ASPR TRACIE Technical Assistance Request

Request Receipt Date (by ASPR TRACIE): August 27, 2021
Response Date: September 13, 2021, **updated October 25, 2021**
Type of TA Request: Complex

Request:

ASPR TRACIE received a technical assistance request from private sector healthcare partners on considerations for healthcare facilities planning for and responding to the Afghan Evacuation/ Operation Allies Welcome Response.

Federal Resources

- Administration for Children and Families (ACF)
- Assistant Secretary for Preparedness and Response (ASPR)
- CDC
- Customs and Border Protection (CBP)
- DHS Office of Health Affairs
- List of Resettlement Agencies by State
- National Language Service Corps (NLSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- State Level Refugee Coordinators

Response:

Note: On September 20, 2021, the Centers for Disease Control and Prevention (CDC) issued an official health advisory titled Guidance for Clinicians Caring for Individuals Recently Evacuated from Afghanistan.

ASPR TRACIE developed this information in close collaboration with our Subject Matter Expert Cadre, including private sector healthcare emergency management partners.

This document provides general considerations that may be helpful for healthcare facilities that are caring for Afghan Special Immigrants (ASIs) during this response.

Afghan Relocation Response Evacuee Categories/ Status

There are four primary categories/status of evacuees who are going through the federal relocation response process; please note non-governmental organizations (NGOs) and other parties are assisting some ASIs outside the federal relocation process. The first two categories will fully integrate into the U.S. healthcare system with minimal impact. The last two are the primary ASIs to whom healthcare facilities need to plan to provide immediate support and potentially longer-term care:

1. American citizens
2. Long-term residents/ green card holders
3. Special Immigration Visas (SIVs)- may have already obtained full or partial visas
4. Paroled refugees who have gone through background checks but are in the process of applying for a temporary visa or parolee process

Pre-Departure and Immediate Arrival to U.S. Medical Screening

The following are excerpts from CDC's *Medical Screening and COVID Guidance: Infection Control and Mitigation Measures for Afghan Relocation Response, version 8/16/21* (not publicly available). **NOTE: ASPR TRACIE cannot verify its current accuracy but include it here so healthcare providers can incorporate it into follow-up questions to ask ASIs.**

- The majority of ASIs will not have had any pre-departure COVID-testing, fitness-to-travel evaluations, or immigration medical exams before arrival in the U.S. Prior to 13 August 2021, some ASIs may have received COVID-19 testing and medical exams at the American or German Medical Centre Clinics.
- During flight and ground transportation, all persons aged 2 and older were asked to wear a mask, and social distancing between family units was maintained as much as feasible. Frequent hand hygiene was encouraged.
- ASIs should have undergone a medical examination as specified in the Technical Instructions for Civil Surgeons. Consider tuberculosis [TB] and syphilis screening options, treatment, and follow-up care at the final destination.
- Mumps, measles, and rubella (MMR) vaccinations should be provided as soon as possible for ASIs between 6 months through birth in 1957 (64 years old) or later.
    - Afghanistan is currently ranked #7 worldwide for measles outbreaks. The recommendation to reduce the minimum age of MMR vaccination (12 months to 6 months of age) is to provide post-exposure prophylaxis since the ASIs are coming from a country of high risk, with no medical screening or documented vaccination prior to travel, and arriving in a congregate setting at the base. Measles vaccine administered within 72 hours of exposure may reduce the risk of infection and/or the severity of disease. Thus, administering MMR vaccine as soon as possible to the ASIs is a top public health priority.
    - Females of child-bearing age (ages 12 through 50) should have urine pregnancy testing before MMR vaccination.
- Other vaccines can be administered simultaneously with MMR vaccine, or later during ASI medical processing at the base. Only live virus vaccines need to be given simultaneously.
- Varicella vaccine is to be administered simultaneously with the MMR vaccine. Note that mumps, measles, rubella, and varicella (MMRV) should not be administered to children < 12 months of age. MMRV vaccine can be administered to children 12 months through 12 years of age but is not indicated for people outside this age group.
- Inactivated polio virus (IPV) vaccination should be given to all ASIs (without a medical contraindication) who are 6 weeks and older. Afghanistan has circulating wild-type polio type 1 and vaccine-derived circulating polio type 2.
- COVID-19 vaccination will be offered to all medically- and age-eligible persons.
- ASIs should be tested as soon as possible for COVID-19 (rapid antigen, point-of-care nucleic acid amplification test [NAAT], or laboratory-based polymerase chain reaction [PCR] or other NAAT are acceptable) and should be retested 3-5 days after arrival.

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- ASIs should have been given two sealed copies of their exam results (I-693 form)- one for DHS and another for the clinic that will conduct their routine post-arrival medical exam and follow-up care at their final destination in the US.

Additional Resources

- CDC Guidance for the US Domestic Medical Examination for Newly Arriving Refugees
- CDC Immigrant, Refugee, and Migrant Health
- CDC Interim Clinical Considerations for Use of COVID-19 Vaccines
- CDC Refugee Medical Screening Guidance
- Minnesota Department of Health, CareRef Clinical Assessment for Refugees

Planning Considerations

As a facility that may be providing post-arrival or follow-up medical care to ASIs, the following considerations can help you begin working with your state and local partners, public health, healthcare coalitions (HCCs), acute care, and community members:

- Unified Command
  - Does it exist and, if so, who is involved and where is it located?
  - What are the 24/7 point of contact (POC) numbers?
- Integrate coordination efforts with state and local government agencies, HCC, and military installations to address:
  - Transportation services (public and emergency medical services [EMS])
  - Social services
  - Public health surveillance and testing
  - Medical needs- during and after intake at military installations and initial disposition centers (e.g., convention or expo center)
  - On-site medical screening assistance
  - Memoranda of understanding (MOUs) to cover service delivery (e.g., transportation, medical care)
  - Patient tracking (e.g., in Northern Virginia, they are using a regionally deployed system and have found that sharing a single POC [such as the nursing supervisor line] in each facility for bases or intake/disposition centers to call is more useful when sending a patient for evaluation or follow up care)
  - Family reunification if needed - ASIs should be asked if all expected family members are present. This may benefit planning for downstream services and potential unaccompanied minor situations.
- Clarify roles with respect to medical care already being provided:
  - Onsite screenings/ pharmacy/ medical expertise
  - Transfers to medical facilities for emergencies - who will do it and cost considerations
  - Transportation back to refugee transfer locations from the hospital following discharge

    - Coordination of prescription medication
    - Coordination of discharge planning - including return destination, transportation, and medical follow-up (case management), if needed
    - Connection and access to ongoing care
        - Primary care
        - Specialty (e.g., dental, optometry)
        - Needed referral care for subacute/ chronic conditions (e.g., orthopedic, infectious, cardiac)
- Integrate communication efforts with local military installation and community partners:
    - Public messaging
    - Outreach to local Afghan and Islamic community leaders
    - Coordination with local NGOs or charitable organizations offering support
- Plan for and manage resource needs:
    - Ensure you have access to adequate and appropriate medical translation services
        - There are more than 40 languages and 200 dialects spoken in Afghanistan, with Pashto and Dari/Farsi being the most widely spoken.
        - National Language Service Corps may be an additional resource.
    - Determine which response partner is coordinating donation management
    - Ensure access to:
        - Prayer rugs and prayer locations for those able to ambulate if hospitalized
        - Hygiene kits as part of discharge
    - Provide telecommunication support for hospitalized family members and family that are not able to visit
    - Consider food considerations:
        - Note that some ASIs may have been suffering from food insecurity so precautions should be in place for providing nutritionally appropriate food.
        - Cultural sensitivity and dietary customs.
- Ensure cultural and religious competency:
    - The *American Red Cross DR-255 Cultural Competency Guidelines* (not publicly available) provides guidance in the following areas: team composition and behaviors; sheltering greetings, engagement, setting, prayer, feeding; religion and culture; mental, emotional, and spiritual care; emblems and fundamental principles; traumatic situations and conflict resolution; cultural context; and common words and phrases.
    - A few considerations of note:
        - In general, male providers should not shake hands with Afghan women unless it is proffered. Female patients often prefer female providers and interpreters, particularly if the history or exam involves reproductive/ genitourinary issues.
        - Histories are often in context of life events and related in story form.
        - Focused questioning can often be seen as disrespectful by the patient.

        - Deference to providers is common – assent to the evaluation and treatment plan does not mean the plan is understood or agreed to.
        - A "thumbs-up" sign is considered extremely offensive in Afghan culture and should not be used by providers.

Additional Resources

- HHS Ensuring Language Access and Effective Communication During Response and Recovery: A Checklist for Emergency Responders
- HHS National Culturally and Linguistically Appropriate Services (CLAS) Standards
- HHS Office of Civil Rights, Limited English Proficiency Resources for Effective Communication
- Padela, A. et al. (2011). Meeting the Healthcare Needs of American Muslims: Challenges and Strategies for Healthcare Settings. Institute for Social Policy and Understanding.
- SAMHSA Treatment Improvement Protocol 59: Improving Cultural Competence
- Summit County Public Health Department. (n.d.). Health Needs Assessment Report for Afghan Refugees of Summit County. (Accessed 9/13/2021.)

Medical Considerations

- Acute conditions
    - Consider underlying anemia and infections (including malaria and parasitic) contributing to other disease progression.
    - Include in screening studies during initial/ referral visit complete blood count, electrolytes, urinalysis with strong consideration for stool ova and parasites, stool pathogen screening/ culture, chest x-ray, ECG for patients at age/ other risk for ischemia, and malaria smear, particularly from March-November for those living in Kabul or eastern portions of the nation.
    - Determine need for delayed medical care for traumatic injuries sustained during the evacuation. Clinicians should look for potential injuries that may have occurred prior to, during, or after the evacuation. Some ASIs may need a tetanus vaccine.
        - Hospitals in Northern Virginia treated patients with gunshot wounds, broken bones, and other trauma. Patients may have received some stabilization prior to evacuation, but not yet received definitive care.
    - Expect a surge of pediatric and obstetric (OB) patients. Questions to consider include:
        - What is available onsite vs. what will need to be provided at final destination?
        - What facilities are available to assist with normal and high-risk pregnancy prenatal, perinatal, and postnatal care?
        - What is the appointment process?

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        - What postnatal material support will be needed (e.g., diapers, formula)?
- Vaccinations and medical screening forms
    - AFIs should have a copy of their I-693 form but, if not, you may be able to obtain it from their initial intake location (Dulles, Philadelphia).
    - Determine if the federal authorities at the airport or the transfer point are waiving vaccination requirements.
- Management of chronic illnesses
    - Chronic and other specific health concerns based on the geographic region and conditions:
        - According to the World Health Organization in 2015, the top three leading causes of death in Afghanistan are lower respiratory infections, ischemic heart disease, and diarrheal disease.
        - Afghanistan:
            - Has a high incidence of rheumatic heart disease in addition to ischemic.
            - Is currently ranked #7 worldwide for measles outbreaks.
            - Has circulating wild-type polio type 1 and vaccine-derived circulating polio type 2.
        - Several studies report a relative high prevalence of malaria, hepatitis B, TB, cholera, Crimean-Congo hemorrhagic fever, leishmaniasis, and HIV (with TB, multidrug-resistant (MDR) TB, and malaria the most common infectious diseases). Anthrax is also seen among the farming community.
        - According to data extracted from the United Nations High Commissioner for Refugees from 2005-2010, the most common health referral for females and males ages 0-14 years was perinatal diseases. For females aged 15-59 the most common health referral was ophthalmic disease and for males it was nephropathies. Overall, in both sexes the most frequent causes for referrals were for ophthalmic diseases (primarily cataracts), neoplasm, nephropathies, ischemic heart disease, and perinatal disorders.
        - Common diseases found in the Afghan population are intestinal nematodes and iron-deficiency (often arising from the parasitic infections). Giardia or ascariasis are among the most common and may infect up to 25% of adults and 60% of children. Empiric treatment with albendazole or mebendazole may be warranted. Iron deficiency anemia is a leading cause of disability as well, along with lower back and neck pain and conflict related injuries.
    - Specialty care - many refugees may require rapid referral for specialty care including for cardiac disease and infectious symptoms, dental, etc.
    - Pediatric chronic illnesses - for example, children with congenital diseases may need to work with ACF and local community partners to find appropriate sponsors and facilities that can provide long-term specialized care. Determine the

    current outreach and coordination with pediatric hospitals.
    - The American Academy of Pediatrics published a webpage called Welcoming Afghan Arrivals with information and links to resources on cultural awareness and strategies for treating adults and children.

- Alternative health practices
    - Many Afghans believe strongly in environmental causes (heat/cold/dirt) as causative of medical problems.
    - Traditional healing practices and remedies are very common as adjuncts to or substitutes for Western medical care, particularly among the older population.
- COVID-19-positive patients
    - Clearly outline quarantine and isolation considerations to include coordination with EMS to ensure situational awareness of patients transported from designated quarantine locations (such as hotels).
    - Develop a plan for unaccompanied minors
    - Develop a plan for contact tracing
    - Ensure a process exists to provide access to medication and prescription refills
    - Considerations for releasing patients and follow up care plans
- Behavioral health considerations and resources
    - Afghan refugees are especially at risk for mental illness, primarily post-traumatic stress disorder, depression, anxiety, and psychosomatic illnesses. Nonspecific physical symptoms without clear cause may be tied to emotional distress. Healthcare providers should watch for substance abuse disorders, mainly alcoholism. According to the WHO (as noted in the Summit County Health Department report), "while alcohol is forbidden to Muslims and is not legally sold in Afghanistan, many Afghan refugees may begin drinking in the United States and can develop addiction to alcohol as a coping mechanism."
    - Domestic violence is another large concern; a report by Global Rights notes that approximately 87% of Afghan women experiences domestic violence at least once in their lifetimes.
    - The National Child Traumatic Stress Network (NCTSN) recently published Psychological First Aid for Displaced Children and Families, a modular approach that can be used by staff and volunteers to help newly arrived children and families to the U.S. The resources include a set of tools to support them through early transitions and can also help staff care for themselves while they work in challenging circumstances.
        - Additional NCTSN resources related to families transitioning out of Afghanistan can be found in the document Resources in Response to the Recent Terrorist Attack and Afghanistan Transition and on their Culture and Trauma webpage.
    - The National Association of School Psychologists provides tips for educators on supporting refugee children and youth and general information on Students Who Are Displaced Persons, Refugees, or Asylum-Seekers.

- The National Association of Social Workers has a webpage dedicated to immigration and racial justice that includes links to articles and educational resources.
- The Health Needs Assessment Report for Afghan Refugees of Summit County provides useful information regarding considerations for Afghan refugees based on research and a focus group that reviewed the following themes: need for healthcare services and education, need for cultural competency, understanding the American healthcare system, timeliness, lack of knowledge on community services and resources, and access to care (including barriers such as language, transportation, distance, and/or payment).

Additional Resources

- CDC. (2021). Guidance for Clinicians Caring for Individuals Recently Evacuated from Afghanistan.
- CDC. (2021). Traveler's Health- Afghanistan.
- Divkolaye, N., Brukle, F. (2017). The Enduring Health Challenges of Afghan Immigrants and Refugees in Iran: A Systematic Review. PLoS Curr, Version 1.
- Malik, M. et al. (2019). Disease Status of Afghan Refugees and Migrants in Pakistan. Frontiers in Public Health.
- NCTSN Understanding Refugee Trauma: For Mental Health Professionals
- NCTSN Understanding Refugee Trauma: For Primary Care Providers
- Summit County Public Health Department. (n.d.). Health Needs Assessment Report for Afghan Refugees of Summit County.
- WHO. (2019). Afghanistan Country Office.
- WHO. (2015). Afghanistan Health Profile.

Financial/ Insurance Considerations

- ASIs were provided short-term insurance upon arrival. Confirm:
  - What services are covered (dental, vision, general health)?
  - Who is it with?
  - How to contact insurance company?
- Are ASIs eligible for Medicare/ Medicaid? If so, what will be covered and is there a special application process?
- Billing considerations
  - What federal resources may be available to reimburse otherwise non-covered expenses?
  - Are there NGOs providing financial or other support?
  - Are other financial and human services support being provided (e.g., Temporary Assistance for Needy Families [TANF])? Is there other aid that can support independent living once ASIs are cleared from a healthcare facility?