SECONDARY MIGRATION TO RURAL MEAT PROCESSING COMMUNITIES IN THE UNITED STATES AND THE IMPLICATIONS FOR REFUGEE HEALTH

by

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ABSTRACT

Each year the United States resettles around 58,000 refugees from various cultural backgrounds. The majority of new arrivals are either children or of reproductive age. While U.S. refugee policy is designed to support refugees in the eight months after arrival, it does not account for secondary migration. Commonly, refugees leave the initial resettlement destination to reunite with families or in search of employment opportunities. As refugees leave primary settlement locations, they also leave behind many entitlement benefits. This results in new destination communities, often low-resource, bearing the weight of providing care. Many secondary migrants move to meat processing communities. Located primarily in rural America, the meat processing industry attracts refugees with higher wages and few skill requirements. In an effort to understand the relationship between secondary migrants and rural meat processing communities this paper explores the unique challenges to providing health care in rural America; the health needs of refugees, particularly vulnerable populations; and provides recommendations for reinforcing a community's capacity to care for refugees.
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BACKGROUND

The United States is the largest official refugee resettlement country in the world. Of the 10.5 million refugees across the globe, around 1% are resettled through the United Nations High Commissioner for Refugees (UNHCR).\(^1\) On average each year the United States admits 58,000 of these refugees.\(^2\) Eighty five percent of new arrivals are either children or of reproductive age.\(^3\) The U.S. works with resettlement agencies to settle refugees in cities with resources and systems in place to assist the new arrivals. However, many individuals choose to leave these initial destinations in search of better economic opportunities. This process is referred to as secondary migration. The meat processing industry attracts many secondary migrant refugees. Meat processing plants are primarily found in rural communities throughout the Great Plains, Midwest, and Southeast. In recent years rural meat processing communities have seen growing numbers of refugees. These communities are often low-resource communities, with limited capacity to accommodate new arrivals, particularly from other cultures. The addition of new cultures presents challenges in the delivery of health care. Refugees often have unique health challenges resulting from the refugee experience and migration process. Some populations may have higher rates of communicable diseases, reproductive health challenges, and mental health concerns. In order to better serve refugees, it is important to understand the unique needs of both the refugee population and the host community in which they settle. This paper aims to explore the impact refugee communities have on rural meat processing communities in the United States by identifying the unique challenges of providing health care in rural
America, the health needs of refugees, and providing opportunities for communities to better serve this vulnerable population.

**U.S. Refugee Policy**

The United States leads the world in refugee resettlement with a commitment to resettle at least 50% of the total resettled refugees referred by UNHCR each year. In 2012, the U.S. resettled around 76% of the world’s resettled population. The U.S. president, through the council of a Congressional team, determines the number of refugees admitted into the country each year by setting a refugee ceiling. Within the total allocation are sub-ceilings arranged by different geographic regions and priority levels. Additionally, a number is left unallocated to account for unforeseen circumstances. In 2012 the ceiling was set at 70,000 and the actual admissions were 58,238. In 2013 the ceiling was placed at 70,000 and the proposed ceiling for 2014 is 70,000. The resettlement process occurs abroad, involving multiple government departments. The Department of State (DOS) conducts the processing of refugees abroad and the U.S. Citizenship and Immigration Services (USCIS) and the Department of Homeland Security (DHS) make the final determinations. Determinations are made based on a three-tiered priority system. Priority 1 cases are individual refugees referred by the UNHCR, a U.S. embassy, or a designated NGO; Priority 2 cases are “groups of special humanitarian concern to the United States;” and Priority 3 cases are refugees seeking to reunify with family in the U.S. Once approved, the DOS works with nine domestic resettlement agencies to determine the placement for the refugee. These agencies have around 350 affiliates across the country that provide direct services
after settlement. Efforts are made to resettle the individual near family when possible. The remaining refugees are resettled in communities determined to have adequate refuge resources.

Current refugee policy in the United States dates back to the Refugee Act of 1980. This act amended the Immigration and Nationality Act (INA) in response to growing concerns about the number of refugees entering the country in previous years. Among the important changes made to refugee policy was the regulation of the admissions process that includes an annual refugee ceiling, the creation of the Office of Refugee Resettlement (ORR) to assist with the provision of federal assistance, and a definition of refugee that matches the United Nation’s definition. The current legislation defines a refugee as “a person who is outside his or her country and who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.” The ORR is housed under the Administration for Children and Families within the U.S. Department of Health and Human Services.

In the past, the majority of U.S. resettled refugees originated from Southeast Asia and former Soviet Union countries. Today refugee policy is designed to resettle some of the world’s most vulnerable populations. This means that the refugee population in the United States is becoming more diverse with a greater representation of countries and cultures. Furthermore, many prioritized groups are minority groups least familiar to a general American population. These populations may be the least likely to have exposure to U.S. culture and tend to have more
difficulties securing employment and being provided adequate health services. Additionally, these populations often require customized support programs that are not available in rural environments. Today Southeast Asians still represent the largest group of refugees, followed by East Asians, and Africans.

Benefits for Refugees

The United States provides a number of benefits to refugees intended to ease the transition into the American culture. Assistance is also designed to ensure the individual secures employment soon after arrival. After being admitted to resettle in the U.S., refugees have the option to take an interest-free loan for travel to the country. The loans are DOS monies processed by the International Organization for Migration (IOM). If accepted refugees must sign a promissory note and repay within 46 months of arrival. Once in the country, refugees are legally eligible to work. Upon arrival individual refugees receive a one-time placement grant of $1875 to help with arrival expenses and rent. Eligibility for Temporary Assistance for Needy Families (TANF) and Medicaid (non-emergency care) is then determined. These programs and Supplemental Security Income (SSI) for the Aged, Blind and Disabled are available to refugees for five to seven years depending on the program and state policies. If ineligible for TANF and Medicaid, refugees are eligible for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) for up to eight months after arrival. In addition, they are eligible to access Supplemental Nutrition Assistance Program (SNAP) benefits. There are also limited number of grants available to resettlement agencies through the Refugee Social Services (RSS) and Targeted Assistance (TAG) funds. RSS and TAG funding is available up to five years.
after arrival and primarily for employment assistance including; “employability services, employment assessment services, on-the-job training, English language instruction, vocational training, case management, translation/interpreter services, social adjustment services, health-related services, home management, and if necessary for employment, day care and transportation.” It is important to note that RSS and TAG funds are allocated based on refugee concentration numbers and may not be available in secondary migration destinations. Once employed, refugees are eligible for health benefits as provided by employers. After living in the country for one year refugees are eligible to apply to become a legal permanent resident (LPR) and after five years they are eligible to apply for citizenship. Despite the availability of benefits to refugees and efforts to ensure employment security, a large proportion of the population are left behind. Between 2006 and 2011 38% received cash assistance. Assistance utilization varies by country of origin. Moreover, many refugees remain unemployed. In 2011, 58% of the total refugee population reported working in the year.

The Division of Refugee Health within the ORR runs the Refugee Preventative Health Program. This program provides grants to states. The states administer the funds to designated health agencies to conduct medical screenings and follow-up activities for refugees. The primary interests of the program are to reduce the spread of infectious disease and promote preventative health practices.
RURAL AMERICA

Unique Challenges

Defining rural is not as easy. The U.S. government does not have one standard definition, and typically defaults to one of three primary definitions. These definitions vary from defining rural as any population of 2,500 or less (Bureau of the Census) to all non-metro communities with fewer than 50,000 inhabitants (Office of Management and Budget). From a quantitative viewpoint there is no clear way to delineate populated areas as rural and urban, and at this time each official definition captures a different view of rural America. The absence of a standardized definition of what constitutes rural presents challenges from a policy standpoint. Federal funding is allocated based on the classification of an area. As a result, the way a community is classified can influence the amount of resources to which it has access.

The rural United States presents many challenges to providing adequate care for the general population. These challenges are often exacerbated when attempting to care for vulnerable populations like refugees. Rural U.S. tends to have higher rates of unemployment and poverty, older populations, is more likely to be medically underserved, and has access to fewer resources than many urban areas. Additionally, populations are often spread over large land areas and geographic access issues are commonly reported as barriers to care. Rural residents tend to have poorer health outcomes and less continuous medical coverage. The United States is experiencing a primary care provider shortage. However, rural
areas carry a heavier weight of this burden. Roughly 10% of primary care physicians practice in rural areas. This is a physician to patient ratio of 46 per 100,000 (urban areas is 100 per 100,000). Language can also be a major barrier in these locations, as there are fewer interpreters. For refugees the limited number of resources often has the largest impact. Additionally, because the destinations are not primary resettlement locations it is harder for refugee agencies to reach individuals living in secondary migration locations. As a result, they may not have access to the assistance available to them.

Many rural communities are experiencing rapidly changing demographics. Populations are declining in much of rural America. However, in locations where the population is growing the racial and ethnic make-up is changing. Historically, rural communities have been more homogenous non-Hispanic white communities. However, this trend is changing in recent years. Trends show population growths declining for non-Hispanic whites while minority populations, including refugees, continue to grow. Between 2000 and 2010, minorities represented 82.7% of the population growth. Latinos represent around half of this growth. Rural communities unaccustomed to new cultures are learning how to incorporate new ideas. This can result in tension between native community members and new arrivals. Additionally, the institutions in these communities, like health care and schools, do not have the staff or funding for culturally appropriate services. Meat processing communities have a longer history employing immigrants and may have better systems in place to accommodate changes within institutions.
Another challenge in rural environments is the limited ability for robust data collection. Once refugees leave the initial resettlement area they are no longer tracked, and are more difficult to identify for eligibility for federal assistance programs. Data can translate into future federal and state resources. However, without a strong system for data collection and staff to carry it out communities can miss out on potential opportunities. This is particularly important for communities with large proportions of refugees as TAG and RSS funding are allocated based on refugee concentrations. Weak data collection prevents us from knowing exactly how many refugees are living in each community. Therefore, at this time the best information we have are local studies and reports by local agencies. The ORR tracks the location of initial refugee resettlement, but does not have a system in place to collect data for this population long-term.

Secondary Migration

Many refugees choose to leave the initial resettlement location and migrate to new locations in order to be closer to family and cultural networks or in search of economic opportunities. This is called secondary migration. Many of these destinations are new immigrant communities. Around the year 2000, immigrants began moving away from immigrant gateway destinations into more suburban and rural new immigrant communities. Refugees have been a part of this trend. When secondary migration happens to rural areas it is most commonly in conjunction with employment opportunities at factories. High levels of in-migration can strain a community’s resources, particularly when there are limited resources to
begin with. Introducing new cultures to rural communities can add additional challenges.

**Animal Processing**

Meat and poultry industry employees in the United States represent 32% of the total food and beverage manufacturing employees. Animal slaughtering and processing plants are primarily positioned in rural communities. Employment at these plants is dangerous and undesirable. The remote location, low pay, and undesirability make it difficult recruiting a workforce. Historically, these jobs have attracted an immigrant workforce. The foreign-born represent 29.2% of the meat processing workforce. State and local employment agencies and incentivized recruiting programs have played a role in recruiting this workforce and overtime immigrants networks are developed. The pay is typically higher than other low-skill jobs available to immigrants. In 2012 the mean hourly wage for meat processing jobs was $11.99. Furthermore, the positions do not have language requirement or require previous experience, which makes them appealing to refugees. Additionally, in recent years there have been reports of immigration raids at processing plants that resulted in large losses of undocumented laborforce. Because refugees are permitted to work legally, they can fill vacant positions without legal repercussions.
REFUGEE HEALTH

Refugees have specific health needs resulting from the environment they are fleeing, interim refugee camps, and the migration process. Prior to being admitted to the United States, refugees must undergo a medical examination. Those found to have a “communicable disease of public health significance” are not eligible for admission to the country.\textsuperscript{27} Communicable diseases include tuberculosis, syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, and Hansen’s disease. Additional health conditions that render a refugee ineligible for admission include those who fail to provide documentation showing they have received vaccination associated with certain vaccine-preventable diseases, those with physical or mental disorder and associated behavior that could result in harm of property, selves, or others and known drug abusers.\textsuperscript{27} Upon arrival to the United States, the ORR recommends an additional medical evaluation take place within 30 days.\textsuperscript{28} This screening includes a nutritional assessment and examination of reproductive, mental, dental, hearing, and sight health.\textsuperscript{28}

Despite initial available medical attention and assistance, over a third of refugees are uninsured.\textsuperscript{9} Moreover, refugees are more likely to work lower-wage jobs that do not offer health benefits and are less likely to have employer-sponsored health insurance. One study found that 87.6\% of uninsured refugees were either employed or had an employed spouse.\textsuperscript{29} According to a 2011 ORR report to Congress, in a one-year period 8\% of refugees reported having health insurance through an employer, 48\% received health benefits through Medicaid or RMA, and 40\% had no medical coverage.\textsuperscript{9}
Identifying refugee health concerns is challenging for several reasons. First, the population is very diverse. For example, individuals vary by country of origin, culture, conditions from which they fled, duration in refugee camps, and location of refugee camps. This makes it very difficult to generalize about the population. Second, much of the data we have on refugee health combines refugees and immigrants. As we know, the motives for migrating to the U.S. can be very different for these two populations and the unique health needs of refugees can get lost in the data. Third, the United States does not have a system for tracking refugees after the initial assistance period or after individuals move to new locations. This makes it very difficult to track long-term health outcomes. The majority of information we have on refugee health comes from this initial period after arrival to the U.S. Given this information, an overview is provided of the primary health concerns found to be associated with refugees in the United States.

Reproductive Health

In 2012, 53% of newly arriving refugees were of reproductive age (18-44). Of these new arrivals, 54% were identified as male and 46% as female. The refugee experience and migration process affects the reproductive health of both men and women. However, women are disproportionately at higher risk for adverse outcomes. Prior to arriving to the United States, refugee women are in environments where they are vulnerable to gender-based violence including rape, sexual abuse and exploitation, and physical abuse. In addition, women may have unmet family planning needs, higher-risk pregnancies and childbirth, complications from unsafe abortions, be undernourished, and risk exposure to communicable diseases. In
addition, women are more vulnerable to be victims of trafficking, polygamy, and child marriage. All of these factors put women’s reproductive health at risk and add to the difficulties providing adequate care upon arrival to the United States. In the initial domestic medical examination women are given the option to have a reproductive health screening. In an effort to be culturally sensitive, ORR recommends providers disclose to women their ability to opt-out of a gynecological exam. Additionally, they are advised to be attentive to signs of childbirth and gender-based violence trauma. These recommendations are important, however it is difficult to assess whether they are available to providers working in non-traditional refugee receiving areas.

The importance of a cultural understanding is of particular importance in providing reproductive health care. Many refugees maintain cultural practices that increase the difficulty providing appropriate care. For example, research has shown Somali women who have undergone female genital cutting have reported experiencing insensitivity from health care providers. Additionally, some Southeast Asian cultures practice coining, which can leave bruises on the body and be interpreted as signs of abuse. Moreover, providers may encounter pregnant Muslim refugee women who intend on fasting during Ramadan. Communities newly exposed to these cultural practices will need to work to understand the practices and their risks and benefits and ways to ensure refugees receive safe and sensitive care.

There are very few studies on the specific reproductive health care needs of refugee women in the United States. Furthermore, there are no studies on refugee
men’s reproductive health. One study looked at the health of refugee women within 90 days of arrival to the U.S.\textsuperscript{36} The study found health care utilization to be low. Of the total participants, 15\% were pregnant and none were receiving prenatal care.\textsuperscript{36} None of the women in the study received prenatal or reproductive health care while in the refugee camps.\textsuperscript{36} Moreover, low utilization of preventative screening for breast and cervical cancers. Additionally, the women in the study had limited knowledge about preventative screening tests and how to use them in the U.S.\textsuperscript{36} This is consistent with other research on the utilization of preventative services among immigrants. Oftentimes, the concept of preventative care is foreign to the refugee. It has been found that Somali refugees utilize preventative services once they understand the importance.\textsuperscript{37}

\textbf{Child Health}

Thirty five percent of refugees admitted to the United States in 2012 were children 17 and under.\textsuperscript{3} Many of these children have special health care needs. Moreover, a number, often fleeing violence, arrive unaccompanied through the Unaccompanied Refugee Minor Program and are placed in foster homes or with licensed care providers.\textsuperscript{38} Refugee children are at higher risk for nutritional deficiencies, lead poisoning, and mental health disorders. Research suggests the effects of trauma on a child’s mental health often depends on the child’s age, stage of development, and gender.\textsuperscript{38} Some common problems resulting from the stress of the refugee experience include “adjustment disorders, sleep disturbance, nightmares, grief reactions, inattention, social withdrawal and somatization.”\textsuperscript{39} Moreover, it has been found that boys more often externalize their problems while girls internalize
problems.\textsuperscript{39} Refugee children are also at higher risk for lead poisoning. One cause for higher lead levels is due to higher absorption rates resulting from malnutrition and anemia.\textsuperscript{40} In addition, prior environmental exposure to lead from poor living conditions can increase risk. Moreover, lead has been found in various traditional medicines and cultural products including pottery and cookware.\textsuperscript{40} After arrival, lead exposure may continue if refugees are living in lower-income homes with lead paint.

**Mental Health**

Many refugees have been exposed to traumatic events that put them at risk for mental health disorders. Refugees are at higher risk for posttraumatic stress disorder, depression, somatization, anxiety, and other psychiatric disorders.\textsuperscript{41,42} Additionally the migration process and transition into a new culture may influence to the mental health status of refugees. Social isolation, acculturation, and situations challenging traditional gender roles all add stress. Prior traumatic experiences combined with the stress of resettlement can also contribute to higher risk of suicide. Since 2009, there have been 16 suicides among resettled Bhutanese refugees.\textsuperscript{32} In one of the only studies tracking long-term mental health outcomes, researchers found Cambodian refugees at high risk for psychiatric disorders two decades after arrival.\textsuperscript{43} Prior traumatic exposure to the brutalities of civil war greatly impacted the study population. The study found 62\% of the sample had post traumatic stress disorder and 51\% tested positive for depression.\textsuperscript{43} Communities in rural America are often ill-equipped to provide adequate mental health care for native residents. The introduction of complex mental health needs is guaranteed to
exceed the community’s ability to provide care. Moreover, cultural stigma or awareness about mental health and mistrust of mental health screenings may prevent individuals from seeking help. Without a strong mental health care infrastructure, including regular screening, many needs will be overlooked.

**Other Health Concerns**

Refugees often display a very different health profile than immigrants to voluntarily migrate to the United States. Prior exposure to violence, torture, famine, exposure to environmental pollutants, and unsafe living conditions put them at higher risk for poor health outcomes. Refugees are significantly more likely to report chronic health conditions, particularly diabetes and hypertension. In addition, refugees are at higher risk for having latent tuberculosis, intestinal parasites, nutritional deficiencies, and hepatitis. Among new arrivals in Texas in 2012 29% had a positive tuberculosis and 50% were given presumptive treatment for parasites. Among Bhutanese refugees in the United States, 30-60% were found to have Vitamin B12 deficiency between 2008 and 2011. Additionally, physical disabilities are prevalent among refugees. These are often the result of injuries incurred from previous perilous conditions. Finally, living conditions after arrival to rural areas can also be a health risk for refugees. Many rural communities have a limited number of housing options, which can make it difficult for refugees to find adequate housing. Refugees may end up living in overcrowded or in deteriorating conditions, which can affect their health. In Cactus, TX it was reported refugees were living in FEMA trailers.
Workplace Injuries

Many refugees living in the rural United States are employed with the animal slaughtering and processing industry. It is unlikely refugees living in rural environments are exclusively working animal processing and slaughtering jobs. However, the younger healthier population represent a good proportion of the workforce. These are difficult jobs in a hazardous environment. Common injuries include “strains, sprains, lacerations, and contusions.” While there is no specific research on the prevalence of workplace injuries among refugees, it is plausible to expect this workforce will experience similar risk. Research has highlighted disparities in processing facilities among immigrants. As one researcher put it, “…racial and ethnic minorities are disproportionately exposed to pathogenic job designs and work characteristics, health-compromising supervisory practices, and injury-prone safety climates that culminate to create an unequal burden of illness and disease among these workers relative to more privileged workers.” Moreover, it is plausible that limited language skills could place refugees at a higher risk for workplace injuries, as they will be less likely to read and understand safety messages.

Barriers to Health Care

Refugees in the United States encounter a variety of barriers to receiving health care. Oftentimes, these barriers are exacerbated in rural environments where resources are limited. Primary barriers to care are individual and cultural. Structural barriers including cost and transportation did not appear in the literature.
as major barriers. One reason for this could be that most of the studies are conducted during the time immediately after arrival to the United States. This is a time when refugees are covered by either Medicaid or RMA and also have the support of a resettlement agency. It is unclear how large a role structural barriers play after a refugee has migrated to a rural environment. However, considering the high rates of uninsured refugees and information we know about barriers to care among the general rural population, it is highly refugees encounter structural barriers to care.\textsuperscript{9,12}

Individual barriers to care include the length of time in the U.S., lack of knowledge about health care, language, and trust. Many refugees are unaware of the medical services available to them. It is the responsibility of the resettlement agency to inform newly arrived refugees of the benefits available to them, however this information comes at a tumultuous time of change and health care is not always prioritized. The duration a refugee has been in the country can affect the likelihood of utilizing the health care system. Newly arrived refugees may be preoccupied with adjusting to a new environment and finding employment. Prioritizing housing, job, and educational needs over health care has been cited as a barrier to health care.\textsuperscript{36} Moreover, health care seeking motives may differ by culture and the importance of preventative health care may not be well understood. In an effort to educate refugees and assist providers the Centers for Disease Control and Prevention, the Office of Refugee Resettlement, and the Refugee Health Information Network have developed a number of refugee-specific educational materials. However, because of the diversity of the refugee population, these materials are not available in all of the
languages and dialects present. Furthermore, a number of refugees are illiterate in their own language and may rely on word-of-mouth information sharing. Finally, trust is cited as a barrier to care.\textsuperscript{49,50} This may be do to a lack of knowledge about the provider’s motives or the health care system in general.

Cultural barriers include religious beliefs, gender preferences, autonomy, and provider cultural fluency. Religion is a barrier when refugees prefer religious ceremonies and prayer over the provision of health care.\textsuperscript{50} Additionally according to certain religious beliefs, as is the case with the Hmong, obtaining medical services may be seen to harm an individual more than help.\textsuperscript{49} Gender is a barrier to receiving health care services for both men and women. One study focused on the reproductive health needs of Somali Bantu women in Connecticut.\textsuperscript{51} This study highlighted culturally unique barriers to care for this population. Among the top concerns was having or the fear of having a male provider for their reproductive health care.\textsuperscript{51} Additionally, women felt uncomfortable discussing their reproductive health with male translators when female translators were unavailable.\textsuperscript{51} This has also been reported as a barrier for Bhutanese refugees.\textsuperscript{32} Finally, it is important for providers to have a basic understanding of the refugee’s culture. The lack of cultural fluency has been cited as a barrier to care.\textsuperscript{49–51} Patients may feel frustrated during a visit when they are not understood. Lacking an understanding of the culture can also be a barrier to providers feeling comfortable providing adequate care.\textsuperscript{50}
RECOMMENDATIONS

At this time there are no studies on the health outcomes of refugees living in rural America. The unique health needs of refugees combined with unique challenges in a rural U.S. context may result in refugees with different health profiles than those living in more urban areas. Moreover, there is very little information on secondary migrants within the United States. Better data collection and improved funding systems are needed to ensure communities are equipped to care for refugee populations. In the meantime, the Affordable Care Act includes several provisions that may be of use to rural communities as providers work to deliver appropriate care.

Improved Data Collection

As rural America becomes more diverse, it is important to ensure communities and residents have full access to available services. Accurate demographic data of the population living in rural communities and health outcomes can lead to access to new state and federal funding sources, support policy efforts, track the health of the population over time, and contribute to further research on the population. Improved data reporting should allow for immigration status, range of ethnic backgrounds, and country of origin. More systems are needed to facilitate data in rural communities including standardized reporting forms and additional funding for staffing and training. The ACA attempts to address data collection by requiring enhanced standardized data collection and reporting, however this new standards still fail to capture the full diversity among individuals. 
in the U.S. Furthermore, there is no system in place to collect migration status information.

**Changes to Refugee Funding Allocation**

Current refugee policies do not account for secondary migration. At this time much of the funding for refugee assistance is allocated to communities based on recent arrival history. Communities with larger populations of newly arrived refugees receive more funding. This would make sense if refugees stayed in the initial destination community, however many migrate to secondary locations. As a result, many refugees do not have access to the full range of services available to them. Rather than allocating funds towards resettlement organizations receiving the largest quantities of refugees the policy needs to be rewritten to reach secondary migrants. Moreover, there is not a current system in place to transfer entitlement benefits across state boundaries. This means that many newly arrived refugees are not receiving government support, including health care. Better data collection methods and communication with local social services and health departments can aid in tracking refugees longer-term.

**Affordable Care Act Implementation**

This is a unique time in American health care history with the passage of the Affordable Care Act (ACA). The ACA contains multiple provisions that can benefit rural communities caring for refugees and refugees in obtaining affordable health care. Additionally, it is also important to note potential negative implications of the bill.
Anti-discrimination Measures

There are a number of provisions within the ACA that prevent insurers from discriminating based on poor health. First, insurers are no longer allowed to deny coverage to adult and child individuals with preexisting conditions. Next, insurers are not allowed to charge higher premiums or deny coverage for higher-risk individuals. Additionally, insurance policies under the ACA are no longer allowed to charge different premiums to individuals based on health status and must offer insurance to any individual seeking it.

Increased Individual Coverage

Under the ACA, employers with 50 or more full-time employees are required to offer health insurance to employees or pay varying penalties. Additionally, employers with 200 or more employees are required to automatically enroll their employees in health insurance plans. This could increase access to coverage for some refugees working for larger employers. However, one way this requirement could hurt refugees is referred to as the “family glitch.” This happens because although there are premium limits on individual coverage, there are no limits on family coverage. Because they have been offered insurance through an employer, individuals with families who are unable to afford employer-sponsored health insurance are not eligible to apply for insurance under the exchanges. Those fortunate to have insurance coverage with young adult children are now able to offer coverage to the children up to age 26.
Medicaid Expansion

The Affordable Care Act expands Medicaid to individuals living at or below 138% of the Federal Poverty Level (FPL). This benefit is only available in states that elect to participate. Refugees are eligible for Medicaid and CHIP. Because not all states are expanding coverage, this benefit will not be available to everyone within the target population. However, only 25 states have elected to expand Medicaid coverage. This means for refugees not receiving health insurance through their employers and not eligible for Medicaid with incomes under 400% FPL do not qualify for subsidies and may be left uninsured.

Children’s Health Services

The ACA enhances and reinforces the health insurance for children through a variety of measures. It establishes a minimum Medicaid eligibility level of 138% FPL for all children up to age 19, it requires states extend Medicaid coverage to children aging out of the foster care system up to age 26, and it eliminates waiting periods for coverage. Additionally, the law reduces the cost burden on states by increasing matching funding over the 2016-2019 period, assuming the program is reauthorized in 2015. Through a combination of state and national efforts, the number of uninsured children continues to decrease. Added protections in the ACA are designed to continue this trend. However, difficult enrollment procedures and a lack of parental information continue to be a barrier to eligible children receiving coverage. Over a third of uninsured individuals in the country eligible for
Medicaid are children. Moreover, children represent 75% of uninsured eligible for Medicaid or CHIP in states not implementing Medicaid. These numbers are likely to be reflected in the refugee population as well. Additionally, the ACA guarantees all recommended vaccines and preventative exams for infants, children, and adolescents are covered by insurance.

**Reproductive Health Services**

For refugees who do have access to health insurance, the ACA specifies new plans are to cover a number of preventative health services for no additional out-of-pocket cost. Included services are a full range of contraceptive methods, screening for cervical cancer, screening for select sexually transmitted infections, recommended vaccinations, reproductive health counseling, and breastfeeding support.

**Primary Care**

The ACA provides incentives to students pursuing a medical career to enter primary care. First, scholarships are available through the National Health Service Corps for students to study primary care. Upon graduation, students agree to work for two to eight years in a Health Professional Shortage Area. Additionally, there are loan repayment programs targeted for primary care providers choosing to practice in an underserved area for two years. Reinforcing the primary care work force and encouraging providers to work in underserved locations provides more opportunities to access care.
Safety Nets

Community Health Centers can often play a large role in a community's health. These centers often take care of a large portion of the immigrant population seeking care. In 2012, 62% of those receiving care at Community Health Centers identified as part of an ethnic or minority group. Additionally, Community Health Centers are safety nets for many uninsured. Over a third of those receiving services are uninsured. The ACA has allocated $11 million to be distributed to Community Health Centers over five years to expand their capacity to serve a largely vulnerable and uninsured population.

Higher Costs

While more refugees will be eligible for insurance, it is important to note that cost may still be a barrier to coverage. At this early stage in the implementation of health care, competition varies across states. Some areas lack any provider competition. These locations include rural areas and result in residents offered plans with higher premiums. One reason for this is that they are less-desirable areas to cover from an insurance standpoint. Rural areas tend to have higher rates of unemployment, older populations, and poorer health outcomes. While the ACA offers several opportunities for refugees to obtain coverage, geographic location will still play a role in the accessibility to affordable coverage.
CONCLUSION

While the total population of refugees in the United States is relatively small, the high needs of this population and limited resources can burden any refugee resettlement community. Additionally, a large proportion of refugees are children or of reproductive age, vulnerable populations with complex health needs. This burden disproportionately affects rural communities. As refugee networks in rural U.S. environments continue to grow so does the need for culturally appropriate services. Rural communities across the country recognize their limitations to adequately accommodate growing diversity. Better systems are needed for communicating refugee policy to local communities and ensuring entitlement benefits are available to refugees after secondary migration. We know that many rural communities with refugee populations are meat processing communities. More research is needed in order to understand the specific health needs of this population and the opportunities available to these communities to provide care. In addition, the federal government will need to officially recognize the impact of secondary migration and the number of refugees negatively affected by it, and identify solutions for allocating resources to individuals and communities most in need. Finally, the refugee population as a whole is a vulnerable population, many with special health care needs. The large proportion of children and individuals of reproductive age deserves particular attention. As the United States moves forward with health reform national, state, and local collaboration is essential to ensure resources are utilized and the needs of secondary migrant refugees in rural America are met.
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