995	WWW
	<i>AWAIR (Arab World and Islamic Resources)</i>	www.dnai.com		WWW
D. Immigration & Refugees				
	<i>A Source Book for Orientation, Language and Settlement Workers</i>	Citizenship and Immigration Canada		Binder
	<i>Immigrants & Refugees: Create your New Life in America</i>	Raimonda Mikatavage, Melodija Books	1998	Book
	<i>Assimilation American Style</i>	Peter D. Salins, Basic Books	1997	Book
	<i>Race, Ethnicity and Self: Identity in Multicultural Perspective</i>	Elizabeth Pathy Salett & Diane Koslow (ed.), NMCI Publications	1994	Book
	<i>Refugee Children: Guidelines on Protection and Care</i>	UNHCR	1994	Book
	<i>Resettlement of Refugees With Special Needs</i>	UNHCR	1999	Booklet
	<i>Six Steps Toward Cultural Competence: How to Meet the Health Care Needs of Immigrants and Refugees</i>	Refugee Health Program, Minnesota Department of Health	1996 (Aug.)	Booklet
	<i>Human Rights and Social Work</i>	UN Centre for Human Rights	1994	Booklet

Section VIII: Education

Outline

- A. Adult Education
- B. ESL

Category	Title	Publisher	Date	Type
A. Adult Education				
	<i>Adult Learning & Literacy Clearinghouse; Bibliography of Resource Materials</i>	Division of Adult Education and Literacy (DAEL)	1997 (Jan.)	Booklet
	<i>A Practitioner's Guide to Reflection in Service-Learning: Student Voices & Reflections</i>	Janet Eyler, Giles Dwight Jr., Angela Schniede. Vanderbilt Univ.	1996	Booklet
	<i>Service Learning Workshop</i>	IRSA	1997 (June 6-7)	Booklet
	<i>Critical Issues in K-12 Service-Learning: Case Studies and Reflections</i>	National Society for Experiential Education		Booklet
	<i>Issues and Options for Refugee Women in Developing Countries</i>	Refugee Policy Group (RPG)		Brochure
	<i>The Adult Education Act (P.L. 100-297) and amended by the National Literacy Act of 1991 (P.L. 102-73)</i>	National Literacy Act	1991	Document
	<i>ESL Volunteerism: A Study of ESL Volunteer Programs in the State of Illinois</i>	Adult Education Travelers & Immigrants Aid of Chicago		Handbook
	<i>Executive Summary; Adult ESL Literacy Programs and Practices</i>	National English Literacy Demonstration Program for Adults of Limited English Proficiency		Handbook
	<i>Adult Learning & Literacy Clearinghouse; Model ESL Transitional Demonstration Programs</i>	Division of Adult Education and Literacy (DAEL)	1995 (July)	Manual

Category	Title	Publisher	Date	Type
	<i>Designing Parent Education Programs for Limited English Proficient Parents</i>	Office of the Washington State Superintendent of Public Instruction	1990	Sheet
	<i>Get It Fast with FactsLine</i>	Division of Adult Education and Literacy (DAEL)		Sheet
	<i>Office of Vocational and Adult Education: A Teacher's Guide to the U.S. Department of Education</i> <www.ed.gov>		1995 Fall	WWW
B. ESL				
	<i>Multilevel ESL Curriculum Guide (General)</i>	Clackamas Community College	1992	Handbook
	<i>Teaching Strategies for Multilevel ESL Classes (Spanish-Fluent Speakers)</i>	Clackamas Community College	1992	Handbook
	<i>English as a Second Language; Literacy Handbook (General)</i>	Chester County Opportunities Industrialization Centers, Inc.		Handbook
	<i>The Connector: Forging Links Between Language and Employment Skills for Adult Immigrants</i>	CAL (Center for Applied Linguistics) (No. 3; Fall/Winter)	1995	Newsletter
	<i>The Connector: Forging Links Between Language and Employment Skills for Adult Immigrants</i>	CAL (Center for Applied Linguistics) (No. 1, Spring)	1995	Newsletter
	<i>The Connector: Forging Links Between Language and Employment Skills for Adult Immigrants</i>	CAL (Center for Applied Linguistics) (No. 2, Summer 95)		Newsletter
	<i>World Language Classes</i>	Interpreter		Newsletter
	<i>Teaching Reading Skills in an ESL Class (General)</i>	Mayer's Commission on Literacy, Philadelphia		Printout
	<i>Teaching Speaking Skills in an ESL Class (General)</i>	Mayer's Commission on Literacy, Philadelphia		Printout
	<i>Teaching Writing Skills in an ESL Class (General)</i>	Mayer's Commission on Literacy, Philadelphia		Printout