An Assessment of the Health of Iraqi Refugees in Chicago

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Introduction

Heartland Alliance Refugee Health Programs (RHP) has been successful in engaging Burmese and Bhutanese refugees newly resettled in Chicago in its health and nutrition education and outreach programs. Given the rise in the number of Iraqi refugees resettling to Chicago over the past year, RHP had hoped to see more Iraqis engaging in their services, but it has not yet happened. However, the low level of Iraqi engagement in refugee services is not unique to RHP. Before this assessment was conducted, RHP had collected similar anecdotal information from resettlement agency staff regarding the lack of Iraqi participation in their programs and services. Discussions among RHP staff and with clinicians working with the newly arriving Iraqi refugees led RHP to suspect that the major health issues and health education needs of the Iraqi refugee population differed from those of other refugee populations resettling to Chicago.

In an effort to improve its health education outreach to Iraqi refugees and collaborate more effectively with other agencies, RHP undertook an assessment of the health of the newly arrived Iraqi refugee population living in the Chicagoland area. The assessment identified the major health issues newly arrived Iraqi refugees living in Chicago were experiencing as well as their major health education needs. It also assessed how those issues were currently being addressed along with the associated challenges and barriers. The assessment additionally sought to highlight effective modes of outreach to Iraqi refugees in Chicago, existing assets that can be utilized in reaching out to the population, and strengths in the Iraqi refugee community that can be built upon to improve upon their health and improve their health knowledge. The purpose of this report is to summarize the findings of that assessment and provide RHP and other key stakeholders recommendations on how they might more effectively address the major health needs of newly arrived Iraqi refugees in Chicago that have been identified through the assessment.

Background

The Situation in Iraq and the Surrounding Region

The Displacement of Millions

While Iraq has experienced the problem of internal displacement in past years, the newest wave started in 2003 with the US-led invasion of Iraq. From 2003 to 2005, 402,000 people were displaced from their homes. When the Askirya shrine in Samarra was bombed in 2006, sectarian violence spread across Iraq and led to the displacement of an additional 1.6 million people within the country (Morton & Burnham, 2008). By 2007, “One of the largest forced population movements in the region since 1948 was going largely unnoticed and placing a heavy burden on the Syrian Arab Republic and Jordan in particular, as well as on Lebanon, Egypt and Iran” (Refugee Studies Centre, 2007, p4). That same year, UNHCR estimated that 2.2 million Iraqis were living outside

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1 Here on out simply referred to as Chicago. For anything specifically referring to the city and not the surrounding suburbs, it will be written specifying “the city of Chicago.”
of Iraq, with an estimated 750,000 of them living in Jordan at the time, another 1.2 to 1.4 million in Syria, 40,000 in Lebanon, about 10,000 in Turkey, 80,000 in Egypt, 54,000 in Iran, and an estimated 200,000 in the Gulf States (UNHCR, 2007). In March of 2008, the International Organization for Migration (IOM) estimated 80 percent of refugees in the region “originated from Baghdad, with half identifying themselves as Sunni and around 25 percent as Shiite” (Lischer, 2008, p102). In 2009, the United States DHHS reported estimates given by the Iraqi government and IOM of a total of 2.8 million IDPs in Iraq as well as more than 40,000 third-country refugees, consisting mainly of Palestinians and Iranian Kurds.

Table 1 Number of Iraqis Seeking Asylum by Country of Asylum

<table>
<thead>
<tr>
<th>Country of Asylum</th>
<th>Number of Iraqis Seeking Asylum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syria</td>
<td>1.2 – 1.4 million</td>
</tr>
<tr>
<td>Jordan</td>
<td>750,000</td>
</tr>
<tr>
<td>Egypt</td>
<td>80,000</td>
</tr>
<tr>
<td>Iran</td>
<td>54,000</td>
</tr>
<tr>
<td>Lebanon</td>
<td>40,000</td>
</tr>
<tr>
<td>Turkey</td>
<td>10,000</td>
</tr>
<tr>
<td>Gulf States</td>
<td>200,000</td>
</tr>
</tbody>
</table>

Source: United Nations High Commissioner for Refugees, 2007 data

The majority of displacement has been caused by sectarian violence and persecution (United States Department of Health and Human Services [US DHHS], 2009; Lischer, 2008). However, Ghareeb, Ranard and Tutunjii (2008) give a clear description of the complexity of the situation as it affects people in Iraq from various ethno-religious groups, political parties, and even occupations:

People flee Iraq for different reasons. For Muslims, Sunni–Shi’i violence is the most common reason for flight. Members of non-Muslim minorities, including Baha’is, Christians, Jews, Sabean-Mandaean, and Yazidis, have increasingly become targeted for religious reasons or because of their ethnicity. Still other Iraqis have suffered persecution for political reasons. They are supporters, or perceived to be supporters, of the former regime, the insurgency, the current Iraqi government, or the multinational forces. People who are accused of un-Islamic behavior, as well as members of certain professions, such as doctors, journalists, actors, and artists, have also been targeted. Women in Iraq, particularly female heads of households or single women without male protection, form a vulnerable target for militias, insurgents, Islamic extremists, and family members seeking to commit honor killings (the growing practice in Iraq of killing a woman believed to have shamed the family in some way) (p30).
Still, Ghareeb, Ranard and Tutunji (2008) suggest the Assyrian and Chaldean communities in Iraq are at an even greater risk of experiencing violence against them for many reasons including their lack of a militia to protect them from attack, accusations that they are distributing political propaganda in support of the multinational forces, the fact that they have traditionally run businesses the extremist groups do not approve of (like establishments selling alcohol), and the perception that their communities are wealthier than others and would thus be “a good target for kidnappers” (p30).

The large population of Palestinian refugees that was living in Iraq at the time of the 2003 invasion has also been determined to be one of the most vulnerable groups and a priority group for resettlement in the United States. When the invasion began in 2003, approximately 35,000 Palestinian refugees were estimated to be living in Iraq, while in early 2010, the estimated number of Palestinians still in Iraq was only 11,000 (Campbell, 2010). Many of them had been in Iraq since 1948, but after the conflict erupted in 2003, they found themselves “left threatened, stateless and largely neglected by the international community” (Refugee Studies Centre, 2007, p21). By 2007, the United Nations High Commissioner for Refugees (UNHCR) (2007) had received “unconfirmed reports of multiple kidnappings, rapes, and murders” of Palestinian refugees in Baghdad as well as reliable reports of the murder of roughly 600 Palestinians in Baghdad since 2003 (Refugee Studies Centre, 2007). Until recently with increasing numbers being admitted for resettlement in other parts of the world, the Palestinian population in Iraq had found it difficult to leave the country and claim asylum in surrounding countries due to not having the proper documentation to do so (UNHCR, 2007). Hundreds if not thousands ended up in terrible living conditions, stranded in refugee camps in Iraq close to the Syrian-Iraqi border or in camps in Syria and Jordan (Morton & Burnham, 2008).

Internally displaced persons (IDPs) within Iraq and those seeking asylum in countries surrounding Iraq have experienced many extreme hardships in addition to the violence or threats of violence they and their families are currently facing or are in fear of experiencing. They often experience isolation and fear leaving their place of refuge, not knowing who they can trust or out of fear of attack (Teff & Calabia, 2009). They frequently experience limited mobility and the inability to travel to certain areas because of their ethnicity, religion, or past or current political affiliations (Younès, 2007). Reports have suggested there are an inadequate amount of international assistance and government services to the IDPs in Iraq and refugees in the surrounding region, and organizations serving IDPs in Iraq and refugees in the surrounding region have struggled with insufficient resources and capacity to meet their needs (Younès, 2007; Refugee Studies Centre, 2007).

Many IDPs have fled their cities of origin and have moved to urban centers instead of refugee camps, with only one percent of IDPs, mainly Palestinians, found to have been living in refugee camps in 2008 (Lischer, 2008; UNHCR, 2009). Their housing situations are often overcrowded, unsafe, and unsanitary (Lischer, 2008). UNHCR estimated that about 33 percent of Iraqis displaced from their homes in 2006 and 2007 are now squatters living in slum areas (Campbell, 2010). Those Iraqis able to flee to surrounding countries have also moved to urban centers, usually the capital city,
and have experienced temporarily somewhat better conditions, but these conditions are unsustainable (Ghareeb, Ranard, & Tutunji, 2008). They often live in conditions like those of their non-Iraqi neighbors, and some may have come with a substantial amount of wealth, although most of those arriving after the bombings in 2006 arrive with very little (Ghareeb, Ranard, & Tutunji, 2008). Either way, the Iraqis are generally viewed as temporary guests by those countries and are unable to work. While there are some opportunities to access local healthcare and education services in some countries, including Jordan and Syria, without being able to work in these countries, whatever savings with which they may have arrived are usually quickly depleted, leaving some to “[turn] in desperation to crime, prostitution, and child labor” (Lischer, 2008, p119; UNHCR, 2009).

Health in Iraq

Although the health system in Iraq used to be one of the strongest in the region, the Iraq-Iran War of the 1980s, the Persian Gulf War of 1990-1991, and most recently, the U.S.-led invasion beginning in 2003, have all led to its deterioration (Vallejo, Simon, & Zou, 2009; Ghareeb, Ranard, & Tutunji, 2008). Since the beginning of the 2003 invasion of Iraq, chronic food insecurity has become one of the biggest issues, affecting an estimated four million Iraqis in 2007 (Refugee Studies Centre, 2007). Most Iraqis are unable to access the Public Distribution System that distributes daily food rations due to bureaucratic inefficiencies, corruption, and a lack of proper documentation to register in their new places of refuge (Youhès, 2007; Refugee Studies Centre, 2007; Younès & Rosen, 2008; United Nations Development Programme, Regional Bureau for Arab States [UN RBAS], 2009). Electricity and clean water are limited in supply, and unsanitary conditions have contributed to outbreaks of cholera, typhoid, and other diarrheal, gastrointestinal tract and dermatological diseases, although increased attention was given these needs following a large outbreak of cholera in October 2007 (Refugee Studies Centre, 2007; Morton & Burnham, 2009; IOM, 2009; IOM, 2008). Still, as the Refugee Studies Centre (2007) reported, “Iraq – once the Middle East’s most developed country – today has benchmarks and indicators normally associated with developing countries…Only 32% of Iraqis have access to safe drinking water” (p27).

Considering Iraq already had high chronic disease rates similar to those in the West, the recent rise in infectious disease rates has led to a “double burden of disease” within the Iraqi population (WHO, 2007).

Maternal and child health in Iraq has been severely affected by the crisis as well. Although Iraqi women experienced more freedom than women in other parts of the Middle East before the 2003 invasion, recently the increasing power of radical religious groups within Iraq has resulted in the loss of many of the rights women previously held (Ghareeb, Ranard, & Tutunji, 2008; Teff & Calabia, 2009). There have been increasing reports of gender-based violence, including sexual abuse and rape, which has consequently led to an increase in the incidence of sexually transmitted infections (Teff & Calabia, 2009; Refugee Studies Centre, 2007). Maternal mortality has risen, as well as the number of miscarriages (Morton & Burnham, 2008). Moreover, prenatal, maternity, and postnatal care rates have decreased (Morton & Burnham, 2008). The Refugee Studies Centre (2007) told this tragic story of pregnancy complications experienced in Iraq by the wife of an Iraqi man they interviewed named Hani:
My wife had complications when she gave birth to our son but we were sent to a hospital that didn’t have an intensive care unit. I had to take her to another hospital but I didn’t have enough money to pay for it, and there were no ambulances to transport her and the baby and give them oxygen. I had to go to a friend and borrow money and then transport my wife in a taxi. By the time I reached the second hospital, my new-born son had died in the taxi (p36).

The high maternal mortality ratio in Iraq and number of pregnancy complications are likely related to the fact that about 45 percent of births in Iraq are like the one described above: they do not take place at a health institution and may not be attended by a skilled birth attendant (WHO, 2007).

With respect to child health, the Iraqi Ministry of Health estimates roughly half of the children in Iraq are experiencing some form of malnourishment (Ghareeb, Ranard, & Tutunji, 2008), and child leukemia rates have seen significant increases because of radiation exposure (Refugee Studies Centre, 2007). The under five mortality rate in Iraq rose from 56 deaths per 1000 live births in 1990 to 130 in 2003, or one in eight children (Burkle, Woodrumm, & Noji, 2005; Refugee Studies Centre, 2007; WHO, 2007). In addition, children’s mental health is a great point of concern as a result of the violence and instability. Some, especially boys, have been forced into sex work (Refugee Studies Centre, 2007).

Mental health is a serious concern. Iraqis have experienced considerable trauma since the start of the crisis in 2003, contributing to a significant rise in anxiety, depression, and other mental health disorders (UN RBAS, 2009). In 2008, UNHCR reported that in Syria, 89.5 percent of the 745 refugees interviewed suffered from depression, 81.6 percent from anxiety, and 67.6 percent from Post Traumatic Stress Disorder (PTSD) (Ghareeb, Ranard, & Tutunji, 2008). “77% of respondents had experienced air bombardments, shelling, or rocket attacks; 80% had witnessed a shooting; 68% had undergone interrogation or harassment by militias; and 75% knew someone close to them who had been killed” (Ghareeb, Ranard, & Tutunji, 2008, pp31-32). Even so, mental health services in Iraq and the surrounding region for Iraqis experiencing these traumas has generally been severely lacking (Morton & Burnham, 2008). Programs like Heartland Alliance International Programs are working to fill the gap in services.

Health status has been further threatened due to the flight, beginning in 2003, of the professional class in Iraq who were more likely to receive targeted threats and had the resources to be able to leave the country as soon as the crisis began (Morton & Burnham, 2008; Lischer, 2008; UN RBAS, 2009). A study conducted by Oxfam in partnership with the NGO Coordination Committee in Iraq found that, since 2003, over 40 percent of the professional class has left Iraq (Lischer, 2008). The Iraqi Medical Association estimates half of Iraq’s doctors have left since the 2003 invasion (Lischer, 2008). This ‘brain drain’ has only further exacerbated the health situation in Iraq.

Additionally, inadequate funding has led to a major shortage of health supplies and medication within Iraq, which has made it incredibly difficult to properly treat the war-related wounds experienced by Iraqis and the large amount of the population with chronic diseases like diabetes, hypertension, and cancer (Morton & Burnham, 2008; Burkle & Noji, 2004; Campbell, 2010; UN RBAS, 2009; Ghareeb, Ranard, & Tutunji, 2008; Burkle, Woodruff, & Noji, 2005). Security issues, a lack of clean water, and
electricity cuts make it difficult for hospitals to properly function (Burkle & Noji, 2004). Surrounding countries have also struggled with limited resources to meet the health needs of Iraqis seeking to claim asylum within their borders (Refugee Studies Centre, 2007; Ghareeb, Ranard, & Tutunji, 2008).

Finally, public health capacity has become severely limited. Insecurity and lack of access have greatly hindered public health surveillance since the start of the crisis (Burkle & Noji, 2004; Burkle, Woodruff, & Noji, 2005). Immunization rates have fallen dramatically, with a measles immunization rate of only 65 percent and a polio/OPV3 immunization rate of 75 percent (Ghareeb, Ranard, & Tutunji, 2008). The DTP3 immunization rate among one-year-olds decreased from approximately 82 percent in 1990 to 64 percent in 2007 (WHO, 2009). In 2008, UNHCR reported that in Syria, Jordan, Lebanon, Turkey, Egypt, and Iran, “Over 100,000 patients with secondary and tertiary health care needs, including for cancer, cardiac conditions and diabetes were assisted,” (p150). By the end of 2009, UNHCR had identified “43,900 Iraqi refugees with serious and chronic medical conditions” (UNHCR, 2009, p171). Despite these high numbers of Iraqi refugees experiencing chronic health issues, disease prevention efforts involving health education and promotion have been virtually non-existent, a point of much concern (WHO, 2007). These efforts have failed to take place due to continuing security issues, limited mobility, and general instability throughout the country (Burkle, Woodruff, and Noji, 2005; UNHCR, 2009).

Resettlement in the United States

In 2008, 25,600 Iraqi refugees returned to Iraq, with 2,500 assisted by UNHCR (UNHCR, 2009). Additionally, in 2009, approximately 167,000 IDPs in Iraq returned to their place of origin (UNHCR, 2009). Even so, UNHCR maintains that voluntary repatriation, or the voluntary return of refugees to Iraq, is not an option for most Iraqi refugees at this time given the lack of safe and dignified conditions in the country. Integration of the Iraqi refugees into their countries of asylum in Syria, Jordan, Lebanon, Iran, Egypt, and elsewhere, has also been deemed a non-viable option (Ghareeb, Ranard, & Tutunji, 2008; US DHHS, 2009). Although advocacy organizations began to call for the resettlement of Iraqi refugees to the United States, Europe, and other nations with the resources to receive them several years ago, the United States acted very slowly (Georgetown Human Rights Action [GHRA] & Human Rights Institute [HRI], 2009). For example, in fiscal year (FY) 2006, only 202 Iraqi refugees were resettled to the United States (UNHCR, 2007; Martin and Hoefer, 2009). In FY2007, there were still only 1,608 Iraqi refugees admitted to the United States for resettlement (GHRA & HRI, 2009; Martin and Hoefer, 2009).

| Figure 1 Timeline of Important Events Pertinent to Iraqi Refugees |
|------------------|-----------------|-------------------|-------------------|
| Iraq-Iran War | Persian Gulf War | U.S.-led Invasion of Iraq | Bombing of Askirya Shrine | Enactment of Refugee Crisis in Iraq Act |
Almost a year and a half after the bombing of the Shiite shrine in Samarra that set off a long-lasting wave of violence across Iraq, the United States Government (USG) finally decided to increase the amount of Iraqi refugees it would permit to resettle to the United States by a substantial amount. In the fall of 2007, Congress passed the Refugee Crisis in Iraq Act, which was enacted on January 28, 2008. The act allowed certain Iraqis with close ties to the USG – for example those who had worked for or were currently employed by the USG or an organization closely associated with the USG, along with their family members – direct access to the United States Refugee Admissions Program (USRAP) instead of having to wait for a UNHCR referral (US DHHS, 2009).

The passage of the act caused a dramatic increase in the number of Iraqi refugees being admitted for resettlement in the United States. Iraqi refugee admissions in the United States increased from 1,608 in FY 2007 to 13,822 in 2008, and then climbed to 18,838 in 2009 (Martin, 2010). While Iraqi refugees made up only 3.3 percent of the total number of refugees who arrived to the U.S. in FY2007, the percentage increased dramatically following the passage of the Refugee Crisis in Iraq Act, such that Iraqis made up 23.0 percent of total refugee admissions in FY2008 (Martin, 2010). This percentage increased even further in FY2009, with Iraqi refugee admissions that year making up 25.3 percent of total refugee admissions to the U.S. (Martin, 2010). Even so, according to the United States DHHS (2009), “The long term U.S. strategy for Iraq’s displaced is to help Iraq develop the capacity to reintegrate returning Iraqis into stable neighborhoods, while maintaining resettlement for the most vulnerable” (p45).

**Table 2 Iraqi Refugee Arrivals to the United States, FY 2006-2009**

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Iraqi refugee arrivals to the US</td>
<td>202</td>
<td>1608</td>
<td>13,823</td>
<td>18,838</td>
</tr>
<tr>
<td>Percent of total refugee arrivals to the US who are from Iraq</td>
<td>0.5</td>
<td>3.3</td>
<td>23.0</td>
<td>25.3</td>
</tr>
</tbody>
</table>

*Source: U.S. Department of State, Bureau of Population, Refugees, and Migration (PRM), Worldwide Refugee Admissions Processing System (WRAPS)*.

The 'most vulnerable' refugees admitted for resettlement to the United States have to meet certain health requirements and then must be sponsored by a resettlement agency within the United States (Martin, 2010; Martin & Hoefer, 2009). These resettlement agencies and other healthcare and social service providers are charged with helping these newly arrived refugees achieve self-sufficiency in the United States within eight months of arrival while effectively responding to whatever needs may
arise, a task that has proven quite challenging with the large influx of Iraqi refugees arriving to the United States over the past few years.

**Role of the Resettlement Agencies and Programs**

Refugees resettled to the Chicagoland area are served by five programs or resettlement agencies: Heartland Alliance Refugee and Immigrant Community Services (RICS), a program of Heartland Human Care Services; RefugeeOne (formerly Interfaith Refugee and Immigrant Ministries); Ethiopian Community Association of Chicago (ECAC); Catholic Charities; and World Relief (with offices in Chicago, Wheaton, and Aurora). These organizations have voluntary agreements with the Office of Refugee Resettlement within the U.S. Department of Health and Human Services (US DHHS) which provides matching grants to the organizations to assist them in the resettlement of refugees to the United States.

Resettlement agencies generally receive seven to ten days notice prior to the arrival of a refugee so that they may assign a case manager; find housing, furniture, and necessary household items; and get the apartment ready for their arrival. If the refugee has an anchor relative or U.S. tie (someone they know, usually a relative, already living in the U.S.), the resettlement agency generally establishes a prearrival agreement with the U.S. tie to determine the role of each party in assisting the newly arrived refugee in accessing core services.

The resettlement agency is responsible for assisting the refugee in accessing all needed services, with further support from their U.S. tie if they have one. Resettlement agencies are expected to provide a variety of services to the refugees they serve including cultural orientation to assist them in their adjustment to life in the United States, employment services, English classes, and assistance to complete an initial health screening at a local clinic and enroll in public aid programs for which they qualify. Additional services vary by organization but may include mental health services, children’s programs, youth mentorship and tutoring, family services, and a wide array of other programs. Resettlement agencies are required to assist the refugee in applying for cash assistance within the first seven days of arrival, in receiving an initial health screening within the first ninety days, and in signing up for public aid benefits, including social security, Medicaid, the Illinois Link Card (SNAP/food stamps), and Women, Infants and Children (WIC) benefits, if eligible. These benefits are available to the refugees for the first eight months. After the first eight months, they are expected to be self-sufficient with an income able to support them and any family with whom they arrived to the United States.

In addition to occasional home visits made by case managers, resettlement agencies work with approved health screening sites and mental health service providers to ensure refugees receive adequate health care. During the initial screening at a local health clinic, refugees first see a nurse who takes their blood pressure and measures their weight and height. They are tested for tuberculosis (TB), Hepatitis B, anemia, and parasites. They are seen by a doctor and are asked about their medical history. Finally, children up to age sixteen are screened for blood lead levels. The clinic is also responsible for ensuring all refugees are up to date with their immunizations, which must be completed before they can get their green card a year after arriving to the U.S.
Finally, an informal mental health screening is performed, and resettlement agencies and clinicians are responsible for ensuring that referrals to appropriate services are made.

**Iraqi Refugee Health in the United States**

There are several studies on the health of Iraqi refugees living in the United States, particularly focusing on their mental health, suggesting it is an important health topic of concern for the population. However, these studies have looked at the needs of Iraqi refugees and immigrants in the United States who arrived during earlier waves of conflict in Iraq, such as during the Persian Gulf War of 1990-1991 (Jamil et al., 2002; Jamil et al., 2007; Shoeb, Weinstein, & Mollica, 2007; Connelly, Hammad, & Boushiba, 2000; Aswad & Hammad, 2001), or from the Iraq-Iran War of the 1980s (Young et al., 1987; Jamil et al., 2005).

Published research focusing specifically on the health needs of the Iraqi refugees affected by the U.S.-led invasion of Iraq in 2003, who began arriving to the United States in large numbers by the end of 2007, is currently very limited. Still, general reports on Iraqi refugee issues in the United States have mentioned some health needs within the newly arriving population, including symptoms of PTSD and other mental health issues, as well as chronic conditions like diabetes, cardiovascular diseases, and cancer (Ghareeb, Ranard, & Tutunji, 2008; GHRA & HRI, 2009; Vallejo, Simon, & Zou, 2009). Due to the prevalence of mental health issues among the newly arrived Iraqi refugee population, their inability to access appropriate mental health services in the United States has also been noted (GHRA & HRI, 2009).

A point of concern for newly arriving Iraqi refugees described repeatedly in the literature has been access to health care. Refugees receive Medicaid benefits for their first eight months in the United States. After those eight months, in Illinois, unless they meet the eligibility criteria of having children or a wife who is pregnant and meet the income requirements, they lose their benefits. This leaves most refugees uninsured at the eight month point. This issue affects their ability to receive timely medical care and causes a large amount of stress and health complications for Iraqi refugees (Vallejo, Simon, & Zou, 2009; GHRA & HRI, 2009).

**Methodology and Analytical Approach**

Data and other information utilized in writing this report were collected primarily through a literature review and interviews with key informants who regularly interact with the newly arriving Iraqi refugee population in Chicago. Field notes recording observations made during RHP health education workshops, a refugee outing to a forest preserve in the northern suburbs of Chicago, and at various RHP meetings within the program and with partnering organizations also provided valuable data.

A literature search was performed using the PubMed and JSTOR databases and several different combinations using the key words ‘Iraq’, ‘Iraqi’, ‘refugee’, ‘United States’, and ‘health.’ The search results were limited to articles written after 1985. The publications page of the websites of several international and national organizations working with refugees were also searched for relevant publications about the health of
Iraqi refugees. During the review of literature and existing data, a total of 39 sources were identified and subsequently reviewed. The information collected from the literature search has provided the background information for this report and has also served to corroborate the findings of the research performed for this report about Iraqi refugees newly arrived to Chicago.

Seven formal semi-structured interviews were conducted with a refugee nutritionist, a refugee health promoter, three resettlement agency staff, a physician at a local clinic serving refugees, and the refugee program director at another local clinic serving refugees living in Chicago. These interviews were then analyzed using a qualitative analysis method described below. An Iraqi staff member at one of the Chicago clinics serving Iraqi refugees and an Iraqi community leader who is the co-founder of a community organization aiding Iraqis in Chicago were also interviewed. However, their interviews occurred late in the assessment process and therefore were not coded and analyzed as other interviews were. All but the interview with the physician were conducted in person by the author of this report. Interview responses were not audio-recorded. The interviewer took extensive notes throughout the interview to have a detailed written record of interview responses. All interviews were conducted during the months of June and July, 2010.

Data collected by a former RHP intern during the second half of 2009 was also analyzed for this report and included a small amount of quantitative data about the health status of refugees receiving nutrition services from the RHP nutritionist during part of FY2009; field notes recorded by the former intern based on observations made during his research; and data from an open-ended online survey of two resettlement agency staff – including one who was later interviewed by the author of this report, a mental health service provider, the same clinician from a local clinic who was later interviewed by the author of this report, and the Refugee Program Administrator at the state public health department.

A qualitative analysis of field notes, survey, and interview data from the first seven interviews was performed in an informal manner by the author of this report. The notes and interview and survey responses were coded line-by-line and reviewed a second time to improve consistency. These codes were meant to describe the responses by the issue they addressed and to group similar responses and notes. Each line was then organized by code, and sub-codes were assigned. A frequency count of sub-codes was performed next. Emerging themes were then identified based on issues that arose frequently in the data or were deemed of particular interest and importance by the author.

Once separate analyses of the qualitative data, the small piece of quantitative data collected by the former RHP intern, and the existing information gathered through the literature review were completed, a mixed method analysis was performed. Findings from each individual analysis were compared and contrasted to identify similarities throughout the data and any differences that stood out. The similar findings that were identified were then synthesized to produce a final list of themes and strategic issues that were supported by both the quantitative and qualitative data collected. While there were no major differences or conflicting findings that arose from the analysis, the fact that each key informant sharing their perspective emphasized different issues of
importance concerning the Iraqi refugee community demonstrates the complexity of the topic of study.

Finally, the preliminary findings from the mixed method analysis were then presented to the two Iraqi key informants interviewed last in the assessment in order to find out whether they agreed with the findings, ask for their own recommendations for how to address the major issues identified, and gather additional insight from Iraqi perspectives to incorporate in this report.

Iraqi Refugees in Chicago

The number of refugees resettling to Illinois has significantly increased over the last few years. In FY2006, 1,227 refugees were resettled to Illinois (Martin & Hoefer, 2009) while in FY2007, the number increased to 1,872 (Martin, 2010). In 2008, the number rose to 2,429 and to 2,560 in 2009 (Martin, 2010). Both the absolute number of Iraqi refugees resettled to Illinois during the last few years as well as the percentage of total refugees arriving to Illinois who are Iraqi reflect the increases seen in the United States overall during the same time period.

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Iraqi Refugee Arrivals to IL</td>
<td>21</td>
<td>84</td>
<td>934</td>
<td>1184</td>
</tr>
<tr>
<td>Percent of Total Refugee Arrivals to IL Who Are From Iraq</td>
<td>1.7</td>
<td>4.4</td>
<td>38.5</td>
<td>46.2</td>
</tr>
</tbody>
</table>

Table 3 Iraqi Refugee Arrivals to Illinois, FY 2006-2009

Interview data also reflected that Iraqis currently make up a significant amount of the refugee caseload for agencies in Chicago. The IDPH reported that in FY 2009, at Mt. Sinai’s Touhy Health Center alone, over 500 Iraqi refugees received their initial health screening. A representative from RICS reported that in FY 2009, 180 of the roughly 250 refugees RICS had resettled had been Iraqi, and he estimated the numbers would continue as such for at least the next few years. A director at World Relief Chicago reported that 85 percent of its caseload in FY 2009 was Iraqi. In June 2010, a director at Refugee One said three quarters of those refugees resettling through her agency were Iraqi, and World Relief Chicago estimated about 75 to 80 percent of its clients were also Iraqi. Catholic Charities stated about 60 percent of its caseload was made up of Iraqi refugees. In July 2010, a representative from World Relief DuPage in
Wheaton reported about 130 of the 375 to 400 refugees with whom World Relief DuPage was working at the time were Iraqi and that the number was growing.

The ethno-cultural breakdown of the Iraqi clients served by the various resettlement agencies in Metropolitan Chicago (here on forward simply referred to as Chicago) differs by organization. RICS reported that its current Iraqi caseload consists mainly of Arab Sunni Muslims, followed by Arab Shia and Kurdish Muslims. It reported the next largest group consisted of Christians, who were mainly Assyrian. At the time of the interview, RICS had not yet resettled any Palestinian refugees from Iraq, but reported World Relief and RefugeeOne had.

Catholic Charities reported 85 to 90 percent of its Iraqi cases at the time of the interview were Assyrian or Chaldean, and that they had only recently resettled a few Arab families, two Palestinian families, and no Kurdish families. A few years ago, however, they had resettled some Kurdish families.

World Relief DuPage estimated that two thirds to three quarters of its caseload at the time of the interview were culturally Muslim and that the other third or fourth was mainly Assyrian. The agency also reported resettling some Mandeans from Iraq, who are followers of John the Baptist and who lived mainly in Iran and Iraq.

The general consensus among service providers is that the majority of Iraqi refugees newly arrived to Chicago have a higher level of education than other refugee populations being resettled in the United States. Several providers discussed the highly skilled occupations the Iraqi refugees they interact with in Chicago held in Iraq in the past. Many of them had good salaries and a high quality of life before the invasion of Iraq in 2003. Most had access to a large amount of health information in Iraq as compared to refugees from other countries. Additionally, many Iraqi refugees in Chicago have at least a basic knowledge of English while those who worked for the United States government (USG) during the war in Iraq before coming to the U.S. speak at a much more advanced level.

According to the resettlement agencies interviewed, most Iraqi refugees are being resettled to the Chicago community areas of Rogers Park, Albany Park, the Devon area around Western, Edgewater, and Uptown, although not as many to Uptown as before due to the rising cost of living in the neighborhood. A RICS representative estimated 70 percent of Iraqi cases being resettled through RICS live in the city, while 30 percent live in the suburbs near their anchor relatives or in areas where there is an existing community of their ethnicity and the cost of living is lower.

Several resettlement agencies reported many of their Iraqi cases being resettled to or moving to the suburbs of Morton Grove, Skokie, Schaumburg, Des Plaines, Niles, Elk Grove Village, and Hickory Hills. Many Assyrians were resettled to the area around Devon and Western where there is an already existing strong Assyrian presence, and many Palestinians are being resettled or ended up moving to the southwest suburbs of Bridgeview, Hickory Hills, Palos Hills, Palos Heights, and Worth, where a large existing Palestinian population lives. Further west in the suburbs, World Relief DuPage reported resettling almost all its Iraqi cases in West Chicago, a nearby suburb with affordable housing that was of the highest quality for the price since most of their Iraqi cases were accustomed to a high quality of life in Iraq before the war began.
Iraqi Refugee Health in Chicago

Health Status

At this point, it is not possible to give a full picture of the health status of the Iraqi refugee population in Chicago and the true burden of disease based on quantitative data. RHP does not have the capacity to gather and analyze such information, and knows of no other organization that has collected such information. Still, while several of the key informants surveyed by the former RHP intern reported being unaware of any formal health assessment of the population of interest, the knowledge key informants shared in their interviews during this assessment provided a wealth of qualitative information about the health of the Iraqi refugee population.

Mental Health

Mental health issues among Iraqi refugees were the health issues repeated most frequently among those interviewed. Four resettlement agency representatives noted mental health problems as a great concern, if not the biggest concern for Iraqi refugees.
arriving to Chicago. Depression, PTSD, trauma, anxiety, and acculturation stress were all listed several times throughout interviews and the open-ended survey as greatly affecting many Iraqi refugees. Some witnessed the murder, torture or rape of family members. Others were themselves survivors of torture. All had experienced fear of being killed or of their family members being killed. These issues resulted in other related issues including possible delusions, intense anger, and effects on their physical health.

**Chronic Health**

Following mental health, chronic health issues and the prevalence of nutrition-related disease within the population were noted as serious concerns. Specific conditions mentioned most frequently by key informants were diabetes, high blood pressure, and overweight/obesity. Poor nutrition and unhealthy diets were also referred to several times. This qualitative finding regarding chronic health and the prevalence of nutrition-related diseases among Iraqi refugees newly arrived to Chicago is backed by the small amount of quantitative data that was collected and analyzed using descriptive statistics by the former RHP intern. Of 189 Iraqi adults who were screened for nutritional issues in FY2009 by the RHP nutritionist, 33.0 percent were found to be obese, 6.3 percent were hypertensive, and 6.8 percent had high blood pressure. Of the 189 adult Iraqis screened, 15.8 percent had high total cholesterol and 5.3 percent were anemic or showed signs of iron deficiency. Overall, these quantitative findings support the qualitative findings relating to poor nutrition and high rates of high blood pressure and obesity. But the prevalence of Type 2 diabetes among the Iraqi adults screened was only 3.2 percent, which belies the magnitude of the problem as suggested by the frequency with which it was mentioned among six of the key informants interviewed. An analysis of clinical data for all Iraqi refugees in Chicago would provide a clearer picture of the true burden diabetes presents within the population.

**Domestic Hygiene – Bed Bugs and Scabies**

Domestic hygiene, in general, and bed bug infestations and scabies contraction among Iraqi children, were raised as issues of concern during this assessment. These are issues, however, affecting all populations indiscriminately (refugees and non-refugees alike) in large cities such as Chicago.

**Latent Tuberculosis**

Although PPD-positive status, or having latent TB, was not mentioned by any resettlement agency representatives, it was raised as an issue by representatives from both health clinics serving most recently arrived Iraqi refugees in the city of Chicago. The Refugee Program Director at a local health clinic estimated 80 to 90 percent of all refugees have been exposed to TB and that the issue pertained to Iraqi refugees just as it did other refugee populations. The two clinic representatives emphasized it was an important issue that needed attention, since any refugee who tested PPD-positive had been exposed to TB and had to take the full nine months of preventive INH treatment in order to receive their green card. They reported Iraqi refugees did not always realize the importance of completing the treatment and that the Iraqis often thought if they took the BCG treatment back in Iraq or in their former country of asylum, it was sufficient when it is not.
**Barriers and Challenges**

**Language**

The biggest barrier to effective health care, health promotion, and education was found to be language, mentioned several times by seven of the key informants interviewed or surveyed. When interviewed, RHP staff said workshops were not effectively reaching Iraqi refugee clients due to a lack of Arabic and Assyrian interpretation, and while the RHP Burmese and Bhutanese health promoters were able to make home visits to follow up individually with clients, language barriers made it difficult to make home visits to Iraqi refugee clients in need of follow up and further health education. In interviews with other service providers, language was found to be a major problem affecting communication between the Iraqis and service providers that affected their ability to learn important health information and fully understand how to take their medications. A few key informants emphasized the problem of hospitals and clinics not providing interpretation as they were supposed to. Language was also reported as a problem in other ways in daily life and made it harder to find a job.

**Low Engagement / Participation**

Another major challenge for service providers has been a low level of engagement in services and lack of participation in programs intending to improve not only the health of refugees but also their entire resettlement experience. The language barrier and an inability to provide interpretation during all services appeared to be one reason for the low levels of engagement in services. Moreover, observations seemed to indicate, and key informants agreed, that the attitude among many Iraqi refugees was that the services being offered were unnecessary or that they already knew or had previously received the information being taught in the health workshops, cultural adjustment classes, and other educational sessions.

**Insufficient Information about Iraqi Health**

Insufficient information about the status of Iraqi health is also a barrier to addressing the health needs of new Iraqi arrivals. To the knowledge of RHP, there have been no major assessments of the health of Iraqi refugees who have recently arrived to Chicago. Furthermore, Iraqi refugees themselves have not been given much space or forums to speak to the issues they are experiencing with their health and share their own perspectives on the matter and their experiences with the U.S. healthcare system as they have experienced it in Chicago. Surveillance of the health of Iraqi refugees is made even harder given the fact there is no secondary migration tracking system, so as refugees move, it is much harder to continue follow-up and track the status of their health. This finding is supported in the report published by Georgetown Human Rights Action (GHRA) and the Human Rights Institute (HRI) (2009) about the needs of Iraqi refugees in the United States.

**Iraqi Expectations**

Yet another challenge resettlement agencies have been faced with involves the expectations of newly arrived Iraqi refugees. Several key informants discussed the
unrealistically high or misinformed expectations many Iraqi refugees held upon arriving
to Chicago. One key informant talked about the belief among some Iraqi clients at her
resettlement agency that they deserved special treatment. One woman’s reasoning for
why she deserved to have her rent paid for by the resettlement agency for a year was
because she was Iraqi. One key informant who was interviewed said some of the
Christian Iraqis expected special treatment from their resettlement agency because it
was a Christian organization. One of the Iraqi key informants interviewed during the
assessment explained: “When they come here, they are shocked. They are told they’ll
have a house, but they are given apartments with cockroaches…But because of the
war, most accept it. They say that if they go back, they’ll be killed.”

The challenges become even more difficult as the Iraqis begin to realize their
expectations will not be met. Once they accept their expectations will not be met in their
entirety, they often begin to feel frustration, disappointment, and even anger. Key
informants discussed the extensive complaining they heard from the Iraqi refugees, and
expressions of their frustrations and anger toward the service providers. An Iraqi staff
member at one of the Chicago clinics talked about the return of some families to Iraq
because they believed it was better than living in the United States. She discussed in
her interview how one family only stayed a week and then went back to Iraq because of
how bad their situation was in the U.S. She said they told her before they left, “It would
be better to die in Iraq than live here.”

Representatives from the resettlement agencies discussed the negative views
the Iraqi refugees sometimes held toward them due to misunderstandings about their
role in the resettlement process and the extent they were able to provide support to the
refugees as they adjusted to their new lives in Chicago. They said some Iraqi refugees
did not understand the resettlement agencies were not part of the USG and therefore
did not have the power to increase funding when they wanted to.

This finding regarding Iraqi expectations and frustrations supports the
conclusions of a study by GHRA and the HRI (2009) that discussed the difficult
resettlement experiences of Iraqi refugees arriving to the United States since 2003 and
the perceived lack of support they have been receiving. The report states:

Despite the dire conditions in countries of first asylum, many Iraqi refugees who choose to be
resettled are also finding difficult conditions in the United States. Some resettled Iraqi refugees
said that their situation has gotten so bad that they feel they have no choice but to leave the
United States to return to their country of first asylum (GHRA & HRI, 2009, p19).

Ghareeb, Ranard, and Tutunji (2008) reported similar conclusions:

Early evidence suggests that Iraqi refugees may be arriving with unrealistic expectations
regarding housing, resettlement agency services, and employment opportunities. Refugees have
expected better housing and furnishings, more support than agencies typically provide, and
higher level jobs than they are usually offered. Better-educated Iraqis, in particular, are reluctant
to take entry-level jobs, preferring to put off employment in hopes of landing jobs commensurate
with their work experience and education. Resettlement agencies have found that Iraqis who
worked for the U.S. government in Iraq can be especially disappointed by their employment
prospects in the United States (p33).

One of the resettlement agency representatives agreed that the first several months
were full of frustrations and difficulties for many Iraqi refugees due to the unrealistic
expectations they held when they arrived in the United States: “There’s just a lot of frustration with the Iraqis since it is so different from what they expected. They come here at first and say, ‘We want to go home. This sucks.’ But they adjust after a while.”

Other interviewees were also optimistic. One of the Iraqi interviewees said, “Some of them learn. They change. They learn to accept their situation. Then after one or two months, six months, or a year, they’re fine. They learn to drive even. And then they are okay.” Still, those first several months before they finally settle in and readjust their expectations, present significant challenges to engaging the Iraqi refugees in services and working towards the improvement of their health.

**Limited Funding and Capacity**

The lack of funding mentioned earlier and similar capacity issues represent a rather large barrier to improving the health of Iraqi refugees, and were referenced many times during interviews and the survey given. The need for medical case managers and interpreters was mentioned several times. The need for more providers willing to accept refugee patients, as well as more staff at the clinics to reduce the wait time for refugee patients, were noted. Several key informants mentioned the need for more mental health services and increased funding for existing services, which is especially critical for the Iraqi refugee population. One resettlement agency representative expressed concerns about potential budget cuts given the economic crisis in Illinois. Concerns about limited funding and budget cuts appeared in existing literature as well (Sturm, 2008).

**Health Insurance Access**

Health insurance access appears to be a major barrier. A few interviewees shared concerns about Medicaid benefits only lasting for the first eight months after refugees arrive in the United States and shared stories of uninsured Iraqi refugees in need of expensive medications and treatments for their chronic health issues being unable to afford them. For example, one resettlement agency representative shared:

> One guy we work with has no Medicaid. He is married but has no kids. He just found out the medications he needs for his asthma cost $200 a month. But he doesn’t qualify for Medicaid…I asked if he could get insurance through work, and he said, “With $8 an hour, do you think I could afford paying for the insurance they’d send me home with?”

The same key informant went on to share another story of a couple desperate for medical coverage:

> And then another couple also asked about Medicaid, but we told them unless they had kids or the wife was pregnant, they didn’t qualify. They came back a bit later, and the wife was pregnant. We said, “No, that’s not what we meant!” but they did what they thought they had to.

These examples demonstrate how significant a challenge access to health care is not only for Iraqi refugees, but for all refugee populations in the United States following the first eight months of resettlement.

Such barriers related to health insurance access, along with “fear of inadequate support” in general, are similarly discussed in the 2009 report published by GHRA and the HRI (p16). One account in that report described such challenges that were experienced by an Iraqi refugee family:
Seema is a 56-year-old self-described optimist from northern Iraq who has grown to love Michigan. She has a heart problem, high cholesterol, rheumatism, and no medical coverage because her RMA expired after eight months. Her elderly husband is also sick, and their adult son earns minimum wage. But still, Seema is lucky: hers is one of the few Iraqi refugee families with any wage at all, not to mention her husband's social security benefits. She only asks for her medical coverage to be restored. "We can handle everything else," said Seema (GHRA & HRI, 2009, p30).

The account of Seema’s experiences is just one of many that could be shared about challenges experienced by Iraqi refugees related to a lack of access to health insurance and affordable medical care.

The Existing Community

A few of the key informants interviewed made comments about how the existing communities of Iraqis, Arabs, and Assyrians in Chicago were exacerbating the problems experienced by the resettlement agencies and the newly arriving Iraqi refugees they serve. One resettlement agency representative reported the existing community was further inflating the expectations held by the newly arrived Iraqi refugees by telling them they deserved better treatment or telling them they were not receiving all the support the resettlement agencies were supposed to provide them. Another resettlement agency representative spoke about how the anchor relatives were not providing all the services and information the newly arrived Iraqi refugees needed to have a positive cultural adjustment experience in Chicago. The representatives believe part of the reason the Iraqi refugees are not fully utilizing the services provided by the resettlement agencies is because the existing community is hindering them in one way or another from doing so. For example, one key informant spoke of how some U.S. ties never explained the public transportation system to the newly arrived refugees they were assisting, so they did not know how to get to the agency for programs or services. Furthermore, the clinician interviewed said some of the Iraqi refugee patients at the health center where he worked would go to the clinic but then visit Iraqi doctors from their communities afterward. As a result, they sometimes followed the advice of the doctors from their community and would not always adhere to the directions given them at the health center, especially with respect to following the INH treatment to prevent active TB if they tested PPD-positive.

Limited Understanding of the Community

The last major challenge echoed many times by resettlement agencies and other service providers to the Iraqi refugee population has been great difficulty in understanding the community and how to best engage them with their programs and services, communicate with them, and effectively serve them. One resettlement agency representative said, "We have spent the last two and a half years resettling Iraqis, and we still haven’t figured out how to make them more engaged." Similarly, another representative admitted, “I don’t get it. I still don’t understand the community at all.”

The service providers interviewed for this report expressed their uncertainty about how to lower the expectations of the Iraqi refugees and respond to their frustrations and complaints. Even the Iraqi key informants were not sure how to successfully do so. Resettlement agencies expressed frustrations in having to plead with Iraqi refugees to participate in their programs but having had little success. Key
informants continually pointed out that the Iraqi refugee population differed from other refugee populations they served and that what worked well with other groups was not being effective among their Iraqi clients.

**Other Frequent Challenges**

Several of the barriers to an improved quality of life that were mentioned above – including language and transportation barriers, limited funding, a lack of information about the health of Iraqi refugees, limited health insurance access, and the attitudes of the Iraqis themselves – echo those described in existing studies about Iraqi refugees in the United States (Sturm, 2008; Aswad & Hammad, 2001).

In addition, there were several other barriers and challenges mentioned less frequently by key informants that are important to mention. Some shared about Iraqis feeling overwhelmed with all the information presented to them by service providers and said they sometimes could not handle the additional health information. The Iraqis expressed great concerns over their financial insecurity and inability to find employment with which they were satisfied. Transportation barriers were also mentioned by a few key informants. Additionally, a few resettlement agency representatives spoke of the isolation and lack of cohesiveness that existed within the Iraqi refugee population, a challenge discussed in a study about the Iraqi community in Detroit (Shoeb, Weinstein, & Mollica, 2007). The Iraqis resisted being in group settings although they appeared more comfortable if they were in groups of only Iraqis. For example, the refugee nutritionist who was interviewed gave an example of a gardening activity that required a group of refugees to work together in a garden. There was an Iraqi couple there, however, that wanted their own plot to work on and did not want to be with the other refugees. Issues with trust given their past experiences in Iraq were also mentioned by a few of the key informants.

**Potential Bridges and Existing Assets**

**Culturally Specific Health Outreach**

The most important bridge to improved health care and health knowledge identified during the assessment was the implementation of culturally specific health outreach. There were several aspects of culturally specific outreach mentioned, with the provision of Arabic and Assyrian interpretation repeated the most often as a necessary and effective way to improve health outreach. Both health center representatives interviewed discussed the importance of interpretation and emphasized how beneficial it was to their Iraqi patients that their clinics provided Arabic and Assyrian interpretation. The RHP health promoter who was interviewed also discussed the need for an Arabic interpreter and talked about how much more engaged Iraqi refugees were in RHP health workshops when Arabic interpretation was provided. This finding was further supported in the analysis of field notes taken during periods of observation of RHP activities throughout the assessment. During these educational activities, the Iraqi refugees appeared to be much more interested in the presentations of health information when they were presented the information in Arabic.
The idea of culturally specific activities for the Iraqi refugee population was suggested a few times by key informants as a way to better engage the Iraqis. One resettlement agency representative discussed the success they had with a course they held separately for their Iraqi clients that began and ended with social events where tea and Iraqi treats were served and a space was provided for them to share about their culture. Another key informant discussed the success of having counseling services for the Iraqi refugees that were provided by an Arabic-speaking Jordanian who was very familiar with Arab culture. The refugee program director at one of the local Chicago health clinics discussed the importance of having a clinic staff member from the Iraqi community and how much of an asset she was in services to Iraqi refugee patients at the clinic. The need for culturally sensitive staff, regardless of whether or not they were actually from the Iraqi community, was also mentioned during a couple interviews as a way to improve health outreach to the Iraqi refugee population in Chicago.

Incentives and Time for Socializing

Providing incentives such as public transportation passes and food appears to be a bridge in improving Iraqi participation in the programs and services provided by refugee-serving agencies. One resettlement agency representative suggested having contests promoting physical activity among the Iraqi refugees that would award prizes to those engaging in the most physical activity. Providing time to socialize also appears to be a way to increase the participation of Iraqi refugees in programs and was mentioned several times during interviews. Allowing time for the Iraqis to socialize could work to improve social support and cohesiveness within the community, which would ultimately serve as an important bridge having a positive impact on their overall health (Burnett & Peel, 2001; Shoeb, Weinstein, & Mollica, 2007; Teff & Calabia, 2009).

Transportation

The provision of transportation was mentioned several times as a bridge to increased access to health care and service utilization. One of the resettlement agency representatives and the physician who was interviewed both emphasized the importance of providing transportation to the refugee clients and patients they served, and that the failure to provide transportation greatly limited their ability to access services.

Relationship-building and Trust

Building trust as resettlement agency and clinic staff form relationships with newly arriving refugees from Iraq is another important way to improve Iraqi refugee health. Resettlement agency staff reported their Iraqi clients were more receptive to outreach and engaged in services as their trust in the staff grew and as their relationships with them grew deeper. Furthermore, the refugee program director of a local Chicago clinic discussed the clinic’s efforts to actively follow-up with its refugee patients, and that these follow-up efforts kept the Iraqi refugees engaged in their health care services. It may require a large amount of effort, but as one of the resettlement agency staff who was interviewed stated, when it comes to improving the health of Iraqi refugees through health outreach, “Relationships are key.”
High Level of Education

Most key informants interviewed during the assessment mentioned the high level of education most Iraqi refugees in Chicago had attained in Iraq. Several described how many of the Iraqi refugees they knew in Chicago had previously been doctors, engineers, or professors in Iraq. Although the literacy rate in Iraq in 2000 was only 68 percent for males and 43 percent for females (WHO, 2007), many Iraqi refugees resettled in the United States had ties with the USG, often because of their high level of education and their proficiency in English. Others were family members with those who had ties to the USG, and similarly have a high level of education. These claims are further supported by a study done by the organization RefugeeWorks which reported “that a significant portion of Iraqi refugees have skilled and professional backgrounds. Additionally…a majority of the new [Iraqi] arrivals are college-educated” (Sturm, 2008, p1). The high level of education and degree of skill of many Iraqi refugees in Chicago, therefore, can be considered a strength within the community upon which to be capitalized that can serve as an asset in the attempt to improve health education and outreach to the overall Iraqi refugee community.

Emerging Themes and Strategic Issues

It appears that several of the bridges and challenges to improving the health of Iraqi refugees are related to and affect one another in significant ways. Low engagement in activities and low participation in programs is one of the biggest barriers to improving the health and health knowledge of Iraqi refugees newly arrived to Chicago. However, this challenge is affected by the language and transportation barriers identified as well as the lack of outreach specific to Iraqi culture and incentives to participate. Still, service agencies lack the funding to provide more incentives to participate and may not always be able to provide transportation or public transportation passes. They lack the capacity to always provide Arabic and Assyrian interpretation and do not have the capacity or funding to train their staff on making services, programs, and outreach in general more culturally relevant to each individual refugee population.

The low engagement in activities and lack of participation in programs also inhibits the ability of resettlement agency and clinic staff to build stronger relationships and trust between themselves and their Iraqi clients. It limits the amount of information they have on the health status of the Iraqi refugees they serve, and it makes it more difficult for each party to understand the other and clarify what expectations they each should hold. Moreover, resettlement agencies and clinics serving refugees are severely understaffed and so overloaded with work that their ability to communicate between each other to provide more integrated services that address the biggest health needs of Iraqi refugees appears to be greatly hindered.

Overall, it appears much effort needs to be put in to making health outreach to Iraqi refugees arriving to Chicago more culturally relevant. This should increase Iraqi engagement and participation in activities and programs that aim to improve refugee health and ultimately result in the formation of trusting relationships between service providers and their Iraqi clients. It should also improve communication between them.
and allow Iraqi clients to readjust their expectations so they are more realistic and find the resettlement process less frustrating and stressful. It appears the most effective ways to improve the cultural appropriateness of health outreach to Iraqi refugees require increased funding and the ability to hire more staff and hold trainings to improve the capacity of agencies serving the Iraqi refugee population. It also requires improved collaboration between resettlement agencies, health centers serving refugees, and the many Arab, Assyrian, Muslim, and Iraqi community organizations that exist in Chicago. Such community organizations up to now have been involved in the resettlement of Iraqi refugees in a very limited manner but would provide a rich amount of cultural insight and culturally relevant outreach strategies to improve the effectiveness of health outreach to Iraqi refugees in Chicago. They may also be able to collaborate in providing interpretation and transportation services and may connect the RHP and resettlement agencies with people within the Iraqi and wider Assyrian, Chaldean, and Muslim Arab communities who could serve as informal community health workers and champions of the health messages RHP hopes to convey to the newly arrived Iraqi refugee population in Chicago.

**Limitations of the Assessment**

The assessment took place over eight weeks and cannot in that limited amount of time provide a comprehensive view of the overall health of Iraqi refugees in Chicago and factors that affect it. Only nine interviews were performed, and only two of the key informants worked directly on health-related issues with the Iraqi refugees. The other service providers gave their opinions about the health of Iraqi refugees based on their conversations with clinicians serving their Iraqi clients, what their caseworkers report to them, and what they have heard from RHP and other resettlement agencies. More research is needed for more definitive results.

Furthermore, if there had been more time, a quantitative analysis of the medical records of refugees at the two main clinics serving refugees in Chicago would have provided a much clearer picture of the health status of the Iraqi refugee population newly arrived to Chicago. Even so, the fact that many of the key informants discussed the same issues, and those issues were also addressed in existing literature about Iraqi refugee health in other areas of the United States and the Middle East suggests a high degree of reliability of the data collected during the eight-week assessment.

Another limitation of the assessment was the way in which data were collected during key informant interviews. Interviews were not audio- or video-recorded. Instead, data were collected through note-taking by hand by the interviewer herself. She may have missed certain comments or recorded responses incorrectly, which could threaten the reliability of the qualitative data collected. Moreover, almost the entire data collection and the whole analysis process was performed by a single person due to capacity issues and no reliability check was done by another evaluator to check for biases in the data analysis process.

Lastly, this assessment is largely from the service provider perspective since only two Iraqi community leaders were interviewed. More research is needed that
incorporates more perspectives of Iraqi refugees and other members of the Iraqi community in Chicago.

**Recommendations**

*Health Education Topics to Address*

During interviews, key informants were asked what the biggest health education needs were among Iraqi refugees newly arrived to Chicago. Chronic disease awareness and prevention, including education about diabetes, obesity, high blood pressure, and high cholesterol was mentioned most often, followed by nutrition, sanitation and domestic hygiene. Other topics named a few times included the benefits of exercise, taking medications, and the importance of preventive care including screenings, immunizations and informing one’s self about health. Other suggestions of important health education needs among Iraqi refugees were how to access services like WIC and Medicaid, stress reduction, the de-stigmatization of mental health issues, the importance of completing the nine-month INH treatment for TB if the patient is PPD-positive, child developmental health, and properly preparing for a medical appointment by planning childcare and transportation ahead of time and calling if the patient is unable to make an appointment. Considering mental health issues have been noted most frequently by service providers as the greatest problem facing the Iraqi refugee population, the need to de-stigmatize mental health issues and emphasize the importance of seeking treatment for such issues through health education and awareness campaigns within the community should be a major area of focus (GHRA & HRI, 2009).

*Improving the Effectiveness of Health Outreach to Iraqi Refugees*

Based on the preliminary findings from the assessment performed, the following are the key recommendations to RHP and Chicago’s refugee resettlement agencies that have come out of the assessment and appear the most likely to improve the health of Iraqi refugees newly arriving to Chicago:

- **Develop and deepen an understanding of the Iraqi refugee community.**

  Despite continued frustrations with the inability to effectively engage Iraqi refugees in programs and services and with the high expectations the population holds, RHP and resettlement agency staff should continue their efforts to better understand the Iraqi refugee community and where they are coming from. As Gharreb, Ranard, & Tutunji (2008) write:

  Understand that survivors of torture or extreme trauma will have more needs and require more help than other refugees to rebuild their lives. They will likely require more time and encouragement to access the medical, legal, mental health, employment, educational, and social services they need. They may want to explore their spiritual needs, having strengthened or forsaken their faith due to the trauma (p35).
One of the Iraqi key informants for this report made a further appeal to service providers experiencing frustrations in trying to work with the Iraqi refugee community:

Don’t blame them. In Iraq, they had everything. They had a nice life there and had everything they needed. Here, their apartments are dirty and in bad condition. Of course they will be emotionally unhappy. They were expecting something better. I tell them to find a job and start working and have their kids go to school, and that everything will work out…They will adjust. When they stay, it may take three or four months, but the situation will make them adjust.

As those interviewed for this report repeatedly said, the Iraqi refugee population is different from other refugee groups in the United States. Their past experiences are significantly different from other refugees, and they may have experienced much more extensive trauma as a result of the wars and conflicts in Iraq over the past thirty years which has heightened their emotions and the stress in their lives. Given these differences, it should be no surprise, then, that outreach to the population will look different from previous work.

❖ **Advocate for more funding for Arabic-speaking medical case managers and Iraqi health promoters but also consider alternative community health worker models.**

Arabic-speaking medical case managers who accompany Iraqi refugees on their healthcare visits and ensure proper follow-up along with Iraqi health promoters who engage in health education and outreach in group settings and during home visits could be very effective in improving the health of Iraqi refugees. Although Iraqi refugees are generally familiar with the Western healthcare system and most, especially those from urban areas of Iraq, share many Western views of health and illness (Atallah, 1996; Shoeb, Weinstein, & Mollica, 2007), there are still some differences between their perceptions and beliefs about health and those held by people from the United States (Shoeb, Weinstein, & Mollica, 2007; Jamil et al., 2002). Iraqi health promoters would have a similar cultural lens to that of the Iraqi refugees and would be able to present the health information in a way that was more culturally relevant. They would also be more able to clarify to healthcare and social service providers serving Iraqi refugees any cultural misunderstandings that arise.

Still, since program funding is being cut instead of increased due to the current economic crisis, it is advisable to consider alternate community health worker models. RHP should consider working with the various community organizations in Chicago that invest in the Iraqi community and more generally, the Arab, Assyrian, Kurdish, Chaldean, and Mandeans communities to identify leaders in the Iraqi refugee community who may have been doctors or nurses back in Iraq who could serve as volunteer community health workers and volunteer medical case managers. While volunteering in these positions, they could gain valuable skills and form strong networks in Chicago that could assist them in securing sustainable employment in the future.
Talk to the Iraqi refugee community itself and allow them a space to voice their own perspectives on their health needs.

Iraqi refugees have not been engaging in services, have expressed many complaints about their resettlement experiences in Chicago, and have dismissed health education outreach as unnecessary and sometimes demeaning. Efforts by the resettlement agencies and RHP to address specific health needs of the Iraqi refugee population have not yet shown much effectiveness, in turn, frustrating service providers and leaving them at a loss for how to improve. Still, they have not brought the Iraqi refugees together to discuss the seriousness of the situation with respect to the extent to which mental and chronic health issues are affecting their community. They have not gathered them together to ask them what they want or ask them if they have ideas about how to improve their community’s health.

It could prove extremely helpful to bring together Iraqi refugees for group discussions during which they would be asked to identify the perceived health needs of their community, be presented with the health needs RHP identified during its assessment, determine priority areas, brainstorm ways to address these priority needs in a way that would be most effective in reaching and engaging their community, identify key stakeholders with which the resettlement agencies and RHP can collaborate, and identify key assets existing in the community upon which to build. Giving the Iraqi refugee community in Chicago more ownership over the task of improving their health might increase their interest in engaging in and even helping to lead programs and services aiming to improve the health of their community.

Additionally, resettlement agencies could come together and ask a panel of Iraqi refugee community members to share about their community, what the community likely experienced in Iraq before coming to the United States, what they are likely experiencing now as they transition to life in Chicago, and other helpful background information so the agencies can better understand their situation. Then the panel can answer any questions the agencies have and, through that, provide further insight into the situation and suggest ways to better engage Iraqi refugees in their programs and services.

Incorporate innovative approaches into health outreach that will be more culturally relevant to the Iraqi refugee population.

As mentioned earlier, the outreach should be provided in Arabic and Assyrian and should preferably be led by Iraqi or at least Arab or Assyrian health promoters and community health workers. Additionally, it appears outreach would be more effective if space is provided for the Iraqis to meet together and separately from other refugee groups, have a time for socializing over food, and engage in dialogues about various health topics. This time for health education should not be in presentation form as has been traditionally done by RHP, but should instead be interactive and give the Iraqi refugees the opportunity to share what they already know and ask questions about
what they do not know but would like to know. Space to discuss health as it relates to their culture and life back in Iraq would also be good to provide.

- **Make more of an effort to view the existing Iraqi communities in Chicago as a bridge rather than a barrier to improving the health of newly arriving Iraqi refugees.**

  There is a large Iraqi and Iraqi-American community in Chicago, with an estimated 100,000 Assyrians presenting the largest Iraqi community living in the city. Large numbers of Iraqi Muslims and smaller pockets of Iraqi Kurds, Chaldeans and Sabeans have also lived in Chicago for several years (Ghareeb, Ranard, & Tutunji, 2008). These communities have formed community organizations and associations that reach out to Iraqis all throughout the city and suburbs. These community organizations are already doing great work within the Iraqi refugee community and these existing communities already have the cultural and linguistic knowledge to more effectively engage in outreach to them. Therefore, it would be advisable for RHP and the refugee resettlement agencies in Chicago to make a greater attempt to partner with these organizations and associations and build stronger relationships with them in an effort to work together to improve the health of the newly arriving Iraqi refugees.

  Furthermore, as one of the Iraqi key informants suggested, those Iraqis living in Chicago who arrived to the United States before the 2003 invasion of Iraq may prove helpful in reaching out to newly arrived Iraqis, especially in improving their utilization of mental health services. She says many of them have had therapy and can emphasize to the newly arrived refugees that it is not shameful but rather helps to lower stress and gives strength to move forward. She also suggested that it would be easy to increase physical activity within the Iraqi refugee community by finding champions from the community, or “group leaders”, who could call together a group of their Iraqi refugee friends and family to go out for a walk, go to the park, or engage in some other form of physical activity. She said, “They need someone to guide and encourage them, but I can’t be that person always.”

- **Bring together all the key players in a collaborative effort to more effectively address the health needs of the Iraqi refugee population through improved communication and better coordination of services.**

  These key players should include representatives from the refugee resettlement agencies in the Chicagoland area; RHP; the clinics serving Iraqi refugees; the Arab, Assyrian, Muslim, Kurdish, and specifically Iraqi community organizations located in Chicago; and key community leaders from the Iraqi refugee population in Chicago. Once these players are brought together, the first step is to increase awareness about the health needs of Iraqi refugees newly arriving to Chicago within that group and engage in a dialogue about how to best address those needs in a culturally relevant manner that is owned by the Iraqi refugee community. It might be most effective to take this step after holding the group discussions with various
Iraqi refugees in Chicago in order to be able to present findings from those discussions with the service providers and community leaders gathered. This step should improve communication and collaboration between agencies and community leaders, improve the coordination of services to the Iraqi refugee population, and better integrate these services into a more comprehensive system that will ultimately improve the quality of life of the Iraqi refugee population in Chicago.
References


List of Abbreviations

BCG – Bacillus Calmette-Guérin
DTP – Diphtheria, Tetanus and Pertussis
ECAC – Ethiopian Community Association of Chicago
FY – Fiscal Year
GHRA – Georgetown Human Rights Action
HRI – Human Rights Institute
IDP – Internally Displaced Person
IDPH – Illinois Department of Public Health
INH – Isoniazid
IOM – International Organization for Migration
PAA – Pan African Association
PPD – Purified Protein Derivative
PTSD – Post Traumatic Stress Disorder
RHP – Heartland Alliance Refugee Health Programs
RICS – Heartland Alliance Refugee and Immigrant Community Services
TB – Tuberculosis
UNHCR – United Nations High Commissioner for Refugees
UN RBAS – United Nations Development Programme, Regional Bureau for Arab States
US DHHS – United States Department of Health and Human Services
USG – United States Government
USRAP – United States Refugee Admissions Program
WHO – World Health Organization
WIC – Women, Infants and Children
Resources

International, National, and State Governmental Organizations

- **United Nations High Commissioner for Refugees (UNHCR)**
  The agency is mandated to lead and co-ordinate international action to protect refugees and resolve refugee problems worldwide. Its primary purpose is to safeguard the rights and well-being of refugees. It strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State, with the option to return home voluntarily, integrate locally or to resettle in a third country. It also has a mandate to help stateless people.

  Case Postale 2500
  CH-1211 Genève 2 Dépôt
  Suisse.
  Tel: +41.22.739.8111
  Email: Online contact form: [http://www.unhcr.org/php/contact.php?opt=headquarters](http://www.unhcr.org/php/contact.php?opt=headquarters)
  Website: [http://www.unhcr.org](http://www.unhcr.org)
  Iraq Website: [http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486426](http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e486426)

- **World Health Organization (WHO)**
  WHO is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

  Avenue Appia 20
  1211 Geneva 27
  Switzerland
  Tel: + 41.22.791.21 11
  Email: [info@who.int](mailto:info@who.int)
  Website: [http://www.who.int](http://www.who.int)
  Iraq Website: [http://www.who.int/countries/irq/en/](http://www.who.int/countries/irq/en/)
  WHO Country Office in Iraq Website: [http://www.emro.who.int/iraq/](http://www.emro.who.int/iraq/)

- **International Organization for Migration (IOM)**
  IOM is committed to the principle that humane and orderly migration benefits migrants and society. As the leading international organization for migration, IOM acts with its partners in the international community to:
  
  - Assist in meeting the growing operational challenges of migration management.
  - Advance understanding of migration issues.
  - Encourage social and economic development through migration.
  - Uphold the human dignity and well-being of migrants.

  17, Route de Morillons
  CH-1211 Geneva 19
  Switzerland
  Tel: +41.22.798.6150
  Email: [hq@iom.int](mailto:hq@iom.int)
  Website: [http://www.iom.int](http://www.iom.int)

- **U.S. Department of State, Bureau of Population, Refugees, and Migration (PRM)**
The mission of the Bureau is to provide protection, life-sustaining relief, and durable solutions for refugees and conflict victims, working through the multilateral humanitarian system to achieve the best results for refugees and conflict victims on behalf of the American taxpayer. The Bureau has primary responsibility within the U.S. government for formulating policies on population, refugees, and migration, and for administering U.S. refugee assistance and admissions programs.

2201 C. Street NW
Washington, DC 20520
Tel: 202.647.4000
Email:
Refugees with questions: refquestions@wrapsnet.org
NGOs interested in grants: PRMNGOCoordinator@state.gov
Website: http://www.state.gov/g/prm/
Statistics on refugee resettlement in the US: http://www.wrapsnet.org

U.S. Department of Health and Human Services (DHHS), Administration for Children and Families (ACF), Office of Refugee Resettlement (ORR)

Founded on the belief that newly arriving populations have inherent capabilities when given opportunities, the Office of Refugee Resettlement (ORR) provides people in need with critical resources to assist them in becoming integrated members of American society.

901 D Street, SW, 8th Floor
Washington, DC 20447
Tel: 202.401.9246
Website: http://www.acf.hhs.gov/programs/orr/

U.S. Committee for Refugees and Immigrants

The mission of U.S. Committee for Refugees and Immigrants is to address the needs and rights of persons in forced or voluntary migration worldwide by advancing fair and humane public policy, facilitating and providing direct professional services, and promoting the full participation of migrants in community life.

2231 Crystal Dr., Ste. 350
Arlington, VA 22202
Tel: 703.310.1130
Email: uscri@uscridc.org
Website: http://www.refugees.org/


The Department of Homeland Security has a vital mission: to secure the nation from the many threats we face. This requires the dedication of more than 230,000 employees in jobs that range from aviation and border security to emergency response, from cybersecurity analyst to chemical facility inspector. Our duties are wide-ranging, but our goal is clear – keeping America safe.

US Department of Homeland Security
Washington, DC 20528
Tel: 202.282.8000
Website: http://www.dhs.gov/files/statistics/immigration.shtm

U.S. Citizenship and Immigration Services (USCIS)

U.S. Citizenship and Immigration Services (USCIS) is the government agency that oversees lawful immigration to the United States. USCIS will secure America’s promise as a nation of immigrants by providing accurate and useful information to our customers, granting immigration
and citizenship benefits, promoting an awareness and understanding of citizenship, and ensuring the integrity of our immigration system.

U.S. Citizenship and Immigration Services
Washington, DC
Tel: 800.375.5283
Email: SCOPSSCATA@dhs.gov
Website: http://www.uscis.gov

- **U.S. Census Bureau**
  The Census Bureau serves as the leading source of quality data about the nation's people and economy. We honor privacy, protect confidentiality, share our expertise globally, and conduct our work openly. We are guided on this mission by our strong and capable workforce, our readiness to innovate, and our abiding commitment to our customers.

  4600 Silver Hill Rd
  Washington, DC 20233
  Tel: 301.763.INFO or 800.923.8282
  Email: Question & Answer Center: http://ask.census.gov/cgi-bin/askcensus.cfg/php/enduser/std_alp.php?p_sid=mTmXBx1k
  Website: http://www.census.gov

- **Illinois Department of Human Services (IDHS), Bureau of Refugee and Immigrant Services**
  The Bureau of Refugee and Immigrant Services funds, manages, and monitors contracts designed to:
  - Help newly arriving refugees achieve self-sufficiency in the United States;
  - Provide health services to low-income immigrants;
  - Provide citizenship education and application services to resident non-citizens desiring to become United States citizens.
  - Provide outreach and interpretation services to limited English proficient individuals requiring supportive services.

  401 S. Clinton, 2nd Floor
  Chicago, IL
  Tel: 312.793.7120
  Website: http://www.dhs.state.il.us/page.aspx?item=33137

- **Illinois Department of Public Health (IDPH), Center for Minority Health Services, Refugee Program**
  The Department’s Center for Minority Health Services was created to provide information and technical assistance regarding the health care needs of minority populations; and to develop, maintain and enhance health care services in minority communities. To achieve this goal, the Center works with state and local entities to heighten awareness of minority health issues and services across the state. The Center’s Refugee Program coordinates health assessment and screening for Illinois refugees and Orderly Departure Program immigrants through the identification, referral for treatment and follow–up of observed health problems.

  Illinois Department of Public Health
  535 W. Jefferson St.
  Springfield, IL 62761
  Tel: 212.782.4977
  Email: DPH.MAILUS@illinois.gov

  Refugee Health Program Administration
  122 S. Michigan Ave., 7th Floor
  Chicago, IL 60603
  Tel: 312.814.1538
  Email: DPH.MAILUS@illinois.gov
Research Institutions

- **Johns Hopkins University, Center for Refugee and Disaster Response**
  The Center for Refugee and Disaster Response is an internationally recognized leader in building capacity to meet the physical and mental health needs of refugees and disaster victims worldwide. The Center for Refugee and Disaster Response (CRDR), at the Johns Hopkins Bloomberg School of Public Health, develops and implements emergency systems that meet the needs of underserved, vulnerable populations in crisis. CRDR is a unique, collaborative academic program conducted jointly by the Department of International Health at the Johns Hopkins Bloomberg School of Public Health, the Department of Emergency Medicine at the Johns Hopkins University School of Medicine, and the Johns Hopkins University School of Nursing. CRDR partners globally with nongovernmental organizations, international and governmental organizations, as well as other research institutions on field-based research and humanitarian projects. CRDR enhances humanitarian assistance by providing education and training, research, and response services.
  
  Center for Refugee and Disaster Response  
  Johns Hopkins Bloomberg School of Public Health  
  615 N. Wolfe St., Room E8646  
  Baltimore, MD 21205  
  Tel: 443.287.4842  
  Email: lnburns@jhsph.edu  
  Website: [http://www.jhsph.edu/refugee/](http://www.jhsph.edu/refugee/)

- **Georgetown University, Institute for the Study of International Migration (ISIM)**
  The Institute for the Study of International Migration [ISIM], founded in 1998, is part of the Edmund A. Walsh School of Foreign Service and affiliated with the Law Center at Georgetown University. ISIM focuses on all aspects of international migration, including the causes of and potential responses to population movements, immigration and refugee law and policy, comparative migration studies, the integration of immigrants into their host societies, and the effects of international migration on social, economic, demographic, foreign policy and national security concerns. ISIM also studies internal displacement, with particular attention to the forced movements of people for reasons that would make them refugees if they crossed an international border.
  
  Georgetown University  
  Harris Building  
  3300 Whitehaven Street, 3rd Floor  
  Washington, DC 20007  
  Tel: 202.687.2258  
  Website: [http://isim.georgetown.edu/index.html](http://isim.georgetown.edu/index.html)

Resettlement Agencies and Programs

- **Heartland Alliance Refugee and Immigrant Community Services (RICS), a program of Heartland Human Care Services**
  The Refugee Resettlement & Placement program provides resettlement assistance to newly arrived refugees. Services include picking them up at the airport, securing housing, purchasing food and household items, and providing initial orientation during the first 90 days in the US. The program also provides referrals to mental and physical health providers, third-party mediation, pre-arrival conference with relatives, and affidavits of relationship to reunite families.
RefugeeOne (formerly Interfaith Refugee and Immigrant Ministries – IRIM)

Interfaith Refugee and Immigration Ministries (IRIM) is a 501(c)3 not-for-profit organization that provides a full range of services to refugees and immigrants resettling in the Chicago metropolitan area. Every year, IRIM assists more than 3,000 refugees and immigrants from around the world find housing, learn English, acclimate to American culture, develop computer and other employable skills, find jobs, obtain medical and other care, access the public school system for their children, apply for citizenship, and obtain care for elderly family members.

4753 N. Broadway, Ste. 401
Chicago, IL 60640
Tel: 773.989.5647
Email: irim@irim.org
Website: http://www.refugeeone.org

Catholic Charities

The Refugee Resettlement Program provides comprehensive resettlement services to refugees from various regions of the world during their period of adaptation to a new environment, leading them to greater self-sufficiency. Activities are planned and arranged to address problems specific to individual/family refugees such as linguistic and cultural barriers, housing, financial assistance, interpretation and mediation services, transportation, orientation and case management. Emphasis is placed on early employment for those who are eligible.

651 W. Lake St., Ste. 500
Chicago, IL 60661
Tel: 312.655.7860
Website: http://www.catholiccharities.net/services/refugee_resettlement/

World Relief Chicago (WR-C)

WR-C provides wrap-around, holistic services to refugees and immigrants. WR-C’s resettlement program includes comprehensive resettlement, case management financial literacy classes and employment services to refugees arriving in Chicago. Immigration legal service and citizenship assistance is available to both immigrants and refugees. WR-C also offers adult English as a Second Language (ESL) classes, in-home English tutoring, Family Literacy and an early childhood education program.

3507 W. Lawrence Ave. #208
Chicago, IL 60625
Tel: 773.583.9191
Email: chicago@wr.org
Website: http://worldrelief.org/Page.aspx?pid=1775

World Relief DuPage (WR-D)

The mission of World Relief DuPage is to empower the local Church to serve the most vulnerable. In community with the local Church, World Relief envisions the most vulnerable
people transformed economically, socially, and spiritually. WR-D is a Christ-centered organization that partners with local churches and works with hundreds of individuals as well as community groups to offer a comprehensive range of services to refugees and immigrants living in DuPage and Kane Counties. The goal is to empower the local Church to serve the most vulnerable, and to see refugees, immigrants and members of their communities become fully-functioning, integrated participants in society.

1825 College Ave., Ste. 230  
Wheaton, IL 60187  
Tel: 630.462.7566  
Website: http://worldrelief.org/Page.aspx?pid=1715

- Pan African Association (PAA)
  The mission of Pan-African Association is to serve, empower, and promote the interests of all refugees and immigrants of African descent. Through our work, we enable Chicago's African refugees and immigrants to come together as a cohesive, supportive group. In so doing, people work hand-in-hand to ensure self-reliance, and healthier, happier lives. Our programs provide tools that enable self-sufficiency and improve family health; strengthen mental outlooks through mentorship, workshops, and support groups; build bridges between Africans of all nations and Chicagoans from all backgrounds; form collaborations that build happier lives, and assist Chicago's African community to maintain its rich cultural heritage of music, art, dance, culinary, and literary achievements.

  6163 N. Broadway  
  Chicago, IL 60660  
  Tel: 773.381.9723  
  Website: http://www.panafricanassociation.org/

- Ethiopian Community Association of Chicago (ECAC)
  The Ethiopian Community Association of Chicago (ECAC) is a non-profit, charitable organization committed to serving the cultural, psychological and socio-economic needs of refugees and immigrants in and around metropolitan Chicago. In addition to assisting native Ethiopians, ECAC also supports other African, Asian, Middle Eastern and Eastern European refugee populations who seek its services. Established in 1984, ECAC assists in the promotion of personal growth, financial stability, positive family and community relations and community empowerment. The adjustment and development of all of ECAC's constituents is facilitated with programs in the areas of advocacy, education, employment, healthcare and community outreach.

  1730 W. Greenleaf  
  Chicago, IL 60626  
  Tel: 773.508.0303  
  Website: http://www.ecachicago.org

- East Central Illinois Refugee Mutual Assistance Center (ECIRMAC)
  The purpose of the East Central Illinois Refugee Mutual Assistance Center (AKA ECIRMAC or Refugee Center) is to aid in the resettlement of refugees and immigrants, regardless of country or origin, in the East-Central Illinois area and to aid in the exchange and preservation of their respective cultures.

  302 S. Birch  
  Urbana, IL 61801  
  Tel: 217.344.8455  
  Email: ecirmac@hotmail.com  
  Website: http://www.ecirmac.org/
Direct Service Agencies and Programs for Refugees in the Chicagoland Area

- **Mt Sinai’s Touhy Health Center**
  Mount Sinai’s traditional relationship with the Jewish community continues in our service to thousands of refugees and other patients referred by the Jewish Federation of Metropolitan Chicago. Mount Sinai’s Touhy Health Center in West Rogers Park cares for many of these Jewish Federation patients, as well as for families and seniors on the city’s North Side and in the nearby suburbs.
  
  2901 W. Touhy Ave.
  Chicago, IL 60645
  Tel: 773.973.7350
  Website: [http://sinai.org/who-we-are/MSH.asp](http://sinai.org/who-we-are/MSH.asp)

- **CDPH Uptown Neighborhood Health Center**
  
  845 W. Wilson
  Chicago, IL 60640
  Tel: 312.744.1938

- **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)**
  To safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care. Food, nutrition counseling, and access to health services are provided to low-income women, infants, and children under the Special Supplemental Nutrition Program for Women, Infants, and Children, popularly known as WIC. WIC provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children who are found to be at nutritional risk. Most State WIC programs provide vouchers that participants use at authorized food stores. A wide variety of State and local organizations cooperate in providing the food and health care benefits, and 46,000 merchants nationwide accept WIC vouchers.
  
  Illinois Department of Human Services
  Women, Infants, and Children
  Several WIC Locations. To find a nearby office, go to [http://www.dhs.state.il.us/page.aspx?module=12](http://www.dhs.state.il.us/page.aspx?module=12)
  
  DHS Main Chicago Office
  401 S. Clinton St.
  Chicago, IL 60607
  Tel: 800.843.6154 or 312.793.2354
  Website: [http://www.dhs.state.il.us/page.aspx?item=30513](http://www.dhs.state.il.us/page.aspx?item=30513)

- **Chicago Department of Family and Support Services (DFSS)**
  The Chicago Department of Family and Support Services (DFSS) supports a continuum of coordinated services to enhance the lives of Chicago residents, particularly those most in need,
from birth through the senior years. DFSS provides families with the resources they need to create a strong developmental and educational foundation for children as well as offers youth, opportunities to learn and explore their talents outside of the classroom and through job training.

DFSS offers direct services and referrals for specialized assistance to residents and families in need through its six Community Service Centers. The DFSS Division on Domestic Violence is dedicated to promoting a coordinated multi-system response to domestic violence in Chicago. And the department’s Senior Services Area Agency on Aging administers a variety of informational and recreational programs through our Regional and Satellite Senior Centers, designed to address the diverse needs and interests of older Chicagoans, from those who are healthy and active, to those who are frail and homebound.

1615 W. Chicago Ave., 5th Floor
Chicago, IL 60622
Tel: 312.743.0300
Email: Send message on website.

□ **Heartland Alliance Marjorie Kovler Center**

The Marjorie Kovler Center of Heartland Alliance helps survivors of torture overcome trauma and begin a life without fear through medical, mental health, emergency, and a wide range of other support services. Assistance is provided by staff, volunteers and by referral to other human service organizations. All services provided by the Marjorie Kovler Center are free of charge.

1331 W. Albion Ave
Chicago, IL 60626
Tel: 773.751.4071
Email: kovler@heartlandalliance.org
Website: http://www.heartlandalliance.org/kovler/

□ **Heartland Alliance International FACES**

International Family, Adult, and Child Enhancement Services (FACES) provides comprehensive, community-based mental health services for refugee, asylee and asylum-seeking children, adults, and families suffering from trauma or emotional disorders. Services include individual and family counseling, assistance accessing benefits and entitlements, expressive therapies, linkages to primary and dental health care, and case management.

4750 N. Sheridan Rd., Ste. 500
Chicago, IL 60640
Tel: 773.751.4188
Email: refugeemhas@heartlandalliance.org
Website: http://www.heartlandalliance.org/whatwedo/our-programs/directory/faces.html

□ **Asian Human Services Family Health Center (AHSFHC)**

Asian Human Services exists to provide quality, compassionate, and culturally competent services in over 28 languages to low-income Asian-American and immigrant and refugee communities in metropolitan Chicago. AHSFHC’s mission is to provide culturally competent and linguistically appropriate quality and compassionate health care services to the Asian American and all other underserved or underprivileged communities in metropolitan Chicago. The AHS Family Health Center provides quality primary care services to immigrants and refugees, and other medically underserved residents on Chicago’s North Side. Their staff speaks Vietnamese, Urdu, Hindi, Gujarati, Thai, Tagalog, Punjabi, Somali, Spanish and Pashto.

2424 W. Peterson
□ **Muslim Women Resource Center**

Muslim Women Resource Center's mission is to assist immigrant and refugee Muslim women overcome cultural and language barriers, and prepare them with appropriate occupational skills to become self-sufficient and ready to enter the job market.

6349 N. Western Ave. #205  
Chicago, IL 60659  
Tel: 773.764.1686  
Email: Send message on website.  
Website: [http://www.mwrcnfp.org/](http://www.mwrcnfp.org/)

□ **Stickney Public Health District**

Stickney Public Health District is certified as a local health department by the Illinois Department of Public Health. Founded in 1946, the SPHD provides a variety of health prevention treatments and public health services to the residents of Stickney Township. We are committed to improving and protecting the health of our residents and encourage you to take advantage of our services. These include programs that provide health services to both the youngest and the most senior of Stickney Township's population. In Home Nursing program seeks to maintain the independence of elderly citizens while the Women, Infants and Children program targets the nutritional needs of those in the early stages of life. The SPHD also takes a broader role in servicing the environmental and safety concerns of our community.

5635 State Rd.  
Burbank, IL 60459  
Tel: 708.424.9200  
Email: wic@stickneypublichealthdistrict.org  
Website: [http://www.stickneypublichealthdistrict.org/HealthWIC.html](http://www.stickneypublichealthdistrict.org/HealthWIC.html)

□ **Islamic Circle of North America (ICNA) Relief**

ICNA Relief is a social services department of Islamic Circle of North America. They are a humanitarian relief and development organization responding to human sufferings in emergency and disaster situations through America. Their mission is to strengthen the bond of humanity by serving all those in need, with special focus on their neighborhoods where ICNA Relief programs exist. In addition to providing humanitarian aid to Muslims, they are actively establishing services for the need in poor neighborhoods through the city. For the past three years, they have been actively conducting Feed the Hungry drives multiple times a year serving the community with a special focus on providing year round refugee assistance to over 150 families around Chicago.

Tel: 866.497.9037, ext. 1  
Email: relief@icnachicago.org  
Website: [http://icnachicago.org/index.php/icna-relief](http://icnachicago.org/index.php/icna-relief)

□ **Refugee Assistance Programs**

Refugee Assistance Programs aims to assist refugees to become self-reliant, including through the provision of groceries and personal care products in times of need, Qur’an classes, driving lessons, assistance with rent and college fees, and mentorship. They also fundraise, manage events for refugees, and bring relief to refugee families.
Advocacy, Policy, and Community Organizations and Programs

- **Refugees International**
  Refugees International advocates for lifesaving assistance and protection for displaced people and promotes solutions to displacement crises. Refugee crises left unattended threaten stability around the world. Due to Refugee International's efforts, abandoned refugees receive food, medicine and education; displaced families return home; peacekeepers are sent to protect displaced people from harm; and stateless people obtain legal status. Refugees International was started in 1979 as a citizens' movement to protect Indochinese refugees. Since then, it has expanded to become the leading advocacy organization that provokes action from global leaders to resolve refugee crises. Each year, Refugees International conducts 20 to 25 field missions to identify displaced people's needs for basic services such as food, water, health care, housing, access to education and protection from harm. Based on their field-based knowledge of humanitarian emergencies, they successfully challenge policy makers and aid agencies to improve the lives of displaced people around the world. Where there are needs, they witness what is lacking, present solutions and demand action.

  2001 S Street NW, Ste. 700
  Washington, DC 20009
  Tel: 202.828.0110 or 800.REFUGEE
  Email: ri@refintl.org
  Website: http://www.refugeesinternational.org

- **InterAction**
  InterAction is the largest coalition of U.S.-based international nongovernmental organizations (NGOs) focused on the world’s poor and most vulnerable people. At InterAction, we recognize that our global challenges are interconnected and that we can’t tackle any of them without addressing all of them. That's why we create a forum for leading NGOs, global thought leaders and policymakers to address our challenges collectively. Leveraging our shared expertise, on-the-ground insights from our 180 member organizations and strategic analyses of the foreign aid budget, we deliver a bold, new agenda to end global poverty and deliver humanitarian aid in every developing country. A core mandate of InterAction is to provide a collective voice to advance international awareness and protection of the more than 42 million forcibly displaced people worldwide. Our member organizations work together to influence global dialogue, programming and policies related to protection; strengthen internal capacity of member organizations to identify and respond to protection challenges; and expand partnerships with the UN, the U.S. government and nongovernmental organizations.

  1400 16th St., NW, Ste. 210
  Washington, DC 20036
  Tel: 202.667.8227
  Email: ia@interaction.org
  Website: http://www.interaction.org/refugees-displacement-protection

- **National Immigration Forum**
  Established in 1982, the National Immigration Forum is the leading immigrant advocacy organization in the country with a mission to advocate for the value of immigrants and immigration to the nation. The Forum uses its communications, advocacy and policy expertise to create a vision, consensus and strategy that leads to a better, more welcoming America – one that treats
all newcomers fairly. Ultimately, our vision is to create US immigration policy that honors our
nation’s ideals, protects human dignity, reflects our country’s economic demands, celebrates
family unity and provides opportunities for progress.

50 F Street, NW, Ste. 300
Washington, DC 20001
Tel: 202.347.0040
Website: http://www.immigrationforum.org/

□ Migration Policy Institute

The Migration Policy Institute is an independent, nonpartisan, nonprofit think tank in Washington,
DC dedicated to analysis of the movement of people worldwide. MPI provides analysis,
development, and evaluation of migration and refugee policies at the local, national, and
international levels. It aims to meet the rising demand for pragmatic and thoughtful responses to
the challenges and opportunities that large-scale migration, whether voluntary or forced, presents
to communities and institutions in an increasingly integrated world.

1400 16th St., NW, Ste. 300
Washington, DC 20036
Tel: 202.266.1940
Email: info@migrationpolicy.org
Website: http://www.migrationpolicy.org

□ Heartland Alliance International Programs

For more than 100 years, Heartland Alliance has been working with displaced and vulnerable
people in the Chicago area, including refugees, asylum seekers, migrants and victims of
trafficking. Using the expertise gained through the delivery of such services, Heartland Alliance
has turned its attention to the countries where these vulnerable and displaced persons originate,
which have been adversely affected by war, violence and poverty. In these countries, Heartland
Alliance applies its particular areas of expertise to build the capacity of local partners to provide
quality and sustainable services to vulnerable populations.

Tel: 312.660.1353
Email: Send message on website
Website: http://www.heartlandalliance.org/international/index.html

□ RefugeeWorks

As the national center for refugee employment, RefugeeWorks specializes in providing
exceptional training, consulting and publishing services to the national refugee employment
network. Working in partnership with service providers and employers nationwide, we are
committed to helping refugees achieve economic self-sufficiency.

700 Light St.
Baltimore, MD 1230
Tel: 410.230.2886
Email: information@refugeeworks.org
Website: http://www.refugeeworks.org

□ Exodus World Service
Exodus World Service transforms the lives of refugees and volunteers. We educate churches about refugee ministry, connect volunteers with newly arriving refugees through practical service projects, and equip leaders to speak up on behalf of refugees. The end result is that wounded hearts are healed, loneliness is replaced with companionship, and fear is transformed into hope.

PO Box 620
Itasca, IL 60143
Tel: 312.REFUGE or 630.307.1400
Website: http://www.e-w-s.org/

口 Chaldean Federation of America
The Chaldean Federation of America (CFA) is an umbrella association of nine major Chaldean organizations in Metropolitan Detroit. The CFA represents more than 150,000 Chaldean-American residents in this region. The CFA has served as a catalyst for the assimilation of thousands of Chaldeans into the American culture. Metropolitan Detroit is home to the largest number of Chaldean Americans in the United States. Chaldean Americans make up one of the fastest growing minorities in Southeastern Michigan. Notably, Chaldean Americans have their own culture, language, and religious beliefs, which differ from other Middle Eastern Arab ethnic groups. The CFA works to help advance Chaldean Americans and aid in the settlement of Iraqi Christian refugees.

29850 Northwestern Hwy., Ste. 250
Southfield, MI 48034
Tel: 248.996.8384
Email: info@chaldeanfederation.org
Website: http://www.chaldeanfederation.org

口 Illinois Coalition for Immigrant and Refugee Rights (ICIRR)
The Illinois Coalition for Immigrant and Refugee Rights (ICIRR) is dedicated to promoting the rights of immigrants and refugees to full and equal participation in the civic, cultural, social, and political life of our diverse society. In partnership with its member organizations, ICIRR educates and organizes immigrant and refugee communities to assert their rights; promotes citizenship and civic participation; monitors, analyzes, and advocates on immigrant-related issues; and, informs the general public about the contributions of immigrants and refugees.

55 E. Jackson Blvd., Ste. 2075
Chicago, IL 60604
Tel: 312.332.7360
Email: Send message on website.
Website: http://icirr.org

口 Arab American Family Services
Arab American Family Services (AAFS), a nonprofit social service agency founded in 2001, provides caring, compassionate, multilingual assistance to (South Suburban) Chicagoland residents. AAFS offers support in the areas of public benefits, immigration, domestic violence, mental health, and elderly services and sponsors outreach programs to build healthier families and communities. As a locally focused, nonpolitical and nonreligious agency, AAFS works to build bridges of respect and understanding between Arab-American and mainstream-American cultures. By helping local neighbors overcome personal crisis, strengthen their families, and live healthier, more successful lives, AAFS is making a profound and positive impact in our community.
Arab American Action Network (AAAN)
The Arab American Action Network (AAAN) is a nonprofit, grassroots, community-based organization working to improve the social, economic and political conditions of Arab immigrants and Arab Americans in the Chicago metropolitan area. The AAAN strives to strengthen the Arab community in the Chicago area by building its capacity to be an active agent for positive social change. As a grassroots nonprofit, our strategies include community organizing, advocacy, education, providing social services, leadership development, cultural outreach, and forging productive relationships with other communities. Our vision is for a strong Arab American community whose members have the power to make decisions about actions and policies that affect their lives and have access to a range of social, political, cultural and economic opportunities in a context of equity and social justice.

3148 W. 63rd St.
Chicago, IL 60629
Tel: 773.436.6060
Email: info@aaan.org
Website: http://www.aaan.org

Inner-City Muslim Action Network (IMAN)
The Inner-City Muslim Action Network (IMAN) is a community-based nonprofit that works for social justice, delivers a range of social services, and cultivates the arts in urban communities. Organizers and volunteers strove to make IMAN a holistic community organization that offered a range of programming and services while organizing to affect positive social change. While led by Muslims, IMAN sought from the outset to work for and along side community residents of all ethnic, cultural and religious backgrounds: a commitment clearly reflected in the constituency that IMAN serves and organizes with through its many programs and projects. To foster a dynamic and vibrant space for Muslims in Urban America by inspiring the larger community towards critical civic engagement exemplifying prophetic compassion in the work for social justice and human dignity beyond the barriers of religion, ethnicity, and nationality.

2744 W. 63rd St.
Chicago, IL 60629
Tel: 773.434.IMAN
Email: info@imancentral.org
Website: http://imancentral.org/

Iraq Foundation, Iraqi House (al-Bayt al-Iraqi)
The Iraqi House, an affiliate of the Washington D.C.-based Iraq Foundation, was established in 1998 in order to help Chicago's Iraqi population access local social services. The Iraqi House is involved in advocacy activities, community strengthening programs, and a women's program that helps Iraqi women get involved in community affairs. The Iraq Foundation is a non-profit, 501(C)3 corporation, working for democracy and human rights in Iraq, and for a better international understanding of Iraq’s potential as a contributor to political stability and economic progress in the Middle East. The Iraq Foundation works for democracy and human rights in Iraq and for improving the lives of Iraqis. In 1998, with a grant from ORR, the Iraq Foundation initiated the Iraqi Community Organizing Project (ICOP) to promote the self-help and social integration of Iraqi refugees. ICOP hence established four CBOs in Nashville, Tennessee; St. Louis, Missouri;
Dearborn, Michigan; and Chicago, Illinois. ICOP’s CBOs have relentlessly sought to collaborate with other Iraqi-American organizations, mainly Assyrians and Kurdish, which have collaborated throughout the years in order to better serve Iraqi refugees. The CBOs thus became leading advocates of Iraqi-Americans’ unity.

Iraqi Community Organization
Project – Chicago Office
5151 N. Harlem Ave., Apt. #303
Chicago, IL 60656
Tel: 773.777.2295
Email: iraqihouse@msn.com
Iraqi House
Website: http://www.iraqfoundation.org

□ Iraqi Mutual Aid Society
The purpose of the Iraqi Mutual Aid Society is to foster the well-being and self-sufficiency of Iraqi refugees and immigrants in the Chicago-metro area – easing their transition to life in the United States, forging connections between Iraqi and American society, and facilitating the preservation and exchange of Iraqi culture.

Tel: 773.956.IRAQ
Email: info@IraqiMutualAid.org
Website: http://www.ibrazimutualaid.org

□ Iraqi Christian Relief Council
Iraqi Christian relief Council in coordination with entities and organizations in the United States of America is responsible for educating the Americans of the religious and ethnic cleansing being inflicted on Christians in Iraq. Our objective in raising awareness among the Americans is asking for their prayers, raising, and delivering financial assistance for the Iraqi Christians affected by these atrocities.

PO Box 3021
Glenview, IL 60025
Tel: 847.401.8846
Email: info@iraqichristianrelief.org, jtamraz@hotmail.com
Website: http://www.iraqichristianrelief.org

Arab and Muslim Religious Organizations
□ St. Elias Christian Church
1500 W. Elmdale Ave.
Chicago, IL 60660
Tel: 773.274.8828
Email: steliaschicago@yahoo.com
Website: http://www.steliaschicago.org

□ Muslim Community Center
4380 N. Elston Ave.
Chicago, IL 60041
Tel: 773.725.9047
Website: http://www.mccchicago.org

□ Directory of Arabic Christian Churches
Website: http://www.arabicbible.com/directories/churches/illinois.htm
Online Resources for Service Providers Working with Refugees

- **Heartland Alliance Refugee Health Programs (RHP)**
  Heartland Alliance Refugee Health Programs (RHP) provides culturally competent and linguistically appropriate outreach services to meet the health and nutrition education needs of newly arriving refugees, primarily on the North side of Chicago.
  
  1331 W. Albion Ave  
  Chicago, IL 60626  
  Tel: 773.751.4166  
  Email: refugeenutrition@heartlandalliance.org  
  Website: [http://www.heartlandalliance.org/refugeehealth](http://www.heartlandalliance.org/refugeehealth)

  Resources: PowerPoint Presentations in English on a wide array of health topics.

  Other resources can be found on the New American Health Information Portal website at [http://palantir.lib.uic.edu/nahip](http://palantir.lib.uic.edu/nahip)

- **The Providers Guide to Quality & Culture**
  This project is a joint project of Management Sciences for Health, the US Department of Health and Human Services, the Health Resources and Services Administration, and the Bureau of Primary Health Care. The website is designed to assist healthcare organizations throughout the US in providing high quality, culturally competent services to multi-ethnic populations.

  Website: [http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English](http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English)

  Resources: Cultural training tools and health information about refugees and immigrants from various cultures.

- **Center for Applied Linguistics (CAL), Cultural Orientation Resource Center**
  The Cultural Orientation Resource (COR) Center provides important orientation resources for refugee newcomers and service providers throughout the United States and overseas. Housed at the Center for Applied Linguistics (CAL), the COR Center combines CAL’s linguistic expertise, the cross-cultural and technical knowledge of COR’s many consultants, and the field experience of refugee service practitioners. A basic purpose behind CAL’s work has remained constant: to serve as a central resource on refugees and their resettlement needs. The COR Center’s mission is to enable refugee service providers to conduct culturally and linguistically appropriate orientation training for refugee newcomers to the United States.

  4646 40th Street NW  
  Washington, DC 20016  
  Tel: 202.362.0700  
  Email: Send message online at [http://www.cal.org/co/about/contact.html](http://www.cal.org/co/about/contact.html)  
  Website: [http://www.cal.org/co/](http://www.cal.org/co/)

  Resources: Information about orienting refugees to life in the US, reports about the history and culture of their countries, and lesson plans and tools to assist in the education of refugee populations.