

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

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Commission of Public Health
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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.

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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

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- ❖ 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/>)

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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.*

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Notes:

We encourage you to copy and disseminate this Fact Sheet. We ask only that you acknowledge ISED's Refugee Welfare and Immigration Reform Project.

For additional information about the Project, e-mail us or contact us at the address and telephone number at the end of the Fact Sheet.

To the best of our knowledge, information contained in the Fact Sheet was accurate on September 1, 1999. Eligibility requirements for TANF assistance may have changed between then and the date on which you are reading the Fact Sheet.

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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:

We encourage you to copy and disseminate this Fact Sheet. We ask only that you acknowledge ISED's Refugee Welfare and Immigration Reform Project. For additional information about the Project, e-mail us or contact us at the address and telephone number given at the end of this document.

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.

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.

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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This flyer is available on the web (<http://www.ised.org>) in the following languages: Amharic, Arabic, Bosnian (Serbo-Croatian), English, Hmong, Khmer, Kurdish, Russian, Somali, Spanish, Tigrinya, and Vietnamese.

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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Acknowledgments:

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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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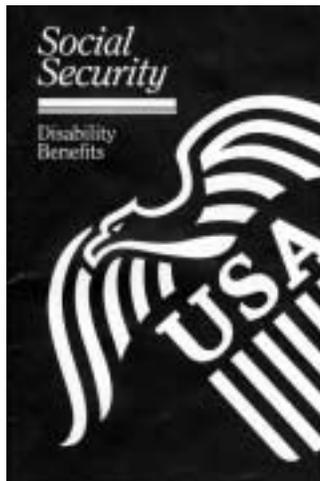
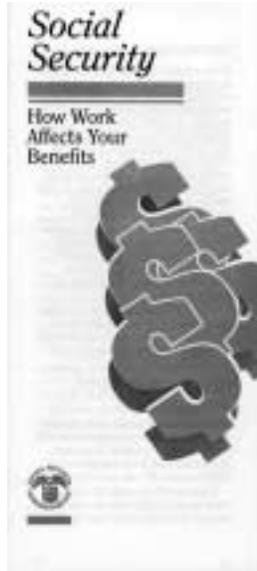
- ❖ Contact ISED to obtain a copy of Fact Sheet: Refugee Eligibility for Food Stamps (available only in English):

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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)*

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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.

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- ❖ 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

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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.

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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	

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.

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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 3—Education/English as a Second Language (ESL)

11. What is your level of education? _____

12. Which languages do you speak? (please list primary language first)

13. Have you attended any English as a Second Language (ESL) classes?
Yes ___ No ___
If yes, how long? _____

14. Are you interested in educational programs other than ESL classes, such as:
___ High School/GED ___ Vocational programs
___ College Other: _____

15. What would keep you from participating in ESL or other educational programs?
___ Not aware of educational opportunities ___ Child care not available
___ Classes are too far from home ___ Clear information not available
___ Transportation not available ___ No one is available to go with you
___ Fees or tuition not available ___ Gender of classmates and/or teacher
___ School officials/teachers insensitive to cultural and/or religious obligations
Other: _____

For Refugee Service Provider:

Section 3—Education/ESL 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 |
| <input type="checkbox"/> Family commitments | |
| <input type="checkbox"/> Female physician/midwife not available | |
| <input type="checkbox"/> Clinic/hospital/physician's office too far from home | |

Other: _____

Journey of Hope

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

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?

- | | |
|-----------------|------------------|
| ___ None | ___ 10 to 15 |
| ___ Less than 5 | ___ 15 to 20 |
| ___ 5 to 10 | ___ 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?

- | | |
|------------|---------------------------|
| ___ Arabic | ___ Somali |
| ___ Amhara | ___ Kurdish |
| ___ 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 |

Journey of Hope

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 | |

