2018 Intramural Emory Global Health Case Competition

Flight & Plight: Refugee Health and Well-Being in Atlanta

EMORY UNIVERSITY

Emory
Global Health Institute

The Emory Global Health Institute Student Advisory Committee
Case Writing Team: Clarissa Myers, Avinash Murugan, and Rachel Safeek
Faculty Advisor: Dr. Parminder Suchdev

All characters described within the case are *fictional* and bear no direct reflection to existing organizations or individuals. The case background and history, however, are meant to portray an accurate representation of circumstances of Atlanta's refugee community. The case scenario is complex and does not necessarily have a correct or perfect solution, and thus encourages a judicious balance of creative yet perceptive approaches. The authors have provided informative facts and figures within the case and appendices to help teams. The data provided are derived from independent sources, may have been adapted for use in this case, and are clearly cited such that teams can verify or contest the findings within their recommendations, if it is pertinent to do so. Teams are responsible for justifying the accuracy and validity of all data and calculations that they use in their presentations, as well as defending their assertions in front of a panel of knowledgeable judges representing different stakeholders.

Introduction

“Life of a Refugee”

Aung Ma jolted awake in her bed, images of her former time in a refugee camp vividly consuming her mind. Nesting back into her sheets, Aung reminisced on the happier moments of her past life in Burma. What used to be a warm awakening to her family and school friends was now replaced with a sullen aura of alienation and lack of familiarity, a sense of “otherness.” As a refugee, Aung’s coming to America was bittersweet. While she longed for the similar closeness and camaraderie she had with her community in Burma, she knew that life there was not possible anymore. She could fill a book with the many horrific events she witnessed. America afforded her safety and security. She and her family were free. This is what ultimately drove her family to seek refuge.

“Happy Birthday!” At once, her two younger brothers and parents had surrounded her with affection. She was 18, no longer a child, and she would begin her adult years living in an entirely new country.

Aung Ma focused her energy on her birthday plans, but the possibility of having a large celebration seemed bleak. The temporary apartment she lived in with her parents and two brothers was superior to the refugee camp, but their home was not completely furnished and she had been sharing a donated mattress with her two younger siblings. Today, the focus was visiting a nearby clinic, where both she and her family would undergo further health screenings in order to establish legal asylum and initiate the process of getting health insurance.

The clinic was an overpopulated melting pot of cultures, languages, and accents. The wait to be seen by a physician seemed prolonged, but eventually a translator was available to speak with Aung and her family with the doctor present. After having reviewed the results of her initial blood draw taken during screening exam, Aung’s doctor asked to speak to her about the results. The words coming out of the translator’s mouth seemed just as foreign as doctor’s speech. Apparently, she had a “positive Hepatitis C” antibody found during her exam. Her doctor believed that she had contracted this after receiving a blood transfusion in her early youth. The doctor discussed liver fibroscans and treatment; he went on to explain that she would need specialized care for her Hepatitis C, and that such care could not be provided to her at a primary care clinic, but by a liver specialist. Her parents looked concerned, but with no insurance and financial insecurities being a primary concern, this still was not their top priority; as a family, they left the clinic feeling confused, scared, and unsure about Aung’s health.

Regardless, Aung left the clinic determined to embrace her new responsibilities as an adult by focusing on getting a job to provide for her family.

If Aung only had the opportunity to seek follow-up care, she would have been informed that her condition had progressed silently over the years. Unfortunately, the happiest event in her and her husband's life — the birth of their first baby girl — was marred by the revelation that the mysterious "positive Hepatitis C" that had been discussed all those years ago at that health clinic had been transmitted to her newborn infant. It was even further upsetting to learn that in the many years between that initial visit and her pregnancy new highly effective anti-virals had been used to successfully cure Hepatitis C, which would have prevented the spread of this disease to her baby.

Prompt for Teams

As a team of multidisciplinary student consultants and experts on refugee health, your team has been asked to submit a proposal to the new president of Atlanta-based Henry University. President Jane Stevenson seeks to establish deeper engagement with Henry University's surrounding community, and is accepting proposals that will help the university achieve this. The proposals you submit should provide avenues for Henry faculty and students to be of service and improve conditions for Atlanta's refugee communities as well as open new teaching and research opportunities for the University. The President's parents were refugees who experienced incredible hardship and overcame adversity and difficult challenges in their lifetimes, thus the matter of refugee health and well-being is meaningful and evocative to President Stevenson. Use this as a motivating factor for your team's presentation.

Each team has been requested to present a well-researched, realistic strategy to enhance refugee health and wellness in and around Atlanta, especially in light of recent policy changes that have the potential to negatively impact the local community. Refugee communities face considerable challenges and obstacles on a daily basis that include the potential loss of social and health services and the fear of being confused as an illegal immigrant. These fears and stressors influence all aspects of refugee life and likely encourage low health seeking behaviors and confounding pre-existing medical conditions such as post-traumatic stress disorder and depression. Careful consideration must be given to the health of refugee populations, specifically chronic health conditions that require both subspecialty services and primary care under a medical home, with adequate consideration for continuity of secondary and tertiary care. You may choose to target one refugee population in Atlanta or approach health and wellness from a broader perspective, but regardless, key health determinants should be addressed. In your proposal, your team may also address assimilation, xenophobia,

education, employment, and other community-related topics such as language, culture, or crime.

As President Stevenson will be presenting the winning student proposal to the Board of Trustees, ethical, legal, and financial considerations must be included as part of your team's proposal. Historically, the Board of Trustees has not prioritized the health of refugee communities, therefore you must deliver your proposal in a manner able to convince the board members of the significance of your strategy or program, including the direct impact on refugees and the indirect impact on the surrounding community and the University.

Your budget for this project is USD 150,000 for a one-year start up. However, attracting donors and in-kind contributions from partners is required to supplement this budget, as well as to demonstrate the long-term growth and sustainability of your team's proposed program. Outline a one-year and five-year plan of your proposed program, and give appropriate thought to whom you will engage to support your proposal — whether within university boundaries, or extending to government, and/or other public or private entities.

Background: History of Refugees in the U.S. and the State of Georgia

Who is a Refugee?

The 1951 United Nations Refugee Convention defines a refugee as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted, because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him - or herself of the protection of that country, or to return there, for fear of persecution." Comparatively, a migrant may leave his or her home country for many reasons unrelated to persecution, and continues to enjoy the protection of his or her own government, even when abroad.[1] Internally displaced persons are individuals who have fled their homes, yet have not crossed an international frontier.[2] To further clarify, the definition of an asylum seeker per the United Nations High Commissioner for Refugees (UNHCR) is someone whose request for sanctuary has yet to be processed.[3] It is worth noting that who is a refugee, migrant, asylum seeker, or an IDP is a legal distinction — but one with certain rights and privileges that nation-states (who become host countries) often politicize.

History and Policy

The history of refugees in the United States (U.S.) began after World War II when more than 250,000 displaced Europeans could not return home. The Displaced Persons Act of 1948

followed this initial resettlement and was the first refugee legislation enacted by Congress.[4] The United States Refugee Act of 1980 was an amendment to two previous Acts: Immigration and Nationality Act, 1965; Migration and Refugee Assistance Act, 1962. Signed by President Jimmy Carter, it was a comprehensive change to U.S. immigration laws intended to improve procedures for the admission and effective resettlement of refugees to the U.S.[5] International refugee law is defined by the 1951 Geneva (Refugee) Convention, with an added protocol in 1976 expanding law to address refugee displacement across the world.[6]

Each stage of refugee resettlement is led by various organizations, and generally the three stages include: 1) overseas processing; 2) determination of individual refugee status; and 3) resettlement in country.[4] Initially, refugees register with the UNHCR in the country from which they fled, which begins the process of determining whether they qualify as a refugee.[7] The Immigration and Nationality Act defines refugees as “any person outside his or her country who has a “well-founded” fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.[8] It is important to note the difference between an immigrant and a refugee: an immigrant relocates based on choice influenced by economic or other factors, whereas a refugee seeks asylum in a country different from their home country due to persecution (or fear of) based on race, religion, nationality, or political opinion.[9,10] UNHCR identifies vulnerable refugees and recommends resettlement options, so refugees have no choice in determining the country they will reside in. The U.S. has historically taken many vulnerable populations including survivors of torture and violence, and those with extensive medical needs; since 1975 three million refugees have resettled in the U.S, across all 50 states.[11] On an annual basis, the President of the United States and Congress determine refugee resettlement priorities and annual ceilings for the upcoming year.[4] In 2016, 96,900 refugees resettled in the U.S., just shy of reaching the ceiling set by President Obama at 110,000; the ceiling was lowered to 55,000 for 2017 and has been set at 45,000 for 2018 [12] — the lowest figure since Ronald Reagan’s ceiling of 67,000 in 1986.[13] The 2018 annual ceiling includes a regional breakdown of potential acceptance across the world: 19,000 from Africa, 5,000 from East Asia, 2,000 from Europe and Central Asia, 1,500 from Latin America and the Caribbean, and 17,000 near East South Asia.[14]

Recent administrative directives released in January, March, and October of 2017 [15,16,17] are changing the climate of refugee resettlement in the United States. Currently, a 120-day suspension of United States Refugee Admissions Program (USRAP) has ended and been replaced with a restricted version with supposed enhanced vetting capabilities; most notably, refugees from the following 11 countries have been banned: Egypt, Iran, Iraq, Libya, Mali, North Korea, Somalia, Sudan, South Sudan, Syria, and Yemen. This ban also affects 2,500 refugee spouses and children under 21 years of age, which accounted for 5% of the refugees admitted in the fiscal year of 2017.[12]

State Resettlement

The vetting process for refugees in the U.S. is extensive, lasting 12-24 months, with screening by eight federal agencies, six security database or biometric security checks, a medical screening, and three in-person interviews with Department of Homeland Security officers.[11] After resettlement in any state, refugees are required to apply for Lawful Permanent Residency (green card application), and after another four years are able to become U.S. Citizens.[18]

The process of reaching a home state is a collaborative effort between the State Department and placement agencies, such as International Rescue Committee, and local communities. Larger states, such as Texas and California, are often better suited to accept refugees; further consideration is given to areas where refugee or immigration communities are already established, and areas where refugees will be able to find employment.[19] Consultation between federal, state, and local governments is required for placement of refugees, to give proper consideration to local factors such as preexisting proportion of refugees, affordable housing, likelihood of refugees becoming self-sufficient, and the likelihood of an area becoming a secondary refugee migration.[8] States provide a recommendation to the federal government, which is weighed heavily in deciding location for resettlement. Understanding how refugee resettlement will impact the community — adversely or otherwise — as well as understanding organizations and assistance that refugees will need are two large factors that are considered by state and local authorities.[8] Funding is provided to states for medical assistance, targeted assistance, and preventative health — assistance is provided directly or through a nonprofit organization that provides such services. The Office of Refugee Resettlement, whose budget for 2015 fiscal year was $1.56 million/year (USD) provides these funds to states, allocating money according to number of resettled refugees.[20]

For example, nearly 1,000 Somali refugees — of 7,000 total in 2014 — settled in Minnesota primarily because of a well- established Somali immigrant community and the Lutheran Church. Now, nearly one third of the Somali-born U.S. population lives in Minnesota.[19]

Health Insurance Enrollment

Upon arrival in the U.S., refugees receive short-term health insurance, Refugee Medical Assistance, a federally funded program that is available for up to eight months. After that time period, some are eligible for Medicaid or the Children's Health Insurance Program (CHIP), and recently with the Affordable Care Act, refugees have the option of purchasing health insurance through the marketplace.[21] Roughly 60% of refugees obtain health insurance through employment, which many have secured by the end of the eight-month time frame. Cultural and language barriers and the complexity of U.S. healthcare system pose a great barrier to quality,

continuous care received by refugees, with nearly 40% of individuals left without health insurance after the end of their first eight months in the country.[22]

Refugee Resettlement in Georgia, USA

In the 2015 fiscal year, 69,920 refugees were admitted into the United States. Of this total, 2,889 individuals, roughly 4% of all newly admitted refugees, resettled in the state of Georgia. As a top ten destination for refugee resettlement in the United States, Georgia has experienced a steady increase in the percent of newly resettled refugees, amounting to the greatest percentage increase observed among the top ten states for refugee resettlement.[23]

Georgia receives a diverse array of refugees from all over the world, with a majority coming from Bhutan, Myanmar, Iraq, and Somalia.[24] In late 2016, Georgia received an increase in refugees from Democratic Republic of the Congo and Syria.[25]

In the state of Georgia, the more than 33,000 refugees who have arrived since 2001 greatly contribute to their communities: 84% of Somali men and 90% of Bosnian men enter the labor force, compared to 81% of U.S. born men; refugee women in the country residing for least 10 years meet or exceed employment rates of U.S. born women. Buford Highway and Clarkston area-businesses are the result of refugee entrepreneurs. Furthermore, the majority of refugees learn English within 10 years of resettlement, and become citizens within the following 10 years.[26] On a smaller scale, refugees in Georgia are a net asset to the state within six months of arrival. Meaning that they are on average, completely financially self-sufficient within their first six months of residency and over time contribute greatly to the local Georgia economy.[18]

"Ellis Island of the South"

As a suburban region of the greater Metro Atlanta area, the city of Clarkston is located 11 miles outside of downtown Atlanta. The city is bisected by a railroad, which emerged in the 1830s, drawing many business owners, including those run by immigrants. The railroad also made work in Atlanta accessible to Clarkston residents, allowing for the city to grow as one of the largest suburban communities in the South. The influence of the railroad is reflected in the name of the city itself, as "Clarkston" was named in honor of Colonel Clark, Director of the Georgia Railroad.

In the 1970s, developers in Clarkston initiated construction of apartment complexes catered to middle-class transplants, who recently moved to Atlanta following the opening of Atlanta's International Airport. However, many recent transplants began settling in other suburban regions leaving vacancies in Clarkston's housing units. Consequently, rent prices dropped and crime began to rise. The fall in rent prices, however, coupled with accessible public

transportation, including the option for commuting into the city of Atlanta, made it a desirable location for newly settled refugees. Beginning in the 1990s, local aid organizations contracted with the federal government and began targeting Clarkston as an area for refugee resettlement.

Beginning in the mid-1990s, the City of Clarkston underwent a gradual shift in community dynamics: schools became filled with children who were non-English speakers, and religious buildings, including mosques, were built. Today, nearly one half of all Clarkston residents are foreign-born, with the majority being refugees. Over 50 languages are spoken across all Clarkston residents.[27]

This culturally and linguistically diverse city faces many challenges, with 32% of residents living below the poverty line in 2013 and one out of every two children living below the poverty line in Clarkston. This poverty rate jumps to 56% when considering only foreign-born Clarkston residents. Furthermore, the uninsured rate correlates to the poverty rate, and research demonstrates that these disadvantaged populations have the greatest health disparities.[28]

Refugee Health

The disease profile of a refugee population mirrors the population health profile of affected communities in their country of origin. Health burdens of communities and individuals dramatically deteriorate during an emergency with increased transmission of communicable disease, but the greatest risk of mortality from disease is actually due to displacement and travel. It is generally accepted that pre-emergency health needs, which then exacerbate and are coupled with known high risk communicable disease transmission, need to be the focus of care in the country of resettlement. UNHCR identified the 10 countries as the largest source of refugees with a high burden of non-communicable diseases (NCD), accounting for up to 62% of total mortality, and a 23-32% range in prevalence of hypertension. Furthermore, a 2012 study found that 51% of refugees arriving in the U.S. had at least one chronic disease, and 9.5% had three or more chronic diseases. NCDs such as cardiovascular disease, hypertension, diabetes, and cancer are plaguing refugee populations, as made evident by the Syrian refugee crisis. It is estimated that 79% of mortality prior to the crisis in Syria was related to NCDs; there is a high prevalence of risk factors associated with NCDs including hypertension, obesity, and smoking in Syria, thus as a country they have undergone an epidemiological transition from a high burden of communicable disease to NCDs.[29]

In addition to what we consider “traditional” chronic diseases, the historically high prevalence of infectious, or communicable diseases, continues to act as a barrier to successful care, treatment, and overall health of refugee populations. A systematic review in the European Union identified high prevalence rates of several infectious diseases that are common among

refugee populations as recently as 2015. Active tuberculosis (TB) was identified to be the most prevalent infectious disease of those crossing international borders, with a higher prevalence of active TB from South Asia and certain parts of Africa. Latent tuberculosis, as reported by several different studies identified a prevalence rate of 14% in Iraqi refugees, 9% in Syrian refugees and as high as 43% in refugee populations from sub-Saharan Africa. Prevalence of Hepatitis B, depending on native location, ranges from 7-11%. Region of origin is a great risk factor in the prevalence of Hepatitis C, as compared to B, with refugees originating from high endemic countries having a higher prevalence than those from different regions of the world. For example, one study in Europe identified a 5% Hepatitis C prevalence for Syrian refugees. Other infectious diseases, including malaria and vaccine-preventable childhood diseases are commonly found to be of higher prevalence in refugee populations.[30]

Continuity of care is critical in effective management and treatment of both communicable and non-communicable diseases — especially infectious diseases that left untreated adopt chronic, long-term disease patterns and treatment demands. During and post-emergency, refugees are often unable to follow recommendations for diet and lifestyle modifications, and often lack access to prescription medications that assist in managing their chronic disease.[31] Furthermore, due to poor living conditions, poor health status prior to emergency, and suboptimal vaccination in children, risk of transmission is a factor to be considered in refugee populations. To conclude, both communicable and non-communicable diseases are of great concern and focus on the present and future health of refugee populations.[30]

The incidence of NCDs and communicable diseases in refugee populations poses a complex problem to the country of resettlement. How do they treat and manage refugees with chronic health conditions that demand continuous, diligent care and frequent monitoring of patient status? [32] Furthermore, the U.S. faces difficulty in providing adequate service to its own citizens with NCDs, therefore the lack of strategies to address NCDs will undoubtedly influence the care received by refugees.[33]

Health Screening Process

A medical screening appointment, as stated above, is a required part of the vetting process for resettlement in the United States. This medical screening is conducted within 30-90 days upon arrival in the U.S, and includes 12 guidelines addressing the following specific health screening topics: hepatitis, HIV, Immunization guidelines, intestinal parasites, lead, mental health, malaria, nutrition and growth, sexually transmitted diseases, and tuberculosis.[34] The purpose of this screening process is first and foremost for treatment and care of refugees, but also to track and report diseases in specific populations, respond to and monitor outbreaks in the U.S. and abroad, and to advise on local health care for refugee populations resettling in the U.S.[35] After the initial required medical screening appointment, follow-up appointments are scheduled

appropriately for refugees and their families, yet it is highly unlikely that refugees return for continued medical care. The barriers preventing refugees from follow-up on their care are not well documented, yet a study on refugees conducted in San Diego identified logistical issues such as transportation, hours of service, wait times, appointment availability, and childcare needs as recurrent themes in barriers to health care utilization. Language was also perceived to be a major barrier, depending on the language of the refugee population seeking healthcare and the languages spoken by healthcare providers.[36]

UNHCR advocates for primary health services, such as those included in the U.S. required medical screening of new refugee arrivals, however advocacy for secondary and tertiary care is severely lacking. For various reasons, including financial and cultural, refugees in Georgia are not receiving multidisciplinary, continuous care. Refugees are persons that have been displaced from their native country and have an entirely new and unstable environment, and as such, they are psychologically stressed, lack healthcare coverage, and lack the tools to overcome these barriers. This contributes to the insurmountable difficulty associated with providing effective secondary and tertiary care to refugees burdened with chronic health conditions.[32]

Refugee Health Services in Georgia

The Georgia Department of Public Health (DPH), DeKalb County Board of Health, and the Clarkston Community Health Center are examples of organizations that offer healthcare options to newly settled refugee populations in Georgia. Their programs focus on providing primary care and preventive services, including general health and well-being screenings as well as immunizations. Many of these programs also offer packages that include dental, mental health and women's health services. The DPH Refugee Health program also assists newly arrived refugees to enroll in Medicaid, expanding their number of available health services. While these organizations are present, they are separate entities entirely, with no referral or linkage systems in place for subsequent care from one organization to another. Therefore, gaps exist between these organizations and provision of their services, resulting in discontinuity in healthcare and other related services for newly resettled refugees. While there are established programs to engage newly settled refugees, there is a need for additional primary care services, ongoing specialized care, nutritional services, physical activity programs, as well as culturally competent health promotion and well-being programs that consider the unique problems faced by refugees during resettlement, including social adjustment, employment, legal support, and health insurance enrollment. Finally, there is a need for affordable care options in the face of Georgia's decision to not expand Medicaid, which has left many more without access to health insurance.

These copious barriers also lead to untraditional patterns of healthcare utilization — urgent care and emergency departments are becoming routine locations for refugees to seek care, primarily when their health insurance expires after their first eight months in country, but also for reasons related to lack of understanding how to access routine care through regularly scheduled visits.[37]

The Clarkston Clinic

The Clarkston Community Health Center is a nonprofit clinic with diverse funding sources including grants and privately donated funds. It was founded in May 2013. The clinic offers comprehensive care, including dental, mental health, preventative care, prescription drug, and women's health services to low-income residents of the Clarkston community, many of whom are refugees, without charge. Recently, however, the Clarkston Clinic has faced issues with capacity, as the patient population has steadily increased, while the number of volunteer nurses and doctors have remained the same. Increases in patient enrollment at the free clinic have been attributed to the reputation of Clarkston, a popular destination for refugees; these issues the Clarkston Clinic is facing was confounded by Georgia's decision to not expand Medicaid, which has left many low-income populations without access to healthcare.

The Ponce Infectious Disease Program of Grady Health System

The Ponce Infectious Disease Program (Ponce IDP), located in the heart of Midtown, is a model for clinics providing comprehensive care for HIV infection and related illnesses in metro Atlanta. As a safety-net clinic, the Ponce IDP serves low-income and often uninsured persons (and their children) living with HIV/AIDS in the greater Atlanta area. The clinic also offers patient education and HIV prevention services, dental and mental health services, and wellness, nutrition and wellbeing supportive services to all patients. There is also a pharmacy on-site for HIV-related medications. Social workers are available to enroll patients who are eligible for the AIDS Drug Assistance Program (ADAP), which assists low-income persons living with HIV/AIDS with the financial burden of their HIV-related treatments. The clinic is renowned for its unique and highly progressive model of care, which affords underserved and vulnerable populations living with HIV access to many health services in one setting.

Social Services

Many organizations, such as The Clarkston Community Center, offer programs for youths, seniors, and a wide array of different courses for refugees recently resettled, with the goal of promoting assimilation in the U.S. These programs are designed to promote language skills, bridge cultural gaps, and overall adjustment to the new country. Refugees are placed in location for resettlement based on various economic and social factors that suggest they will

succeed, so such services are designed to promote independence and economic self-sufficiency. In Georgia, the services to be discussed are generally offered to refugees who have lived in the U.S. for less than five years. Employability Services are offered to refugee and immigrant populations with services including job placement, orientation, vocational English language instruction, and other services addressing specific job training. English Language Instruction services teach communication (speaking, reading, and writing) for employment obtainment; these courses also focus on newly arrived refugees, more specifically focusing on females and/or elderly individuals to promote their language skills and address topics including instruction, childcare, and transportation. Other service areas include Social Adjustment Services, offering integration and emotional counseling, Parent/School Involvement Services to orient and educate parents on local school systems, and Refugee Youth Programs providing services such as after-school and gang-prevention programs.[38]

Food assistance programs are offered through various state, local, and non-profit organizations that are available to low-income populations, including refugees. The United States Department of Agriculture (USDA) offers the Emergency Food Assistance Program that provides food and nutrition at no cost, in emergencies.[39] Other organizations, like International Rescue Committee in Atlanta provides many services, including housing rental assistance and offers nutritious foods on a more regular basis.[40] Housing opportunities — both assistance with rental cost, and finding housing — can be found in Atlanta; many housing options are affordable, as developers are often given tax credits in exchange for lower rent cost that refugee families can afford.[41]

Despite the extensive options for social service support, recent political changes have the potential to greatly impact the continuation of such services offered to resettled refugees. The U.S. State Department recently issued a statement indicating that offices expecting to process less than 100 refugees in the 2018 fiscal year will lose authorization and, therefore, will likely close. This will influence availability of social service support to refugees who have resettled as recently as this past year.[42]

Refugee Employment

After refugees have resettled in Georgia, one of the most important factors determining whether they are able to comfortably adjust to life in their new country is whether each family is able to find a source of employment. Jobs provide income, a support network, and oftentimes, a sense of security. When refugees enter the U.S., they receive full authorization from the U.S. Department of Justice to lawfully obtain employment.[43] According to recent studies, refugees in the United States pay over $21,000 more in taxes than they receive in benefits over their first 20 years in the country.[44] Yet despite being employed overall at a higher rate than other

immigrants, refugees earn a slightly lower average salary of $42,000 per household.[45] While navigating the legal process of employing refugees may be complicated for some employers, there are nevertheless examples of multiple organizations in the Atlanta area that focus primarily on refugee employment training and placement.[46,47] There are even examples of refugees opening their own businesses, such as refugee-founded and operated Refuge Coffee in Clarkston, GA.[48] Finally, refugee employment levels also play a role in refugee healthcare, as employment oftentimes can be correlated with higher rates of health insurance coverage, and increased income can lead to more opportunities for preventative care before major illnesses strike.

Refugee Education

The educational status and opportunities of refugees can be broken down into two main areas: education prior to entering the U.S. and educational opportunities after immigrating. In data from recent years, educational background amongst refugees varied based on country of origin as well as gender, with male refugees being slightly more likely to have finished high school than female refugees, and refugees from Russia, Iran, and Ukraine being the most likely to be highly educated.[41] Certainly, these factors, which are dependent upon country and society of origin, play a significant role in these statistics. Educational opportunities after immigration to the United States vary. In communities such as Clarkston, GA, with a high density of refugees, there are various community-based learning programs for both adults and children. Children often enter the local school system, which is open to a large population of refugee and non-refugee children. In Clarkston, Clarkston High School has students from over fifty countries.[49] Some areas are utilizing technology to improve educational access at scale, as well as implementing programs to aid cross-cultural learning and interaction among students of all backgrounds.[50]

Culture in Clarkston

With a booming refugee population including 57 nationalities and over 50 languages, the culture imbedded in the Clarkston community is unique and vibrant.[51] In the 1970s, the white, lower-middle class began leaving Clarkston and moving to suburban areas, with a slow influx of African-American and Hispanic families, followed soon by refugees. As this pattern continued and more refugees were resettled in Clarkston, familiar languages, food, and culture from across the world emerged throughout the city. The food scene offers a diverse set of choices ranging from a Kathmandu Grill, an Ethiopian cafe, or Myanmar cuisine. Further shopping experiences include the DeKalb Farmers Market where fresh produce, meat, fish, spices, and hard goods are sold representing nearly every culture from around the world.[52] The Clarkston Community Center offers classes that enhance culture and a sense of community. These offerings reflect the multitude of cultures that built the foundation of the

Clarkston community. Such activities and classes offered include Vietnamese Games, Tabala Martial Arts, and Uhuru Drum and Dance Games, representing traditional African Dances from areas such as Senegal and the Ivory Coast. Other opportunities include job fairs, community gardens, and various opportunities for children and adults to further their education and English language skills.[51]

Crime in Clarkston

The crime rate across nearly all categories of crimes including robberies, assault, rape, murder, and other lower-level crimes are greater in Clarkston than surrounding areas, such as Avondale Estates, Stone Mountain, and Decatur, and are also greater than the U.S averages per 100,000 individuals. As compared to other U.S. cities, Clarkston has a crime index 92.9% greater than other U.S. cities.[53] The total crime rate in Clarkston is 43.47 per 1,000 residents, with nearly 531 crimes (both violent and property) occurring annually. The rate of violent crime, at 6.06 per 1,000 residents is higher than the rate of 3.78 in Georgia and the national median of 3.8. A similar trend holds true for property crime in Clarkston.[54] Crime tracking is now accessible to the public through Crime Mapping, a free application that allows Clarkston residents to stay informed about recent crimes. The Clarkston Police Department hopes this will assist in crime prevention and reduction.[55] Other safety measures offered and implemented by the Clarkston Police Department include a House Check Form, which allows residents to request police officers to check on their house while they are away, and educational classes for the community on personal protection.[56]

Legal Aid for Refugees

For many refugees, legal processes are an ongoing part of regular life. While their initial immigration process can be highly procedural and filled with paperwork, once they have settled into their new life in this country, many scenarios can arise in which legal counsel can be advantageous or even required. These can include obtaining and maintaining legal employment, adapting to changes in immigration policy, domestic abuse issues, and even in some cases, help with establishing new businesses in the community. In these difficult times in refugees' lives, the complicated legal environment of the U.S. can be very difficult for refugees to understand and navigate by themselves.

Traditional legal counsel can be very expensive, and as such, there are a multitude of reduced cost and pro bono legal resources available to refugees in Georgia, split typically between services offered by NGOs and reduced cost attorneys.[57] For certain immigration-law related issues, where a refugee may find themselves facing deportation from the country, the U.S. Department of Justice's Executive Office for Immigration Review offers a Legal Orientation Program, where select refugees can obtain pro-bono counsel from attorneys.[58] In Georgia, there are a wide range of pro-bono attorney networks as well as local charitable organizations, such as the Georgia Asylum and Immigration Network and Catholic Charities of Atlanta that provide support to refugees in need of legal aid.[59,60] In fact, Emory Law School students often

work for many of these organizations, under the supervision of attorneys, on refugee legal cases.[61]

Example of Other U.S. Refugee Communities

Minnesota

In three decades, over 97,000 refugees have resettled in Minnesota, including large populations of Hmong, Somali and Vietnamese.[62] Resettlement of certain populations to common areas is strategic: for example, nearly 1,000 Somali refugees — of 7,000 that resettled in 2014 — ended up in Minnesota primarily because of a well- established Somali immigrant community and the Lutheran Church. Now, nearly one third of the Somali-born U.S. population lives in Minnesota.[19] Organizations exist to facilitate a smooth, successful transition, such as the Karen Organization of Minnesota — a social service agency founded by Karen refugees of Burma with a sole mission of enhancing the quality of life of Burmese refugees in Minnesota. The Karen Organization was founded by refugees, demonstrating their success and the support they provide to new refugees. They maintain their Karen culture, while helping refugees assimilate to the U.S.[63] Larger organizations also exist, like the International Institute of Minnesota, providing a broader range of services to refugees: encompassing workforce development; education; immigration and citizenship; and additional services (presentations, passport photos).[64]

Washington

During 2016, Washington State accepted 1,135 refugees, 463 of whom were children from 28 different countries including Ukraine, Afghanistan, and Iraq. World Relief Seattle is an organization that assists refugees in finding stable housing, learning English, and securing employment, with a unique focus on friendship and making connections. One-on-one volunteerism is how they establish and support friendship and connection development, with 13% of 110 households in 2017 being connected to a committed volunteer within six months of resettlement in the U.S. Volunteer responsibilities include visiting with families three to four times per month, exploring the local community with the family, and familiarizing them with American culture and customs.[65]

References

1.) The 1951 Refugee Convention. UNHCR. http://www.unhcr.org/en-us/1951-refugee-convention.html

2.) Refugees and displaced persons protected under international humanitarian law. International Committee of the Red Cross. https://www.icrc.org/en/document/protected-persons/refugees-displaced-persons

3.) Asylum-Seekers. UNHCR. The UN Refugee Agency. http://www.unhcr.org/en-us/asylum-seekers.html

History and Policy

4.) History of the U.S. Refugee Resettlement Program. Refugee Council USA. http://www.rcusa.org/history/

5.) The Refugee Act. August 29, 2012 . Retrieved on November 6, 2017. Office of Refugee Resettlement. https://www.acf.hhs.gov/orr/resource/the-refugee-act

6.) What is a Refugee? https://www.unrefugees.org/refugee-facts/what-is-a-refugee/

7.) Refugee Admissions. U.S. Department of State. **https://www.state.gov/j/prm/ra/**

8.) The Roles of States in the Refugee Resettlement Process. Federation for American Immigration Reform. https://fairus.org/issue/legal-immigration/role-states-refugee-resettlement-process

9.) Refugees & Asylum. (11/12/2015). https://www.uscis.gov/humanitarian/refugees-asyl

10.) Martinez, M., Marquez, M. July 16, 2014. What's the difference between immigrant and refugee? CNN http://www.cnn.com/2014/07/15/us/immigrant-refugee-definition/index.html

11.) Refugees in America. https://www.unrefugees.org/refugee-facts/usa/

12.) Trumps new refugee policy would slash entries to U.S. by nearly half. October 26, 2017 https://www.usatoday.com/story/news/world/2017/10/26/analysis-revamped-refugee-program-could-block-half-refugees/800609001/

13.) Davis, J.H., Jordan, M. Trump Plans 45,000 Limit on Refugees Admitted to U.S. New York Times. September 26, 2017. https://www.nytimes.com/2017/09/26/us/politics/trump-plans-45000-limit-on-refugees-admitted-to-us.html

14.) Background Briefing: U.S. Government Officials on the refugee cap for fiscal year 2018. https://www.state.gov/r/pa/prs/ps/2017/09/274464.htm

15.) Executive Order Protecting The Nation From Foreign Terrorist Entry Into The United States https://www.whitehouse.gov/the-press-office/2017/03/06/executive-order-protecting-nation-foreign-terrorist-entry-united-states

16.) Executive Order Protecting The Nation From Foreign Terrorist Entry Into The United https://www.whitehouse.gov/the-press-office/2017/03/06/executive-order-protecting-nation-foreign-terrorist-entry-united-states

17.) Presidential Executive Order on Resuming the United States Refugee Admissions Program with Enhanced Vetting Capabilities https://www.whitehouse.gov/the-press-office/2017/10/24/presidential-executive-order-resuming-united-states-refugee-admissions

18.) Refugees in Georgia: The Facts http://www.welcomingrefugees.org/sites/default/files/documents/resources/CRSA-RefugeesInGATheFacts.pdf

19.) Where refugees go in America. The Washington Post. https://www.washingtonpost.com/news/wonk/wp/2015/09/11/where-refugees-go-in-america/?utm_term=.c8c5a55754d3

20.) The US Refugee Resettlement Program: A primer for policymakers http://www.ncsl.org/research/immigration/the-u-s-refugee-resettlement-program-a-primer-for-policymakers.aspx

21.) Health Insurance. Office of Refugee Resettlement. October 19, 2015 https://www.acf.hhs.gov/orr/health

22.) Norris, L. Georgia and the ACA's Medicaid Expansion: Lawmakers might consider modified expansion during 2017 season. September 29, 2016 https://www.healthinsurance.org/georgia-medicaid/

23.) Mossaad, N. (2016). Refugees and asylees: 2014. Annual flow report, April. US Department of Homeland Security, Office of Immigration Statistics.

24.) Georgia Refugee Arrivals by Country of Origin and County of Residence Calendar Year 2012. May 21, 2013. **https://dph.georgia.gov/sites/dph.georgia.gov/files/RHP-2012.pdf**

25.) Redmond, J. (2017). Georgia's 'Ellis Island of the South' braces for Trump's ban. The Atlanta Journal-Constitution.

26.) Refugees help make GA a better place! https://gbpi.org/2016/refugees-help-make-georgia-a-better-place/

27.) John WS. Clarkston, GA. September 22, 2007. The world comes to Georgia, and an old church adapts. The New York Times.

28.) Our Mission — History & Background. Clarkston Community Health Center. https://www.clarkstonhealth.org/philosophy

29.) Policy Brief, Syria's health: the silent burden of chronic diseases. Syria Public Health Network. http://www.syriahealthnetwork.org/attachments/article/34/NCD%20SPHN%20report.pdf

30.) Eiset, A.H., Wejse, C. Review of infectious diseases in refugees and asylum seekers — current status and going forward. Public Health Reviews. 2017 38:22. https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-017-0065-4

31.) Lebanon: Treating chronic diseases among Syrian refugees, a priority for MSF. Medecins Sans Frontieres. April 2014 http://www.msf.org/en/article/lebanon-treating-chronic-diseases-among-syrian-refugees-priority-msf

32.) Miriam Rabkin, Fouad M. Fouad & Wafaa M. El-Sadr (2018) Addressing chronic diseases in protracted emergencies: Lessons from HIV for a new health imperative, Global Public Health, 13:2, 227-233 http://www.tandfonline.com/doi/pdf/10.1080/17441692.2016.1176226?needAccess=true

33.) Amara, A.H., Aljunid, S.M. Noncommunicable diseases among urban refugees and asylum-seekers in developing countries: a neglected health care need. Globalization and Health. February 2014. 10:24. https://globalizationandhealth.biomedcentral.com/track/pdf/10.1186/1744-8603-10-24?site=globalizationandhealth.biomedcentral.com

34.) Guidelines for the U.S. Domestic Medical Examination for Newly Arriving Refugees. February 6, 2014. Centers for Disease Control and Prevention. https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html

35.) Immigrant and Refugee Health. June 22, 2016. Centers for Disease Control and Prevention. https://www.cdc.gov/immigrantrefugeehealth/index.html

36.) Morris, MD., Popper, S.T., Rodwell, T.C., Brodine, S.K., Brouwer, K.C. Healthcare Barriers of Refugees Post-resttlement. J Community Health. 2009 Dec; 34(6): 529-538. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2778771/

37.) Heavey, S. Refugees, undocumented immigrants often face 'roundabout care'. May 9, 2017 Association of Health Care Journalists. https://healthjournalism.org/blog/2017/05/refugees-undocumented-immigrants-often-face-roundabout-care/

38.) Refugee Program. Georgia Division of Family and Children Services .https://dfcs.georgia.gov/refugee-program#eli

39.) The Emergency Food Assistance Program. Georgia Division of Family and Children Services. https://dfcs.georgia.gov/emergency-food-assistance-program

40.) Rescue Lives in Atlanta, GA. International Rescue Committee. https://www.rescue.org/united-states/atlanta-ga#how-does-the-irc-help-refugees-in-atlanta

41.) Finding Affordable Housing. Office of Refugee Resettlement. September 2017. https://www.acf.hhs.gov/orr/resource/finding-affordable-housing

42.) Exclusive: State Department Tells Refugee Agencies to Downsize U.S. Operations. U.S. News December 21, 2017. https://www.usnews.com/news/us/articles/2017-12-21/exclusive-state-department-tells-refugee-agencies-to-downsize-us-operations

43.) Legal Issues in Refugee Employment. http://www.refugeesinpa.org/employingrefugees/legalissuesemployment/index.htm

44.) Kopf, D. June 15, 2017. Refugees in the US quickly pay more in taxes than they get in benefits, according to new research. Quartz. https://qz.com/1005073/new-research-shows-refugees-in-the-us-pay-more-to-government-than-they-receive/

45.) Economic and Social Research Council, Shaping Society. http://www.esrc.ac.uk/research/

46.) Global Growers Network. https://www.globalgrowers.org/

47.) Atlanta Refugee Staffing Agency — Amplio Recruiting. August 20, 2015. https://ampliorecruiting.com/atlanta-recruiting-staffing/

48.) Refuge Coffee Co. http://refugecoffeeco.com

49.) Giambalvo, E. May 19, 2017. Refugees, immigrants help Georgia high school build diverse cross country dynasty. http://www.espn.com/sports/endurance/story/_/id/19389944/refugees-immigrants-help-georgia-high-school-build-diverse-cross-country-dynasty

50.) Clarkston Community Center. https://clarkstoncommunitycenter.org/technology

51.) Clarkston Community Center. https://clarkstoncommunitycenter.org

52.) Ellis Island South: Welcome to the most diverse square mile in America http://www.atlantamagazine.com/great-reads/ellis-island-south-welcome-diverse-square-mile-america/

53.) Crime rate in Clarkston, Georgia (GA): murders, rapes, robberies, assaults, burglaries, thefts, auto thefts, arson, law enforcement employees, police officers, crime map. http://www.city-data.com/crime/crime-Clarkston-Georgia.html

54.) Clarkston, GA. Crime Rates. https://www.neighborhoodscout.com/ga/clarkston/crime

55.) City of Clarkston.Crime Mapping http://clarkstonga.gov/crime-mapping/crime-mapping.html
56.) City of Clarkston. http://clarkstonga.gov

57.) Legal Aid Information. UNHCR – The UN Refugee Agency. http://www.unhcr.org/en-us/legal-aid-contact-information.html

58.) Legal Orientation Program. The United States Department of Justice. https://www.justice.gov/eoir/legal-orientation-program

59.) Georgia Asylum and Immigration Network (GAIN). Georgia Legal Aid. November 13, 2012. https://www.georgialegalaid.org/organization/atlanta-bar-asylum-project/immigrant-rights-immigration/political-asylum-and-refugee-status?ref=8VDIL

60.) Immigration Legal Services. Catholic Charities Atlanta. https://catholiccharitiesatlanta.org/immigration-legal-services/

61.) Pro Bono Program. Emory Law. http://law.emory.edu/careers/public-interest/pro-bono-service.html

62.) About Refugees: Refugees in Minnesota. Twin Cities World Refugee Day. http://tcworldrefugeeday.org/aboutrefugees-2/

63.) Karen Organization of Minnesota. https://www.mnkaren.org/about/

64.) International Institute of Minnesota. https://iimn.org/programs/.

65.) World Relief Seattle https://worldreliefseattle.org/impact

66.) Interactive Map of Refugee Crisis. Mashable. http://mashable.com/2017/06/06/refugee-crisis-map-explorables/#jOilxoOTHmqi

67.) A visual guide to 75 years of major refugee crises around the world. The Washington Post. https://www.washingtonpost.com/graphics/world/historical-migrant-crisis/

68.) U.S. Refugee Resettlement Agency Map. Refugee Congress. February 16, 2017http://refugeecongress.org/u-s-refugee-resettlement-agency-map/

69.) Guo, J. Where Refugees go in America. September 11, 2015. The Washington Post https://www.washingtonpost.com/news/wonk/wp/2015/09/11/where-refugees-go-in-america/?utm_term=.f08c0e26dd8f

70.) State of Georgia Refugee Program: Reports & Data. Georgia Refugee Community. https://garefugees.wordpress.com/state-reports-data/

71.) Miriam Rabkin, Fouad M. Fouad & Wafaa M. El-Sadr (2018) Addressing chronic diseases in protracted emergencies: Lessons from HIV for a new health imperative, Global Public Health, 13:2, 227-233 http://www.tandfonline.com/doi/pdf/10.1080/17441692.2016.1176226?needAccess=true

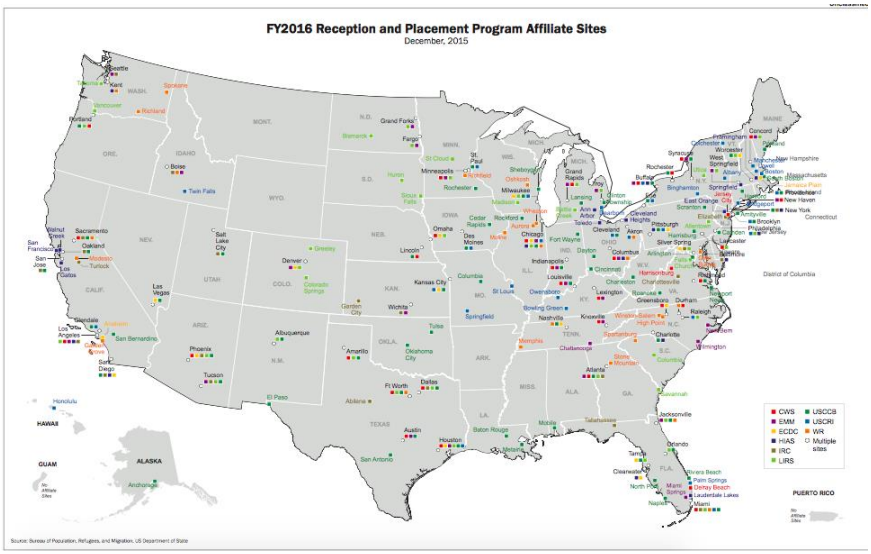
Appendices

1.) Office of Refugee Resettlement Budget [20]

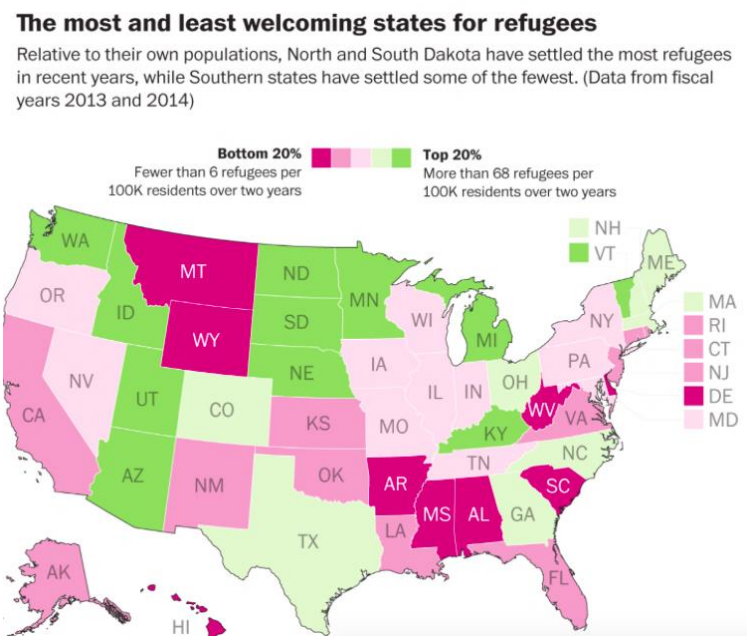
What Is the Budget for Refugee Resettlement?

CORE LINE ITEMS IN REFUGEE RESETTLEMENT BUDGET	
Transitional cash and medical assistance	$383 million
Social services such as English language and vocational training	$150 million
Targeted assistance	$48 million
Victims of trafficking	$13 million
Victims of torture	$11 million
Victims of domestic trafficking	$3 million
Preventative health	$4.6 million
Total	$582 million

2.) U.S Refugee Resettlement Agency Map [68]



3.) Where Refugees go in America [69]



4.) Newly settled refugees in Georgia by Country of Origin [70]

Country of Origin	Grand Total (since 2001)	Total from past 5 years (2010-14)
BURMA	6929	3722
BHUTAN	5437	3161
SOMALIA	3831	1283
IRAQ	2419	1174
DEMOCRATIC REPUBLIC OF CONGO	978	648
ERITREA	901	429
IRAN	811	322

5.) Refugee Arrivals by Georgia County for FY 2015 (Oct 1 – Sept 30) [70]

County Name	Total
Chatham	52
Cherokee	5
Cobb	11
Coffee	3
DeKalb	539
Fulton	1180
Gwinnett	65
Hall	2

Houston	1
Madison	1
Oconee	1
Grand Total	**1860**

6.) Percentage of Deaths cause by NCD's in largest source countries of refugees, 2014 [71]

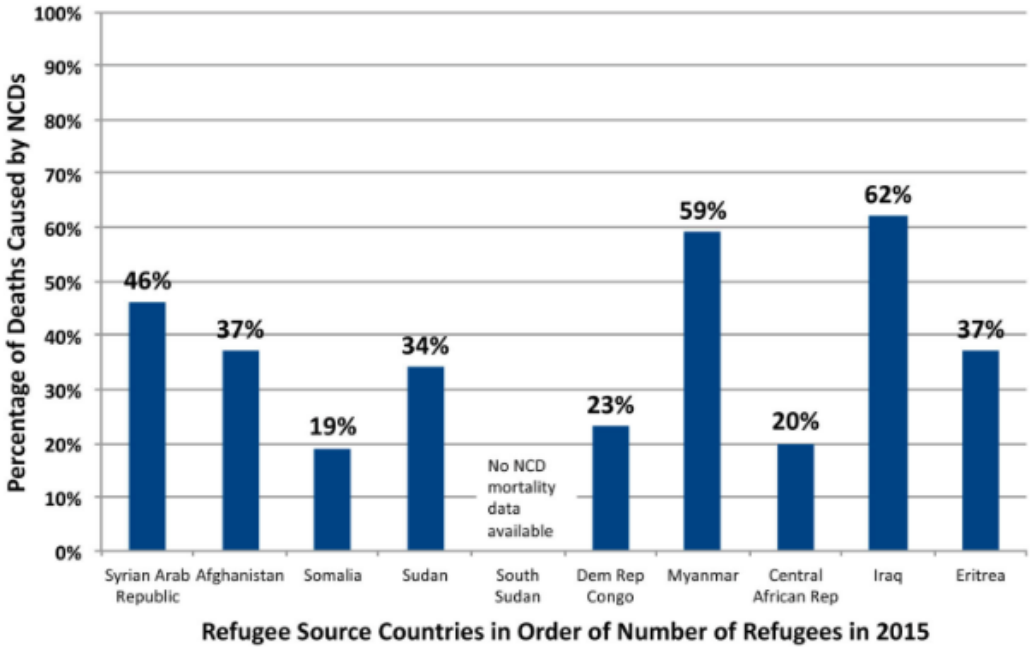


Figure 1. Percent of total deaths caused by non-communicable diseases in the largest source countries of refugees in 2014 (Adapted from: WHO NCD Country Profiles and UNHCR 2015).