

The Implementation of Refugee Health Policies and Services in Virginia's Local Health Districts

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(Abstract)

In 1997, the Virginia Refugee Health Program coordinated a protocol and reimbursement structure to encourage health departments to perform initial health screenings on refugees settling in the Commonwealth by establishing four recommended levels of assessment. This thesis is concerned with these initial health-related services provided to refugees by Virginia's health departments, the quality of these services, and how they vary from one district to another. For this study, I interviewed health department staff representing 13 of Virginia's 19 districts that rendered health screenings in 2000. Information such as the level of assessment provided, and the types of procedures and services offered were the main foci of the interviews. I found that of the 13 districts, three (the cities of Alexandria and Virginia Beach, and Prince William County) offer only the required minimum to refugees. The variations I discovered in the services that health districts provide suggest, conceptually, the workings of both "structure" and "agency." Each health department is formally and informally structured in terms of staffing, services, and resources in accordance with its individual needs and initiatives. The structure of current funding at both the state and local level acts to inhibit some health districts from providing all four levels of assessment. In addition, human agency in the form of personal interest in meeting refugee's health needs as well as district collaboration with local resettlement agencies, also plays an important role in the extent of refugee services rendered.

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List of Abbreviations

INS-Immigration and Naturalization Service

NGO-Non-Government Organization

ONS-Office of Newcomer Services

PRM-Bureau of Population, Refugees, and Migration

RDC-Refugee Data Center

RHP-Refugee Health Program

RMA-Refugee Medical Assistance

TB-Tuberculosis

UNHCR-United Nations High Commissioner for Refugees

USCR-United States Committee for Refugees

VOLAGS-voluntary agencies

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Chapter 1--Introduction

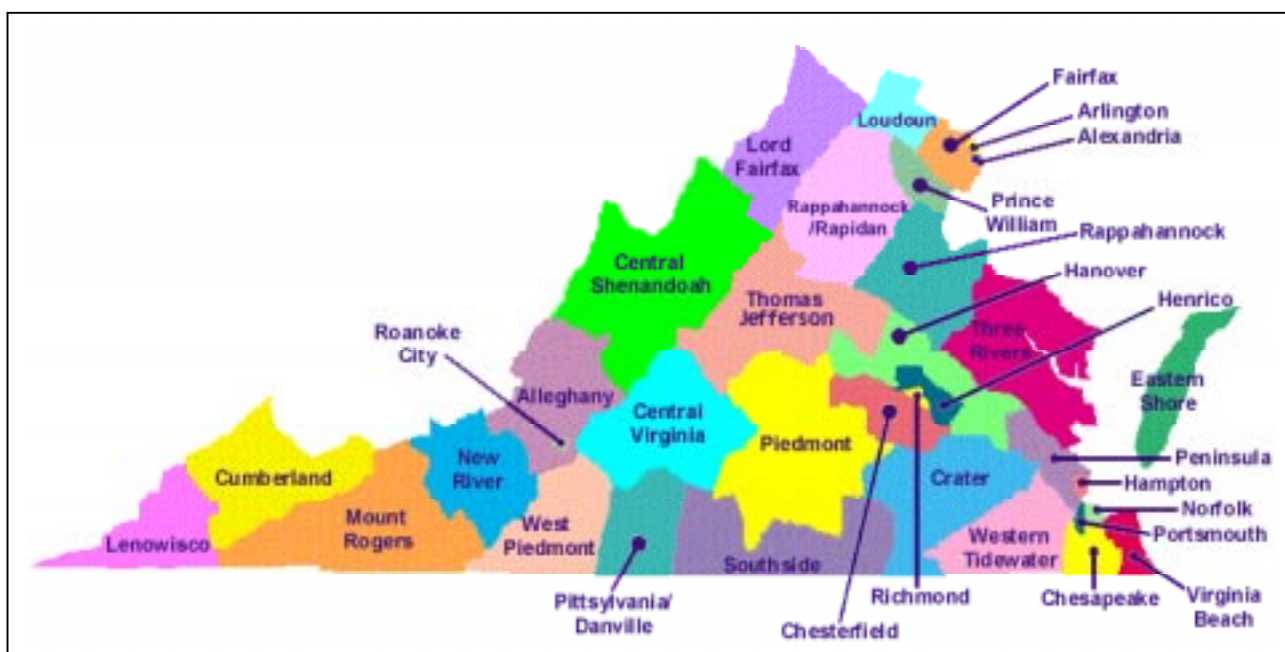
The Thesis Issue:

The focus of this thesis is on the initial health-related services provided to refugees by Virginia's health departments, the quality of these services, and how they vary from one district to another. Do refugees receive the same health services across the Commonwealth? If not, where, how and why do these services vary? Do inequalities exist among Virginia's local health districts and thus among services to refugees? Is resource allocation among health departments in Virginia distributed equitably, or is it based on need?

Figure 1.1 shows the locations of Virginia's 35 Health Districts. Of these, 19 resettled refugees in 2000. This thesis is based upon data collected from 13 of these 19 districts. I interviewed pertinent health officials in the following Health Districts:

- Alexandria
- Arlington
- Central Shenandoah
- Chesterfield
- Fairfax
- Henrico
- Norfolk
- Peninsula
- Prince William
- Richmond
- Roanoke City
- Thomas Jefferson
- Virginia Beach

Figure 1.1
Virginia's Local Health Districts



Source: VDH, 2002

I collected my data mainly from health administrators and public health nurses who work closely with refugee populations. Information gathered includes the levels of assessment provided, the types of procedures and services offered, and the factors that determine the extent to which the state and federal recommendations are followed. I have used both qualitative and quantitative methods in my analysis. My interviews revealed that only three of the thirteen districts (the cities of Alexandria and Virginia Beach, and Prince William County) do not perform all four recommended levels of the health screening. These include the following (RHP, 2001):

- Level One: Risk assessment and evaluation for tuberculosis (TB) disease or infection. A skin test must be done and if tested positive, a chest x-ray should also be completed.
- Level Two: Includes a health history, a gross overall health assessment and physical inspection, and a review of the refugee's immunization status.
- Level Three: Listening to heart and lung sounds. Age specific screening including nutritional and developmental assessments. Cholesterol, hypertension, cancer, diabetes, screenings.
- Level Four: Case management and/or referral to physician for health problems found during assessment.

The variations I found in the services that health districts provide suggest, conceptually, the workings of both “structure” and “agency.” Each health department is formally and informally structured in terms of staffing, services, and resources in accordance with its individual needs and initiatives. For example, Prince William County has recently experienced a dramatic increase in TB cases. In lieu of providing further refugee services, it now allots most of its time and resources to combating this highly infectious disease. The structure of current funding at both the state and local level acts

to inhibit some health districts from providing all four levels of assessment. According to informants, lack of staff and funding are the main reasons Alexandria, Virginia Beach, and Prince William limit their services to refugees.

Human agency also plays an important role in the extent of refugee services rendered. Some health districts have just one or a few individuals taking the personal interest needed to insure the operation and maintenance of refugee programs in their localities. The success of the Roanoke Health Department, which receives the highest reimbursement per refugee in the state, is largely due to staff initiative and collaboration with the local resettlement agency. In contrast, a *lack* of agency is one of the reasons why Alexandria does not provide all four assessment levels. It has services available (such as a general medical clinic which could feasibly provide physical exams), but it is not known by the respondent if refugees access them. In this case, it is my informant's belief that it is up to the resettlement agency rather than the health department to take responsibility for ensuring that refugees utilize their services.

This thesis contains five chapters. The second chapter provides a brief overview of the refugee resettlement process in the United States. Chapter 3 reviews the literature on the conceptual approaches that medical and health geographers and other social scientists use to better understand health care structures, policies, and practices, with specific reference to the approaches that relate to my particular study. I also briefly address the literature on current refugee health problems of refugees as these relate to the importance and utility of performing health screenings on incoming populations. In Chapters 4 and 5, I explain the methodology for my research, and then analyze and discuss the interview data that I collected from the various health department staff across the Commonwealth.

Chapter 6 presents my conclusions and connects them to the pertinent literature and concepts of medical and health geography.

The Context: Refugees and Globalization:

Since World War II, there has been an ever-increasing surge in the number of refugee populations due to civil wars, ethnic persecution, and political upheavals. The profile of the “typical” refugee is often multi-dimensional and in a constant state of flux. These conditions combined with the state of today’s world in terms of globalization and ease of transportation pose new threats to public health. New and re-emerging infectious diseases present risks for every part of the planet. The ease and rapidity of travel allows individuals to journey across the world in less time than it would take for the symptoms of many infectious diseases to present themselves. In addition to infectious diseases, chronic illnesses most prominent in the “developed” regions also pose risks for newly arriving populations. High blood pressure, cancer, and heart disease are increasing in those who have migrated from developing nations, representing the vast majority of the world’s refugees. Causal factors include stress, decreased economic living conditions, and changes in lifestyle and diet. (Ackerman, 1997) Clearly, the issue of refugee health has extensive and complex ramifications beyond the individual. These include rights of access to, and the high costs of health care in the United States. Refugees whose health is not monitored may also present a risk for the transmission of communicable diseases such as tuberculosis (TB).

Current literature on the health of resettled refugees focuses on their health status, including the diseases they bring with them from their countries of origin, the health

problems they develop during long stays in overcrowded refugee camps, and the new, chronic diseases that may occur upon their resettlement in another country. Numerous theories on international migration attempt to explain why individuals migrate, to the factors that influence their destinations, and how refugees, experiencing forced migration, fit into this framework.¹

In terms of health status, refugees are unique from other legal migrants in that they have been forced from their homes due to natural disasters, war, persecution, etc. They generally do not arrive in resettlement countries as materially and economically prepared as traditional immigrants who are commonly seeking economic gain in their new locales. In essence, refugees are fleeing for their lives. They typically leave their homes with few material possessions and with little control over events and consequences. Also, many months or even years may pass between the time they officially become refugees and their arrival in the United States or some other host country.

It is important to look at the health status of refugee resettlement populations geographically. As Gatrell contends, “where you live affects the treatment you get. Our ‘health’ and our ‘geographies’ are inextricably linked” (Gatrell, 2002:3). Individuals and populations in different locations around the world often experience diseases and health problems that arise in distinctive natural and social environments. Thus, information

¹ Further information on the various theoretical concepts pertaining to human migration can be found in an important review by Gunnar Malmberg (1997). The migration-systems approach developed by Mabogunje (1970), and Zelinsky’s (1971) model of the mobility transition, offer additional perspectives on internal migration, including push-pull and other models. Lee (1966) and Dorigo and Tobler (1983) also offer insights into migration theory. Other scholars focus on environmental approaches to migration (e.g. Grigg, 1980, and Wood, 1994). Sassen’s work (1991) emphasizes the role of political economy, cross-border dynamics, and the roles “global cities” play in migration streams, work opportunities, information diffusion, etc. In addition, several journals, such as *International Migration Review* and the *Journal of International Migration and Integration*, provide analyses of a wide variety of current issues in human migration.

about a refugee's place of origin and migration path is of great value to health departments as they seek to treat refugees to develop and implement policies and services that meet their specific needs. In the United States, the common practice is to provide initial health screenings for refugees within 30 days upon their arrival. Thereafter, follow-up treatment can be received at a health department or from a private physician, especially during the first 8 months that the refugee is provided with Medicaid or Refugee Medical Assistance (RMA).

It can be argued that since refugees undergo a medical clearance before arriving in the United States that health problems will be discovered and treated in the refugee camps before the refugee is released. Although this may be the case for some refugees, Ackerman (1997) contends that "the quality and comprehensiveness of the visa medical examination vary, [and]...because the examination is valid for one year before departure, a refugee can develop infectious conditions after clearance and before departure" (1997:338). According to the Division of Global Migration and Quarantine that provides the medical screening guidelines for all examining physicians, the purpose of the overseas medical examination is to identify refugees who cannot (on public health grounds) be admitted to the United States because they have one or more of the following diseases or health-related conditions (CDC, 2002):

- Tuberculosis
- Human Immunodeficiency Virus (HIV) Infection
- Syphilis
- Chancroid
- Gonorrhea
- Granuloma Inguinale
- Lymphogranuloma Venereum
- Hansen's Disease (Leprosy)

However, the overseas medical examination does not test or otherwise check for many infectious diseases such as malaria, nor for existing, chronic health problems such as diabetes or heart disease.

Although most mandates, policies, and procedures for refugee health screenings are developed at both the federal and state levels, their implementation occurs in the local setting. Refugee health policies and procedures also vary from state to state. In the Commonwealth of Virginia, the focus of this study, federal funds are allotted by the U.S. State Department's Office of Refugee Resettlement for specific refugee-related services, including initial health screenings. Health departments that perform assessments of refugees are reimbursed from these funds according to the level of assistance they provide.

Virginia's Office of Newcomer Services (ONS) in collaboration with the Virginia Refugee and Immigrant Health Program (RHP) assist and encourage health departments within the Commonwealth to provide initial health screenings. They have established four levels to the health assessment and they facilitate reimbursement to health departments for each level completed. Of the four levels (described in Chapter 4), only the Level One TB screening is mandatory. Since the other three assessment levels are optional, the intent of the RMA reimbursement is to provide an incentive for health departments to offer further services beyond the TB screening.

Chapter 2--The Refugee Resettlement Process

In the aftermath of World War II, the United Nations General Assembly 1951 Convention Relating to the Status of Refugees established the United Nations High Commissioner for Refugees (UNHCR) to help assist and resettle them as needed. Since then, depending on different conflicts that have occurred throughout the world, refugee numbers have grown dramatically, reaching 12.9 million individuals in 2001. Refugee identity has also changed over the years, moving away from the predominantly European refugees of World War II toward greater ethnic and national diversity. Vietnamese and other Southeast Asians dominated in the 1970s and 1980s. Bosnians and individuals from the former Yugoslavia swelled refugee ranks in the 1990s. Today, Central Asian, Middle Eastern, and African refugees predominate.

UNHCR first determines the refugee status of an individual according to the following definition from the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol which states that a refugee is a person who...

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2002).

Since its establishment in 1951, the UNHCR's mandate has been extended every five years as refugee crises persist. Today, it is one of the main humanitarian agencies in the world assisting more than 20 million people from over 120 different countries. UNHCR identifies two aims: to protect refugees and to find ways to help them restart their lives either by returning them to their country of origin once a crisis has ended, or to resettle them in an alternative country either temporarily or permanently. It seeks to procure respect for refugees' basic human rights by trying to ensure that no person is returned involuntarily to a country where he or she has reason to fear persecution – an action known as *refoulement*. (UNHCR, 2002)

The UNHCR, a non-political, non-profit organization is funded almost entirely by voluntary contributions, mainly from governments. It also receives a limited subsidy from the United Nations to cover administrative costs. UNHCR promotes international refugee agreements and monitors governmental compliance with refugee law and human rights. It also assists internally displaced refugees who do not meet the formal refugee definition of fleeing their homeland, but who are instead displaced from their homes within their own countries. In addition, UNHCR helps to establish refugee camps, which provide food, shelter, and other basic needs and assists in the permanent resettlement of refugees whom are unable to return home.

There are currently an estimated 21.8 million persons of concern, one out of every 269 people on earth and more than half of whom are children, who come under UNHCR's responsibility. Of these, approximately 12 million are refugees (by the formal definition), over 8 million are internally displaced persons, 914,000 are asylum seekers, and 786,000 are returned refugees (those who have decided to return to their homeland

but still seek assistance from UNHCR). (UNHCR, 2002) Throughout the course of this thesis, the term “refugee” will comply with the formal definition and will not refer to internally displaced individuals.

Refugees come from virtually every part of the world, most often from areas experiencing war or other form of civil unrest. Table 2.1 displays the most recent refugee data available from the UNHCR and lists the countries of origin for the major refugee populations and the countries that received them. For those refugees unable or unwilling to return home, the UNHCR helps to place them either in their country of asylum or in a third country where they can be permanently resettled. Although many nations agree to accept refugees on a temporary basis, only 9 countries have regular resettlement programs that accept annual quotas and actively resettle refugees (Table 2.2). (UNHCR, 2002) The United States resettles more refugees than any other country, approximately 74 percent of the total who are resettled.

In addition, the events of September 11, 2001, have had a marked impact on refugees in terms of third country resettlement, particularly those coming to the United States. Refugee entries were immediately frozen on September 11th and did not re-open again until early 2002, but the flow of refugees, although “opened,” is still not back to normal. On August 20, 2002, the U.S. Committee for Refugees (USCR) sent out an internet alert on the current refugee crisis. Although the President authorized the admission of 70,000 refugees for 2002, only 20,000 have been resettled thus far with only 6 weeks left in the fiscal year. (USCR, 2002) These events have greatly affected resettlement agencies whose operational funds are contingent upon the number of refugees they resettle and

will take some time for the resettlement process to normalize once the flows proceed to the authorized numbers.

Table 2.1:
Origin of Major Refugee Populations In 2000
[ten largest groups]

Country of origin (2):	Main countries of asylum:	Refugees:
Afghanistan	Pakistan / Iran	3,580,400
Burundi	Tanzania	568,000
Iraq	Iran	512,800
Sudan	Uganda / D.R. Congo / Ethiopia / Kenya / C.A.R. / Chad	490,400
Bosnia-Herzegovina	Yugoslavia / Croatia / USA / Sweden / Netherlands / Denmark	478,300
Somalia	Kenya / Ethiopia / Yemen / Djibouti	447,800
Angola	Zambia / D.R. Congo / Namibia	432,700
Sierra Leone	Guinea / Liberia	400,800
Eritrea	Sudan	376,400
Vietnam	China / USA	370,300
<p>1. An estimated 3.8 million Palestinians who are covered by a separate mandate of the U.N. Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) are not included in this report. However, Palestinians outside the UNWRA area of operations such as those in Iraq or Libya, are considered to be of concern to UNHCR.</p>		
<p>2. This table includes UNHCR estimates for nationalities in industrialized countries on the basis of recent refugee arrivals and asylum seeker recognition.</p>		

Source: UNHCR, 2002

Table 2.2:
Countries of Permanent Refugee Resettlement 2000

Country of Resettlement	Number of Refugees Resettled	Percent of Total Refugees Resettled
United States	72,500	74%
Canada	13,500	14%
Australia	6600	6.8%
Sweden	1500	1.5%
Norway	1500	1.5%
Finland	760	.01%
New Zealand	700	.01%
Denmark	460	.01%
Japan	140	.001%
Total:	97,660	

Source: UNHCR, 2002

Refugees: An U.S. Overview:

The legal basis of the refugee admissions program in the U.S. is the Refugee Act of 1980 which “embodies the American tradition of granting refuge to diverse groups suffering or fearing persecution” (Dept. of State, 2001:2). The 1980 legislation was enacted in response to Congress’s difficulty in dealing with large-scale refugee flows from Vietnam and Cambodia under the previous ad hoc admission and resettlement process. Since 1980, admissions are proposed on a yearly basis by the President in consultation with Congress, the full funding for which is dependent on funds from the Migration and Refugee Assistance account. Table 2.3 shows the refugee admissions and ceilings for 1999-2001.

In order to be eligible for resettlement in the U.S., refugee applicants must meet all of the following criteria (Dept. of State, 2001:20):

1. Meet the definition of a refugee as stated in the Immigration and Nationality Act;

2. Be among those refugees determined by the President and Congress to be of special humanitarian concern to the U.S.;
3. Be otherwise admissible under U.S. law;
4. Not be firmly resettled in any foreign country.

Table 2.3:
U.S. Refugee Admissions in FY 1999 and FY 2000
Proposed Ceilings in FY 2001

Region:	FY 1999 Actual Admissions	FY 2000 Ceiling	FY 2001 Projection	FY 2001 Proposed Ceiling
Africa	13,038	18,000	18,000	20,000
East Asia	10,204	8000	4300	6000
Europe	55,576	47,000	38,000	37,000
Latin Amer./Carib.	2110	3000	3200	3000
Near East/S. Asia	4078	8000	9500	10,000
Unallocated reserve*	-----	6000	-----	4000
Total	85,006	90,000	73,000	80,000

Source: Dept. of State, 2001:3

*Unallocated reserve is used only upon notification to Congress when needs for the admittance of additional numbers of refugees develop.

The U.S. government identifies three priority classes in terms of the refugees who may succeed in being processed according to the severity of their situation. Priority One refugees are those who are recognized as cases by the UNHCR or by U.S. Embassies. They not only meet the formal definition of a “refugee,” but are also in danger of refoulement or attack in the country of asylum (e.g. women-at-risk). Priority Two individuals are those identified by the Department of State in consultation with non-government organizations (NGOs), UNHCR, the Immigration and Naturalization Service (INS), and others, as groups of special concern. Only members from these groups or

countries may be eligible for resettlement in the U.S. Currently, Priority Two groups include:

- Certain nationals of Sudan, Somalia, and Togo
- Bosnians of ethnically mixed marriages; victims of torture and/or significant acts of violence; former detainees held due to ethnicity, religious, or political opinion; and spouses of civilians who would have met these criteria had they not died in detention or as a result of violence.
- Burmese members of ethnic minorities who have worked for political autonomy and political activists engaged in the pro-democracy movement.
- Cuban political prisoners, members of persecuted religious minorities, human rights activists, and persons subjected harsh treatment due to political and/or religious beliefs and activities.
- Iranian members of religious minorities.
- Former Soviet Union Jews, Evangelical Christians, and certain members of the Ukrainian Catholic or Orthodox Churches with a preference for those who already have family ties in U.S.
- Vietnamese former camp detainees, certain former U.S. government employees, individuals experiencing persecution due to religious, political, and/or human rights activities.

Lastly, Priority Three individuals include spouses, unmarried children, and parents of refugees lawfully admitted to the U.S. (Dept. of State, 2001)

Within the U.S. government, the Bureau of Population, Refugees, and Migration (PRM), a branch of the U.S. Department of State, "has primary responsibility for formulating policies on population, refugees, and migration, and for administering U.S. refugee assistance and admissions programs" (PRM, 2002). It administers and monitors U.S. contributions to international and non-governmental organizations to assist and protect refugees abroad and works closely with the Immigration and Naturalization Service, the Department of Health and Human Services, and various state and private

voluntary agencies by overseeing refugee admissions to the U.S. for permanent resettlement. (PRM, 2002)

Refugees who meet the U.S. criteria are interviewed by INS officers at the country of asylum, and it is up to these officers to decide if the applicant is a "refugee as defined under U.S. law" (IRSA, 2002). Refugee designation by UNHCR does not guarantee admission to the U.S., and only if the INS officer approves the refugee for resettlement, is the refugee then matched with an American resettlement organization. (IRSA, 2002)

Information on refugees approved for U.S. resettlement is sent to the Refugee Data Center (RDC) in New York, which then matches the refugee with one of the ten voluntary agencies (VOLAGS) listed below that provide reception and placement services (Cultural Orientation Project, 2002):

- Church World Services
- Episcopal Migration Ministries
- Ethiopian Community Development Council, Inc.
- Hebrew Immigrant Aid Society
- Immigration and Refugee Services of America
- International Rescue Committee
- Iowa Bureau of Refugee Services
- Lutheran Immigration and Refugee Services
- United States Catholic Conference/ Migration and Refugee Services
- World Relief

Before a refugee can travel to the U.S., the resettlement organization must first assure, by a written guarantee, the Department of State that it is prepared to receive the refugee and his/her accompanying family members and provide them with basic services. The resettlement organization then determines where the refugee will be resettled. Every effort is made to place a refugee with relatives already living in the U.S., but other factors such as availability of housing, employment, services, and the readiness of the host community are also important in determining the location. A refugee must then receive a medical clearance, a security clearance, and cultural orientation before leaving the country of asylum. Most cultural orientation programs emphasize what to expect in the resettlement phase and the importance of self-sufficiency in America. The International Organization for Migration (IOM) based in Geneva, then arranges air travel for most refugees, and relays travel information to the resettlement organization so it can prepare for the refugee's arrival. Refugees are required to reimburse the travel costs to the organization once they have been resettled and have acquired a means of income. (IRSA, 2002)

The resettlement agency assists the refugee in finding housing, employment, English lessons, etc. In Virginia, the resettlement organization also contacts the health department (in most cases) to schedule an initial health screening within 30 days of a refugee's arrival. It is the usual procedure for the refugee's caseworker to arrange transportation for and/or accompany the refugee to his health assessment. Information on the individual health department practices on this topic is discussed in Chapter 5.

During 1999, 14 states resettled 77 percent of the nation's refugees. Table 2.4 illustrates the main states of resettlement, the percentage of the total refugees resettled and the countries of origin from which the refugees arrived.

**Table 2.4:
Major States of Refugee Resettlement—1999**

State:	% Refugees Resettled:	% by Country of Origin:
Florida	21%	81% Cubans 82% Haitians
New York	10%	11% Former Yugoslavs 22% Former USSR 23% Liberians 28% Sierra Leoneans
California	9%	21% Former USSR 23% Vietnamese 62% Iranians
Texas	5%	14% Sudanese 13% Vietnamese 9% Iraqis 7% Former Yugoslavs
Washington	5%	20% Former USSR
Georgia	4%	14% Somalis 7% Vietnamese
Illinois	4%	7% Former Yugoslavs
Michigan	3%	23% Iraqis
Minnesota	3%	27% Somalis 44% Ethiopians 16% Liberians
Arizona	3%	7% Iraqis 9% Sudanese
Pennsylvania	3%	16% Liberians
Missouri	3%	
New Jersey	2%	
Massachusetts	2%	

Source: Dept. of State, 2001:27

According to the State Department's Report to Congress on Proposed Refugee Admissions for Fiscal Year 2001, Florida resettled the largest number of refugees, 21 percent of the total, and the largest population of Cubans and Haitians than all of the

other states combined. New York and California consecutively, resettled the next largest percentages with New York receiving the largest number of arrivals from the former Yugoslavia and USSR, Liberia, and Sierra Leone; whereas California admitted the largest percentage of Vietnamese and Iranian refugees. More Sudanese were resettled in Texas than any other state, and Minnesota resettled the largest number of Ethiopians and Somalis. In addition, Michigan received more Iraqis than any of the other states in 1999. (Dept. of State, 2001:27)

Virginia's Refugees:

Although Virginia is not considered one of the major players in refugee resettlement, it does resettle a significant amount of refugees that has continued to increase over the past several years. Since 1975, Virginia has received approximately 48,000 refugees. About 62 percent between 1975-2000 were from Southeast Asia—mainly Vietnam. However, since 1997, refugees from Southeast Asia have represented only about 10 percent of the new arrivals, and increases have occurred in the following areas (ONS, 2001:7-9):

- Eastern Europe (mainly former Yugoslavia), from 9 to 37 percent
- Middle East, from 9 to 11 percent
- Africa, from 7 to 35 percent
- Former Soviet Union, from 5 to 7 percent

Table 2.5 better illustrates changes in Virginia's refugees in the past several years:

**Table 2.5:
Virginia Refugee Arrivals and Refugee Region of Origin
1998-2000**

Region of Refugee Origin:	1998	1999	2000
Africa	404	1021	1221
Near East	121	214	386
Eastern Europe	596	1077	455
Caribbean	78	103	67
South America	0	13	4
Asia	327	214	112
Former Soviet Union	169	159	102
Totals:	1695	2801	2347

Source: RHP, 2001:2

Virginia's refugee resettlement program is administered by the state's Office of Newcomer Services (ONS) which negotiates and executes interagency agreements and contracts with public and private agencies, directing these funds to local communities where the refugees reside. ONS oversees the Refugee Cash Assistance, Refugee Medical Assistance, health screening, and unaccompanied minors programs within the Department of Social Services. A governor-appointed State Refugee Coordinator is housed in ONS and works directly with the federal Office of Refugee Resettlement for funds to be distributed for refugee services throughout the Commonwealth. (ONS, 2001:2)

Virginia's model of refugee resettlement originates from the stated purpose of the refugee program at the federal level, "namely promoting effective resettlement through attainment of self-sufficiency at the earliest time possible" (ONS, 2001:13). The federal, and hence the state model is based on the following principles (ONS, 2001:13):

- Resettlement is a continuum of services that begins with the VOLAG upon the refugee's arrival in the U.S., moves toward self-sufficiency, and ideally leads to citizenship and full participation in the community where the refugee resides.
- Long-term public assistance utilization is not an acceptable way of life in America, and therefore is not a resettlement option.
- Early employment promotes the earliest possible economic self-sufficiency.
- Self-reliance and personal responsibility must be integrated into each refugee's resettlement plan.
- Coalitions of service providers ensure strong public or private partnerships that work to maximize resources.
- Service providers must work in coordination with other agencies to maximize community resources and create an optimal service delivery system.
- Services must be sensitive to cultural issues and be implemented by a staff that, as closely as possible, mirrors the population served.
- Mutual assistance associations and ethnic organizations are encouraged and bring unique strengths and cultural knowledge to the resettlement process.
- Language access is critical to the resettlement process and must be fostered by all who work in some way with the refugee.

In Virginia, the following VOLAG subsidiaries and service providers, grouped by region, provide services to refugees resettled within the Commonwealth (ONS, 2001:95-96):

- Northern Region:

- Alexandria Office of Employment Training (Alexandria)
- Arlington Employment Center (Arlington)
- Catholic Diocese of Arlington Refugee Services (Arlington)
- Ethiopian Community Development Council, Inc. (Arlington)
- International Rescue Committee (Charlottesville)
- Lutheran Social Services (Falls Church)
- Virginia Council of Churches Refugee Resettlement Program (Harrisonburg)

-- Virginia Council of Churches Refugee Resettlement Program (Manassas)

- Central Region:

--Refugee and Immigration Services (Richmond)

--Virginia Council of Churches Refugee Resettlement Program (Richmond)

- Eastern Region:

--Hampton Roads Refugee and Immigration Services (Hampton)

--Virginia Council of Churches Refugee Resettlement Program (Virginia Beach)

- Western Region:

--Refugee and Immigration Services (Roanoke)

The overwhelming percentage of service providers in the Northern Region is reflective of the larger number of refugees that are resettled there. Table 2.6 below shows where Virginia's refugees were resettled by region in the year 2000:

Table 2.6:
Virginia Refugee Resettlement by Region--2000

Northern	Northwest	Central	Southwest	Eastern
1356 (58%)	313 (13%)	390 (17%)	164 (7%)	124 (5%)

Source: RHP, 2001:10

As the table illustrates, the majority of Virginia's refugees that were resettled in 2000 are located in northern Virginia (particularly around the Washington, D.C. area), constituting over half of the entire refugee population for that year. However, remaining areas of resettlement are not without impact, especially when considerable numbers of refugees are moving into more sparsely populated areas. Such impacts would not only include

those that are demographic in nature but also potential health impacts to the community where the refugee resides. In addition, if a refugee is ill and unable to work and must depend on the state for assistance, economic impacts could affect the resettling community as well. Since almost all refugees have fled their homes due to ethnic and/or religious persecution, war, natural disasters, and civil unrest, they are in a unique situation with respect to health status and health care. They often come from areas experiencing severe poverty and hunger and are already in a state of compromised health when they flee their home countries and oftentimes in the refugee camps where they reside as well.

Just as every country has its own unique cultures and identity, health status can also be distinctive of specific regions in the world. It is therefore important to understand health problems that a refugee may bring with him in order to provide for appropriate health assessments when they arrive. The next chapter will review the theoretical literature pertaining to this thesis and the broader topic of health geography and discuss refugee health issues and policy involvement in further detail.

Chapter 3—Medical Geography, the Geography of Health, and Refugee Health

Issues: A Review of Pertinent Literature

Theoretical Concepts in Medical and Health Geography:

The study of refugees fits naturally into geographical research, in particular the characteristics of sending and receiving places. Geographers are interested in where refugees come from, and what local and wider forces have caused people to leave. Further, they look at refugee destinations and the various impacts migrations have on existing communities. Geographers study the spatial distributions of refugees who have been resettled in receiving countries to better understand where and why they live in the locations they do. They may also investigate the cultural adaptations refugees make in their new locations, the overall appearance of the local landscape, and how the new arrivals may influence policy changes. Historical geographers may research earlier streams of refugee resettlement with regard, for example, to adjustments made in the broader community, employment trends, the spatial implications of emerging class differences, and changes in health patterns.

The sub-field of medical, or health, geography represented in this thesis provides frameworks for examining refugee issues. Researchers can evaluate the health and diseases found in the refugees' areas of origin. They may concentrate on health and sanitary conditions in refugee camps, the medical conditions refugees bring with them from these camps, as well as the problems they acquire living in their new countries. Medical geographers also study policy issues and how these relate to refugees' health,

and may examine the utilization of health services and map and analyze how far refugees travel to obtain health care.

Meade and Earickson (2000) define medical geography as both “an ancient perspective and a new specialization [that] uses the concepts and techniques of the discipline of geography to investigate health-related topics [by] drawing freely from...other social, physical, and biological sciences” (2000:1). The term “medical geography” was first used by 18th-to-19th century physicians as they described and organized information about human diseases, cultures, and environments. However, the emergence of medical geography as a field of study is relatively recent and has been dated to the first report of the Commission on Medical Geography (Ecology) of Health and Disease of the International Geographic Union in 1952. It was initiated as a subdiscipline and specialty by Jacques May, who is often called the “founder” of medical geography (Meade and Earickson, 2000).

In Medical Geography (2000), Meade and Earickson assert that Pattison’s four traditions lie at the heart of medical geography. The four traditions are spatial, regional, man-land, and earth science, with the man-land tradition being the first to develop in American medical geography. The man-land tradition has evolved over the course of a century to become one of the foundations of cultural ecology, which among other concerns, views human health and disease as inextricably linked with human-environment interactions. The earth science approach is largely included with the man-land tradition. For example, how are toxic pollution and trace elements in the soil and water related to various diseases? The spatial tradition emphasizes distance, form, direction, position, location, and distribution over space. The concepts within this

tradition apply to studies of health service location and utilization as well as disease diffusion and its analysis. Finally, regionalization focuses on “integrating all the variable phenomena in order to characterize the special identity of particular places and areas” (Meade and Earickson, 2000:9). In medical geography, this can take the form of locational analysis of particular areas, or focus on the specific living systems in which a disease agent such as West Nile virus may circulate. (Meade and Earickson, 2000)

In contrast, Gatrell’s work, Geographies of Health (2002), incorporates more recent post-modern ideas. He seeks to move the field conceptually away from “medical geography,” with its biomedical and positivist biases, and toward qualitative analyses based in social theory that produce “geographies of health.” The aim is a broader, more comprehensive approach that encompasses the full range of place and social factors that influence patterns of health and diseases in individuals and human groups. Thus the current trend is to shift away from “medical” to “health geography.”

Gatrell contends that, until recently, most traditional medical geographers have approached problems of disease and health from the *positivist* perspective. Positivists emphasize the observable, measurable, and generalizable and rely heavily on the use of quantitative methods of analysis. Gatrell turns attention to several newer concepts that influence the ways many geographers now approach questions about health and disease. These ideas include social interactionist, structuralist, structuration, and post-structuralist approaches. The *social interactionist* perspective addresses human beliefs, values, meanings, and intentions and how they relate to health outcomes. It emphasizes the subjective experience of health and illness and depends on the use of qualitative methods to research their meaning and interpretation.

The *structuralist*, or political economy perspective, examines the underlying causes of health care inequities and disease from the perspective of power and decision-making among political and economic systems. Gatrell (2002) contends that in this approach, the economic determines the social, limiting the scope for human intention and free will. *Structuration*, the conceptual approach that is most applicable in this thesis, reflects the operation of both structure and human agency. It acknowledges that structures shape social practices and actions but that the inverse also holds true. And finally, the *post-structuralist* approach is concerned with how knowledge and experience are constructed in the context of power relations. This perspective involves the process of knowledge creation and has enhanced research on health risk and what it means to be a healthy citizen.

Refugee Health—A Literature Review:

Due to the cross-disciplinary attributes of health geography, not all research pertinent to the field is conducted by geographers but rather by researchers from a variety of backgrounds. Much of the literature concerning refugee health has been written by health professionals and elucidates a positivist approach. Studies conducted by health care providers, Ackerman (1997), Goodridge (2002), and Kemp (2002), focus on the health problems that refugees bring with them from their countries of origin. They offer treatment advice and information to physicians and other health providers who work with refugee populations. For example, physicians Cantanzaro and Moser (1982) evaluated the health of Southeast Asian refugees who had been resettled in the U.S. for two months and found important relationships between health problems and ethnicity.

Such studies reflect a positivist influence because they tend to ignore patient individuality and the political and societal influences that could be associated with their health conditions. In addition, they often are quantitatively oriented and include generalizations regarding particular refugee groups and the health problems that can be expected to be associated with them, such as Chagas disease among Latin Americans and Filariasis among Africans. These works and others like them are invaluable to health providers seeking knowledge to impart better medical treatment to refugees, and for awareness to prevent newly introduced diseases from becoming a potential threat to public health.

In contrast, Olness's (1998) investigation on refugee health and conditions in refugee camps exhibits a structuralist approach. It focuses on the settings of the camps and lack of services within them as a catalyst for refugees' compromised health conditions. The focal point is on the camp settings as "grim places in general...[where] housing is extremely crowded, sanitation is poor...[and] settings lack adequate attention and programs for the most vulnerable—pregnant and nursing mothers, children, and the elderly" (1998:227). Here, human agency on the refugee's part is absent in terms of refugees not having control over their own health and living situations. Olness, a medical doctor, contends that refugee settings "have negative impacts for productivity, economics, and political stability that adversely affect the whole world" (1998:227).

Elliott and Gillie(1998), a geographer and health care practitioner respectively, found that, in general, immigrant groups tend to utilize health care services less frequently than locals. When they do utilize them, they usually terminate their treatment early, and receive poorer quality health services than their non-immigrant counterparts. Their

conclusion (that immigrants receive poorer quality services than non-immigrants) is indicative of a structuralist approach. However, the fact that immigrants tend to end their treatments early shows a social interactionist tendency. The immigrants in this study are both acting of their own free will and exercising their right to make their own decisions concerning health care by refusing treatment. In addition, this could also be seen as a structuration effect because immigrants are terminating treatment due to poor services. This suggests that they would react differently if a better health care structure existed.

Elliott and Gillie's (1998) study in particular relates to my own thesis in that both show structure *and* agency at work. Their study also leads to the questions regarding refugee health for this thesis, as outlined in Chapter 1. To better answer these questions, literature regarding health inequalities and resource allocation was also researched and will be discussed in the next section of this chapter.

Health Inequalities-- Resource Allocation and Health Services Decision-Making:

Medical geographers Meade and Earickson (2000) define medical pluralism as the existence and use of multiple sources of medical care, both traditional and modern, by individuals and groups. From the standpoint of overall resource availability, technological capabilities, and clinical sophistication, Jones and Simmons (1999), a professor in health administration and policy and a medical doctor respectively, assert that "the U.S. health care system is clearly the best in history." Although this health care system exhibits widespread medical pluralism and the quality of care is generally first-rate, many individuals who require treatment are hindered economically. In a privatized, market-oriented, capitalist health care system, those who cannot afford insurance often

suffer in terms of medical care and treatment (Jones and Moon, 1987). Refugees do receive some economic assistance for health care in the form of Medicaid or RMA, but it is only available to them for 8 months, after which they, like other Americans, are dependent on their employer or private sources for health insurance benefits. Since the majority of refugees work in low-wage jobs, insurance is either unaffordable or not offered, and their health status may suffer as a result. It is therefore imperative that health problems they bring with them are detected early on so that treatment can be rendered while the Medicaid or RMA benefits are still valid. This structural feature represents a substantial incentive for refugees to obtain thorough health assessments.

From predominantly structuralist perspectives, various studies of health inequalities have been published by Mitchell et.al. (2000) and Kim et.al. (2000). Their studies, along with those of Farmer (1999), an activist physician, have found that inequalities in health exist across the globe. They identify marked differences between the rich and poor, developed versus developing nations, as well as inequities across groups based on gender, ethnicity, and race. It is well known that health inequalities extend beyond the personal level to encompass entire populations and regions and that such disparities exist as a result of underlying political, social and economic structures that “directly and indirectly shape health policy and health outcomes” (Kim et.al., 2000:11).

Studies on health inequalities have been conducted at various scales and from a number of different perspectives. Steele et.al. (2002) took a small-scale approach in their qualitative study of service providers’ perspectives on the impact of policy changes on the health of immigrants and refugees residing in Toronto’s inner city. Focusing on recently arrived immigrants and refugees, “an important and vulnerable inner city

population” (2002:118), the researchers analyzed their study from a structuralist perspective by focusing on the changes to health and social policy that have taken place in Ontario over the past five years. They then used a qualitative analysis by gathering data in the form of personal interviews with health service providers to better determine from them how the current structure or policy could be altered to better serve the refugee and immigrant population in their area.

Also in Ontario, Newbold et.al. (1998) explored various measures of need for health care that could be used to improve the equity of resource distribution, including the use of standardized mortality ratios and socioeconomic-based mortality indicators. They contend that in Canada, where there is full-public funding of insured hospital and physician services, that funds for health care have been allocated among providers according to the level of services provided as opposed to the needs of the population being served. This study is pertinent to refugee health because it brings to the forefront the important debate on how resources should be allocated and where the needs of the population are factored into the allotment equation.

Equity of access is another area that has been extensively researched in recent years. Goddard and Smith (2001), health economists at the University of York, found that there appear to be important inequities of access to health care services in the United Kingdom, but that it is difficult to identify the potential causes that may be amenable to policy initiatives. Health science researchers, Lavis et.al. (2002), deal with this topic by examining the role health services research plays in public policymaking in the hope that better use of such research will result in better health care policy.

In a national study, medical doctors Jones and Gill (1998), explore the challenges that refugees pose for primary care in the United Kingdom and address the inequalities in that care. From a structuralist perspective, they found that although refugees are entitled to a full range of treatment free of charge, there is evidence that general practices are confused about this and differ in their attitudes in regards to the treatment they provide. This is not unlike the case for this thesis in which funds to perform assessments on refugees are provided to Virginia, and yet not all health departments are accessing them. The next portion of this paper will therefore address similar issues specific to Virginia, beginning with the grounds and methodology for the research followed by a discussion of the study's results.

Chapter 4—Methodology and Research

Methodology:

The origins of my research began at a local health department where I was gathering data on refugee health screenings specifically directed to the health problems that were encountered by conducting such assessments. The health problems that were diagnosed among the refugees in my case study were significant enough that I felt compelled to dig deeper into the state system.

I began by asking the following research questions:

- Which health departments in Virginia conduct health screenings on refugees? Do providers offer the same services and procedures? i.e. does every refugee receive a complete physical upon arrival? What factors explain locational differences in refugee health services?
- Are there guidelines that health departments must follow where refugee health screenings are concerned? And if so, who, if anyone, coordinates and oversees that health departments are performing these services?
- Where does the reimbursement money come from? Does every health department receive the same amount of money for performing refugee assessments? How much is received and how does the disbursement and utilization of funds vary geographically? Why?

- If health departments can receive reimbursement for providing these services, why would they not offer them? And if they do not, what factors contribute or hinder their ability to offer complete domestic health screenings? Who decides, and why?
- Does the location of resettlement in Virginia influence the health of the refugee as a result of the services that are available or unavailable to him in a particular area?

Knowing that federal money is allotted to states by the Office of Refugee Resettlement to coordinate refugee services, I discovered from the local health department the two key players who developed and coordinate the current Virginia Refugee Health Program: State Refugee Coordinator, Kathy Cooper, and the Virginia Refugee and Immigrant Health Program Director, Anna Davis.*

My interview with Ms. Cooper, discussed in further detail in the research portion of this chapter, provided information on the inception of Virginia's Refugee Health Program (RHP) and on how the RMA funds are allotted to local health districts. Information on the particular health districts that deal with refugees was then obtained from Anna Davis, who offered comprehensive data on how many health screenings each district performed as well as how much RMA funds were reimbursed to them for providing these assessments. With this information, I constructed a table that allowed me to calculate the average amount of RMA funds used per refugee for each participating health district. This knowledge enabled me to target which health districts I would interview in further detail. I sought to interview a sample of health districts both in terms of the average amount of RMA they were reimbursed as well as by their geographic locations across the

* All persons cited as sources in this study have given permission for their names to be identified.

state, ensuring that each part of the state was represented as equitably as possible. Of the 19 health districts that performed refugee assessments in 2000, I interviewed officials in 13 of them. The results will be discussed in Chapter 5.

When I knew which health departments I wanted to interview, I then constructed a questionnaire that would serve to best provide me with the answers to the questions I had set out to answer. I wanted to ensure that I asked the same questions to each health department I interviewed to allow for more clear and concise analyses and comparisons of the results. I conducted the first interview with a draft of the questionnaire in order to test its thoroughness and succinctness. The information gathered from this initial interview allowed me to include additional questions that I had not previously thought of for the final draft. The final questionnaire is included as Appendix 1.

I then sought to contact individuals at each health department who were in charge of the refugee program for their locale. The initial contact was made either by phone or email at which time I explained the intent of my research and gave the interviewee the option of how he/she would prefer the interview to be conducted: in person, by phone, by email, or by standard mail. I conducted a few interviews in the form of a conference call with several individuals at the same health district who felt like they had equal participation in their refugee health programs. Most individuals preferred a phone interview, whereas two were conducted in person, one by standard mail, and two by email.

Research:

Virginia's Refugee Health Program was coordinated by Kathy Cooper and Anna Davis, who planned what could be done to make health assessments possible for health districts to provide. They decided that the best way for health districts to render assessments would be to offer readily available reimbursement to all health districts willing to participate. In addition, they developed a protocol to encourage health departments to perform the necessary levels of assessment. Cooper and Davis' collaboration came to fruition on July 1, 1997, and since then local health districts have been financially compensated for providing initial health assessments via RMA (Refugee Medical Assistance) funds that are administered through the Department of Social Services and facilitated by the Refugee Health Program. (Cooper, 2002)

The mission of the Virginia Refugee Health Program is "to enable local health districts to provide high quality initial health assessments to new refugees resettling in the Commonwealth" (RHP, 2001, p.1). Since tuberculosis is the most common classified health condition identified, in terms of federal and state policy, all refugees must be screened for active tuberculosis disease and tuberculosis infection. This is the only portion of the health assessment that is mandatory, but local health departments may and are encouraged by RHP to provide more thorough health assessments and receive reimbursement for them. The assessment targets the early identification of communicable and other conditions which, if undetected, can negatively impact the health of the refugee and the public health of the community as well as impede the refugee's well being and ability to achieve self-sufficiency. (RHP, 2001)

In 1997, Cooper and Davis developed a protocol and reimbursement structure to encourage health departments to perform the four recommended levels of assessment, allowing for higher reimbursement amounts according to the number of levels completed. Each level's requirements are detailed in Chapter 1, and Table 4.1 offers a dissection of the reimbursement amounts by age group.

Table 4.1
Refugee Health Screening Assessment Levels
and Reimbursement Amounts, 2002

Level of Assessment:	Reimbursement Amount (ages 11 & under):	Reimbursement Amount (over age 11):
I	\$60.00	\$60.00
II	\$119.50	\$160.50
III	\$18.50	\$34.50
IV	\$86.50	\$86.50
Total:	\$284.50	\$341.50

Source: RHP, 2001

All health departments are required to perform a Level I, TB assessment on refugees resettling in their districts, and the additional levels of assessment are optional. In order to receive reimbursement for the other levels, all portions of each level must be completed and levels must be done consecutively. For example, if a Level I and Level III are completed, but Level II omitted, reimbursement will not be allotted for Level III. Likewise, if Levels I, II, and III are fulfilled, but not Level IV, health departments will be reimbursed for Levels I-III.

During our interview, I questioned Ms. Cooper on the monetary aspects of the Refugee Health Program and was told that each year, she writes an annual report to the federal Office of Refugee Resettlement (ORR). The report is submitted in August and includes an estimated amount of funds that Virginia will need for its refugee-related programs, including Refugee Medical Assistance, which provides for the reimbursement of the initial health screenings. Money is received on a quarterly basis from ORR, and in addition, the state receives a yearly grant from the Office of Refugee Health in the amount of \$60,000 which covers some of the salary costs for state refugee health and outreach employees.

Of the 35 health districts in Virginia, about 17 resettle refugees on a regular basis and access health screening money. Ms. Cooper explained that there are pockets of more utilization of RMA funds and others where the cash assistance is not utilized at all. She predicted that I would find that the health districts that do the best screenings are in areas of denser refugee resettlement and that some of the reasons for disparity among districts would include staffing issues, lack of education and knowledge of refugee health issues, and training.

After I spoke with Kathy Cooper, she recommended that my next point of contact be Anna Davis, the refugee health program director. From Anna Davis, I requested the most recent data she had available on the number of health assessments provided by each district as well as the reimbursement amount that each one received for that period of time. During the year 2000, Virginia resettled 2347 refugees, 1701 of which received initial health screenings. The reasons for those who did not receive health screenings included secondary migration to another state, the refugee received assessments from a

private provider, or the inability of the refugee to be located or report to the health department. From the data Ms. Davis provided, I constructed Tables 4.2 and 4.3. Table 4.2 shows the number of refugees resettled in each participating health district and the percentage of the state's total resettled there. Fairfax County receives approximately 37% of the Commonwealth's refugees followed by Henrico County, the City of Alexandria, and Arlington County.

Table 4.2
Number and Percentage of Refugees Resettled by Health District, 2000

Health District:	Number of Refugees Resettled:	Percent of State Total:
Fairfax County	858	36.6%
Henrico County	307	13%
Alexandria City	215	9.2%
Arlington County	188	8%
Thomas Jefferson	163	7%
Roanoke City	162	7%
Central Shenandoah	143	6.1%
Peninsula	102	4.3%
Richmond City	65	2.8%
Central Virginia; Chesapeake; Chesterfield; Hampton; Loudoun; New River; Norfolk; Prince William; Rapahannock/Rapidan; Virginia Beach	144	6.1%

Source: Davis, 2002

Table 4.3 allows for a better dissection of what each health district is doing in terms of refugee health assessments. For the year 2000, RMA funds reimbursed to the state's health districts totaled \$435,650. I divided this amount by the number of refugees who received health assessments for the same year (1701) to come up with an average reimbursement used per refugee, \$256.11. Ms. Davis provided data that included the number of assessments performed by each district as well as the amount of RMA funds

each was reimbursed for that year. From this, I developed Table 4.3 and calculated the average amount each health district was reimbursed per refugee. This information emphasized the residuals that stood out as being significantly above or below the state average. It also provided the basis for me to determine those health districts in which I would conduct interviews.

As seen in Table 4.3, the districts highlighted in red, Alexandria City and Prince William County, are those with the lowest reimbursement average. Whereas those highlighted in blue indicate the two districts with the highest average, namely Roanoke City and the Thomas Jefferson health district. These four districts were the obvious choices for interviews, however, I felt that I needed a broader representation from the state. I therefore also chose to interview other districts based on location, such as Norfolk, Virginia Beach, and the Peninsula as representatives of the Tidewater area. I also wanted the viewpoint of districts that receive a small number of refugees such as Chesterfield County as well as those that resettle the largest amounts of refugees such as Fairfax and Henrico Counties. Figure 4.1. illustrates by means of a location-quotient map, the densities of health assessments performed by district in 2000.

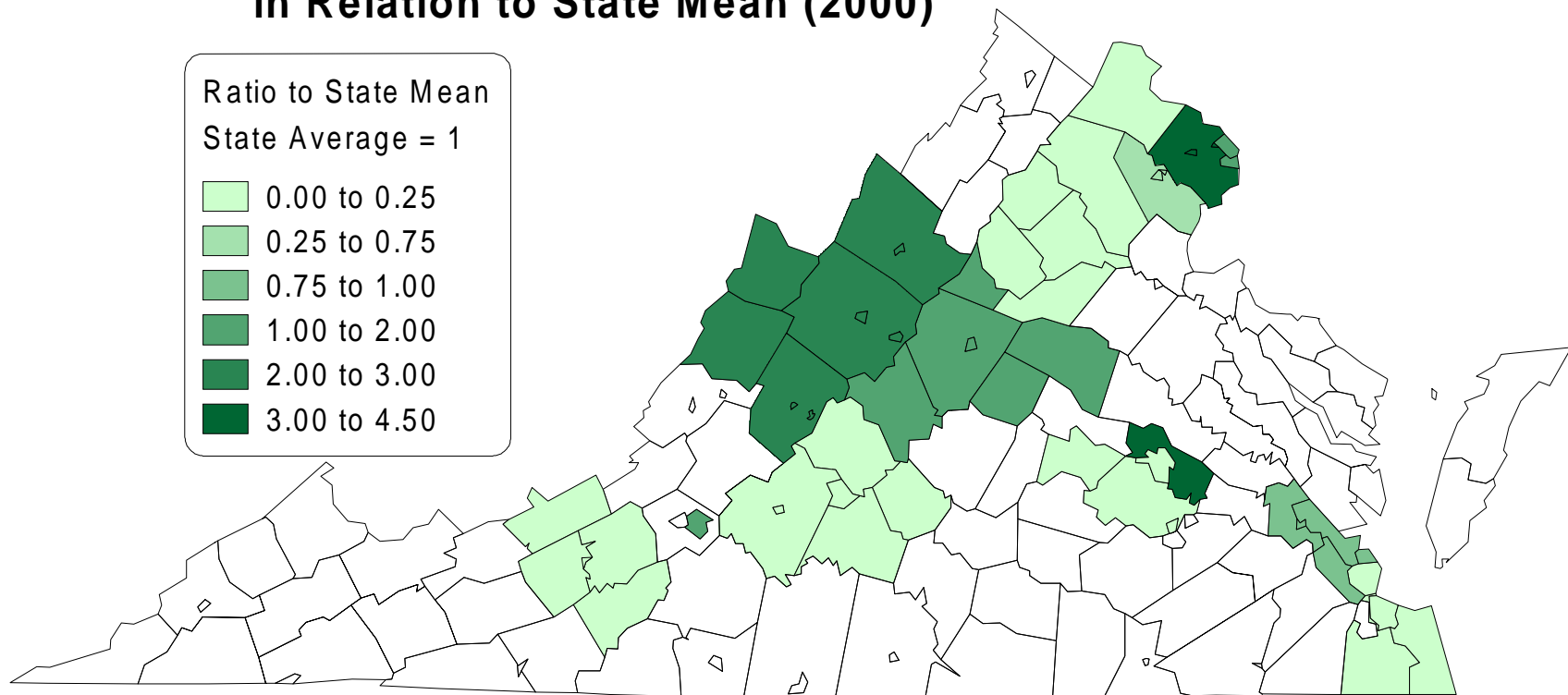
Table 4.3
Health Assessments and Funds Utilized by
Health District, 2000

Health District:	Number of Health Assessments Performed:	\$ RMA (2000) Funds Used:	% of RMA Funds Used:	\$ Used per Refugee
*Fairfax County	404	\$111,086	25.5%	\$274.97
*Henrico County	296	\$79,391	18.2%	\$268.21
*Central Shenandoah (Harrisonburg H.D.)	177	\$51,615.50	11.9%	\$291.61
*Arlington County	165	\$47,329.50	10.9%	\$286.85
*Alexandria City	164	\$12,882.50	3.0%	\$78.55
*Roanoke City	154	\$46,592	10.7%	\$302.55
*Thomas Jefferson	128	\$38,668	8.9%	\$302.09
*Peninsula	78	\$23,042	5.3%	\$295.41
*Prince William	53	\$4125.50	1.0%	\$77.84
*Richmond City	19	\$5567	1.3%	\$293.00
Loudoun	15	\$2726	.6%	\$181.73
Central Virginia	10	\$2825	.7%	\$282.50
*Virginia Beach	8	\$1318	.3%	\$164.75
*Chesterfield	8	\$2212	.5%	\$276.50
Hampton	8	\$2144	.5%	\$268.00
*Norfolk	6	\$1752	.4%	\$292.00
Rapahannock/Rapidan	4	\$1187	.3%	\$296.75
New River	3	\$876	.2%	\$292.00
Chesapeake	1	\$311	.07%	\$311.00
Total:	1701	\$435,650	100%	\$256.11

Source: Davis, 2002

(*'s indicate health districts interviewed)

Figure 4.1
Health Assessments Performed
in Relation to State Mean (2000)



Source: Stacy Boyer, 2002

As can be seen in Figure 4.1, the distribution of health assessments performed, and hence, the number of refugees in the Southwestern portion of the state is minimal compared to the central, northern, and eastern portions. Roanoke City represents the most western district in the Commonwealth that actively resettles refugees. Table 4.3 shows that the New River district, which is further west, did resettle 3 refugees in 2000, but this was an anomaly for that year. Since the New River area does not have an established program and has not received any refugees since 2000, it was decided that it would not be interviewed for this study. Overall, I conducted interviews in 13 of the 19 health districts that performed health assessments in 2000, and the results of these interviews can be found in the next chapter.

Chapter 5—Findings from Interviews with Health District Personnel

Each interview consisted of twenty questions ranging in content from services provided, to health problems found in refugees, to personal opinions regarding the utility of the refugee health program. The following results have been divided by subject content.

Levels of Assessment and Services Provided:

The types of services, screenings, and overall opinions on the refugee program in Virginia varied widely as to individual locality. Given the option to complete all four levels of assessment, 10 of the 13 health districts interviewed choose to do so. The districts that do not perform all four levels include Prince William County, and the cities of Virginia Beach and Alexandria. Prince William performs the mandated Level One assessment on every refugee and sometimes does portions of Level Two, but as stated in the previous chapter, *all* parts of each level must be completed to receive reimbursement. Prince William is therefore not reimbursed for performing only some portions of Level Two. Virginia Beach completes Level One assessments on every refugee and does do some Level Four assessments on those refugees requiring case management due to positive TB screenings. It also has a children's clinic where Level Two, Three, and Four assessments are provided to refugee children only. And finally, Alexandria offers only Level One assessments to refugees residing in its health district.

The other ten health districts perform all four levels of assessment and follow the guidelines discussed in Chapter 1. In most cases, the same level of assessment is

performed on every refugee. However, Arlington County, which performs all four levels on refugees over the age of 18, refers children ages 0-17 to its Child or School Health Clinics. Here, physical exams and immunizations are provided, while the TB screening and urine and stool samples are performed at their refugee health clinic. Chesterfield County states that it generally does all four assessment levels unless a refugee has already been seen by a private physician. This usually happens with refugee children who need to begin school as soon as possible. When this is the case, a Level One assessment is then provided by the health department since it is frequently not covered during the private physician's physical exam. Harrisonburg also offers all four assessment levels the majority of the time with the exception being when a nurse practitioner is unavailable. When this occurs, the Level Three portion of the assessment is then omitted.

Health districts also vary in the additional services that are offered that may exceed the recommendations of the state Refugee Health Program. For example, dental problems are a big complaint among most adult refugees, but dental care for adults is not covered by the state Medicaid program. To help with this need, Arlington County has established a Refugee Dental Clinic that is free to newly arrived refugees and asylees. It can provide a level of service up through extractions, treatment for infection, and fillings, but does not offer dentures or restorative care. Fairfax, Harrisonburg, Norfolk, Roanoke, Thomas Jefferson, and Virginia Beach districts all offer dental services for refugee children under the age of 18. In addition, Thomas Jefferson and Norfolk's program will take a few adults on an emergency basis.

When questioned on the types of tests that are administered, those responding provided diverse and numerous answers. Ten of the health districts follow the RHP

guidelines and three perform the absolute minimum. The Alexandria Health Department, for example, only administers the mandated TB screenings and in the case of a positive screening, chest x-rays are rendered as well. Prince William also provides TB skin tests and chest x-rays in addition to tests for HIV on refugees from Sub-Saharan Africa. It also offers immunizations, especially for school-aged children. Virginia Beach provides immunizations to children through its pediatric clinic as well as some adults (who have to pay) in addition to the TB screening and chest x-rays.

In contrast, several health districts extend services well beyond the recommended procedures, especially where HIV and malaria testing are concerned. Those who opt to test for malaria, do so on those refugees whom are symptomatic or are from areas where malaria is endemic (such as Africa and Asia). These health districts include Fairfax, Harrisonburg, Henrico, Peninsula and Roanoke. Fairfax and Roanoke also opt to test for HIV as well, even though refugees are tested for this virus prior to entering the U.S. Henrico and Peninsula choose not to test for HIV, whereas Norfolk and the Thomas Jefferson districts offer HIV but not malaria testing.

Chesterfield County, Harrisonburg, and Virginia Beach offer a family planning clinic, and maternity services are provided in both Harrisonburg and Prince William County. In Henrico, female refugees have the option for gynecological care that includes such services as pap smears and breast exams. Likewise, in Norfolk, female refugees also receive breast and pelvic exams but as part of the routine health assessment rather than during a separate appointment. Fairfax has a community health care network where refugees can receive treatment for diabetes and high blood pressure, which is usually free or at a minimal cost to refugees. The City of Alexandria's health departments provide

many services but the respondent was uncertain whether or not the refugees access them. They provide services for obstetrics/gynecological exams, family planning, maternal/child health, HIV, cardiovascular problems, breast cancer, and a well-baby clinic.

Twelve of the health districts are equipped to perform on-site laboratory testing, with the exception of some of the more complex tests such as for HIV, TB sputum, and malaria blood smears, which have to be sent to the state lab free of charge. Virginia Beach, the only health district that gave a negative response to this interview question, stated that they send all lab work out because they do not have the adequate staffing to provide any laboratory services.

Several of the respondents were not able to contribute information on how the refugee services they provided have changed over time, largely because of recent employment (as in Alexandria's case) and/or failure to respond to the question (Norfolk, Richmond, and Roanoke). Of those who did respond, Fairfax, Peninsula, Thomas Jefferson, and Virginia Beach districts all stated that their services have not changed over the years. In Arlington however, the program started in 1980 by providing only TB screenings. Later, a health history and physical assessment were added, and gradually, different laboratory tests, as common problems were found among those refugees seen. Initially, no Hepatitis B studies were performed but now that a vaccine is available, everyone is tested. Follow-ups are also done earlier since the refugee only has Medicaid benefits for 8 months. By working with the state refugee health program, Chesterfield has added specific guidelines for malaria, parasites, and Hepatitis B testing. They have also changed their policy on chest x-rays. A routine x-ray to scan for TB used to be automatic but is now contingent

on the skin test reaction. Harrisonburg stated that they now perform more Level Three assessments than in prior years, and Henrico replied that dental services were provided at one time but were stopped. Prince William County has become more aggressive in treating TB as its rates have been rapidly increasing over the past several years, and it has also started testing Sub-Saharan African refugees for HIV.

Decision-making and Service Providers:

When asked who decides what services and levels of assessment are provided to the refugees, four of the health districts interviewed responded that the decision was entirely up to the health director, while seven stated it was a collaborative decision between the health director and health department staff, and two did not answer or were unsure. Those districts that responded that the health department director decided the level of services that would be provided to refugees included Alexandria, Henrico, Peninsula, and the city of Richmond. Those interviewed who were unsure or did not respond were Harrisonburg and Norfolk health departments, while the remaining 7 districts agreed the decision-making process was a collaborative effort between the health department director and participating staff.

Factors that may influence the decision of what services will be provided to refugees are interesting and diverse. The Fairfax, Prince William, and Alexandria health departments all agree that each department has to prioritize and/or update and make changes according to the needs encountered in the community for particular services. Alexandria also interjected that mandated areas have to be performed first before other services are considered, whereas Arlington County bases the services it provides to

refugees on its own experiences in dealing with them on a regular basis. Roanoke City believes that when deciding which services will be offered, a health department should consider staffing, laboratory and physician access, and whether or not it has good cooperation with the refugee resettlement agency. The motivation of the staff working with the refugees is a main factor for the Thomas Jefferson Health District who has one nurse in particular who “took it [the program] over.” Interestingly, both Henrico County and Virginia Beach responded that the decision for the provisioning of refugee-related services is linked to financial issues. Henrico believes the high reimbursement amount it receives is a contributing factor for providing refugee services, while Virginia Beach feels that lack of staffing and financial resources plays a large factor in why it *cannot* provide as many services.

When asked who in the health department performs the assessments on the refugees, ten responded that services are rendered by public health nurses. The remaining thirteen replied that the assessments are carried out both by public health nurses in addition to a physician or physician’s assistant who complete the physical examination portion of the screening. Harrisonburg also has a nurse practitioner and nursing assistant who administer the services under the supervision of a registered nurse. In Richmond, an onsite physician helps the public health nurse in providing the assessments, and the Norfolk public health nurse has two physicians with whom she can consult when needed. In Roanoke City, an epidemiologist does the initial intake including a health history, and the remainder of the assessment is conducted by a public health nurse and a volunteer physician or physician’s assistant.

Refugee Demographics and Health Problems:

Only four of the respondents were able to provide information on how many refugees have been administered assessments in their health district over the past few years. Five were able to give an approximate number, and four did not know at all. Those who did not know or did not respond to this question were Alexandria, Henrico, Peninsula, and Prince William health districts. Those who knew and/or provided the exact number were Arlington, Harrisonburg, and Thomas Jefferson, while Chesterfield, Fairfax, Norfolk, Richmond, Roanoke, and Virginia Beach were able to offer approximate estimates. The actual number of refugees seen by each health district can be observed in Table 4.3 of the preceding chapter.

In terms of where the refugees were from, all thirteen respondents interviewed stated that the refugees they receive are from all over the world. They reported that in previous years, Bosnians and other Eastern Europeans were the largest group whereas recent years have shown a rise in Middle Eastern (especially Iraqi) and African (particularly Sudanese) refugees. In addition, the Harrisonburg health department reported a significant number of Cubans as well.

Question 16 inquired about the health problems that have been encountered while performing the health screenings. All health districts reported serious illnesses of one kind or another that are listed in order of decreasing frequency below:

- Tuberculosis
- HIV
- Severe anemia
- Parasites
- Terminal cancer
- Diabetes
- Hepatitis B
- Malnutrition
- Heart problems
- Syphilis
- Malaria
- Schistosomiasis
- Sickle cell anemia
- Emphysema
- TB of the bone
- Severe dental problems
- Hypertension
- Untreated war-related injuries
- Seizures

All 13 districts interviewed were asked what they consider to be the most important aspect of refugee health both from a public health standpoint and for the successful resettlement of the refugee. Alexandria answered community support and more agency involvement to help refugees find available health resources. For Arlington, it was the screening and treatment for communicable and chronic diseases that may interfere with the refugee's ability to achieve success and self-sufficiency as well as an understanding of how to navigate the American health care system. Finding the refugee a reliable, accessible medical provider and the need to understand the insurance and health care environment in the U.S. were priorities for Chesterfield County. Tuberculosis and mental health issues were of primary concern to Fairfax, while prompt identification and treatment of health problems was of utmost importance to Harrisonburg. Henrico County responded that immunizations and early detection of health problems were the most important aspect of refugee health, whereas Norfolk believes it is performing complete health assessments and following up with health problems that are encountered. Prince William and Virginia Beach answered that Tuberculosis was the major concern, and Richmond replied that health assessments should be mandatory and that every health department should be providing the same services to all of the refugees. Roanoke City believes that early detection of infectious diseases is most important from the public health standpoint and chronic diseases for the success of the refugee. Thomas Jefferson felt likewise in addition to following up on health problems that are found. The Peninsula health district could not think of a response to this question. In short, there was no single dominant priority.

Clinic Operations and Agency Involvement:

Of the thirteen health districts interviewed, eleven receive an initial contact from a refugee resettlement agency notifying them that a refugee has arrived and needs to be scheduled for a health screening. In contrast, two reported that they have to contact the resettlement agency or refugee once they've received the paperwork from the state office (which every health department receives when a refugee is resettled in its area). The 2 health districts that have to contact the refugee or resettlement agency themselves are Fairfax and Prince William Counties. Ultimately, for all health districts, if they receive paperwork on a refugee that they have not yet screened, it is their responsibility to locate the refugee and provide a TB test.

The frequency of refugee health clinic operations varies from each health district depending on the quantity and regularity of new arrivals. In general, districts that resettle the highest numbers of refugees conduct health clinics on a regular basis, and see refugees by appointment during their scheduled hours. However, some districts such as Alexandria and Prince William do not schedule appointments but have refugees walk in during the regular TB clinic times. Fairfax has a mixture of walk-ins and appointment patients. It finds that when it schedules appointments, many refugees have difficulty keeping them due to transportation issues and employment responsibilities. Fairfax therefore offers a walk-in clinic which refugees can access as well as can the general public. The remaining 10 health districts see refugees by appointment only, but the process and frequency varies from a weekly to bimonthly, to a monthly basis, depending on the demand. Arlington County, for example, performs an initial assessment and TB screening by appointment and then schedules a complete physical exam for two weeks

after the initial appointment to allow time for the arrival of all lab results. In Norfolk, the public health nurse in charge of refugee health assessments has refugees come in on Mondays for lab work and screenings and performs the complete assessment on the following Wednesday. In Richmond, the public health nurse visits the refugee's home for a TB screening and stool sample prior to the scheduled assessment.

Eleven of the health districts, interpreters are provided by the resettlement agency which sends an interpreter (oftentimes the refugee's caseworker) to accompany the refugee during the health screening. The two health districts where this is not the case are Alexandria and Fairfax. Instead, they have onsite interpreters and also have access to an AT&T language bank for interpreter services. In the Thomas Jefferson health district, interpreters used to be provided by the local resettlement agency, the International Rescue Commission, for free. Presently, the agency still provides interpreters, but at the health department's expense.

Reimbursement and Adequacy of Services:

When interviewing the health districts on the subject of monetary reimbursement, all thirteen replied that they are reimbursed with RMA funds, the only slight exception being Norfolk, which opts to bill Medicaid if the refugee already has Medicaid benefits at the time of the assessment. If the refugee does not, then RMA money is accessed. The varying responses occurred in the opinions as to whether or not the RMA reimbursement amount is sufficient. In answer to this question, five of the health districts (Chesterfield, Henrico, Richmond, Roanoke, and Thomas Jefferson) felt the reimbursement amount was sufficient with some stating it as being "very generous." In contrast, four of the

respondents were not sure and the remaining four felt that the amount was not enough. Those who were unsure replied thus due to unfamiliarity with the general budget of the health department since several respondents stated that the RMA funds brought in, go into the general budget and do not come back to refugee services. Of those who did not find the RMA money to be sufficient, Alexandria replied that “the reimbursement is not worth the trouble of doing the other levels.” Others, such as the Harrisonburg, Peninsula, Prince William, and Virginia Beach districts argue that the reimbursement amount does not cover the costs of staffing, case management, paperwork, and the overall time involved to perform the assessments. In contrast, Thomas Jefferson contends that RMA reimburses extremely well when compared to the reimbursement amounts of other programs such as WIC, and that if other health departments would consider the costs of other programs, RMA reimbursement is indeed much higher. Likewise, Roanoke states that “it pays to offer all four levels” of assessment because one gets reimbursed more by offering more.

When asked if the refugee services they provide are adequate and meet the refugee’s needs, those districts offering minimal services expressed the wish to be providing more. Seven of the health departments interviewed answered “yes” to this question. Three asserted that their services were satisfactory but mentioned areas in which they could be improved. Arlington County, for instance, feels its services are adequate to the extent that resources can be found for ongoing health needs such as health insurance and that there is a major lack of low cost dental resources. Chesterfield County responded that its services are adequate only for screening for communicable diseases. As in the case of Arlington, Harrisonburg also feels something needs to be done for adult dental services.

In addition, it indicated a need for better transportation and interpreter services to refugees, better educational materials written in the language of the refugee, and a better ability to find providers to accept referred refugee patients. The remaining three health districts interviewed responded that they would like to be doing more in terms of refugee services but do not have the staff to do so. In addition, Alexandria indicated that resources and services are there for refugees and they tell the refugees about them, but believe they are not being accessed. Prince William noted that TB is currently its biggest concern, and its staff are busy doing everything they can to control it. Likewise, Virginia Beach feels it provides conscientious and unhurried service to refugees but is stretched thin and has no time or staffing to offer health assessments beyond the mandatory TB screening.

When asked if there is anything that the health districts do not provide to refugees that they would like to, or vice versa, six respondents could not think of anything else they could be offering. Arlington County, on the other hand, would like the ability to sign off on the I-693 form so refugee clients would not have to pay a Civil Surgeon for a health exam when they apply for their green cards. Fairfax County responded that it would like to do more in the area of transportation for the refugee as well as perform more intensive searches on refugees it is unable to locate for screenings. Harrisonburg and Roanoke would both like to provide adult dental care, while Prince William and Virginia Beach stated that they would like to provide more levels of assessment beyond the TB screenings. Thomas Jefferson feels it could use better back up training for other staff to fill in for the person who usually performs the refugee assessment, as well as more follow up on other health problems besides TB.

The 13 health districts gave varied responses as to what barriers or obstacles prevent them from offering increased refugee services. Alexandria stated staffing as the biggest issue that has resulted in reduced services (not just to refugees) over the past several years. It also indicated that it is difficult to seek refugees out when they are not brought in by the resettlement agency. Arlington replied that it could perhaps use another public health nurse trained in refugee health issues and services as a back-up to the current nurse who handles refugee clinics. Fairfax indicated the transportation barrier as well as the need for more intensive searches to locate refugees it cannot find. Harrisonburg replied that time, money, staff, and lack of space were all barriers that prevented them from offering increased services. Prince William and Virginia Beach also indicated the need for more staffing, time, and resources. Thomas Jefferson replied that it needed a better collaboration with the IRC resettlement agency. Its previous nurse had a good relationship with them, but the relationship has been more strained since she has gone. The remaining 6 health districts felt like what they provide is adequate and there are no barriers to providing better care.

One of the final interview questions involved the respondents sharing what they have learned from their experiences in working with refugees and whether or not this has influenced what services they provide. Alexandria feels that the community as a whole could treat newcomers a lot better and that agencies need a clearer idea of what should be done for refugees in terms of health. Chesterfield replied that refugees need long term support on all levels and that the resettlement agency needs to commit to a year or more of involvement. The tremendous TB problem in Fairfax, especially in the foreign-born population, has resulted in policy to provide as much treatment service as possible to

refugees. Harrisonburg replied that their necessity for interpreters has resulted in resettlement and health department staff jointly working to fulfill this need. Henrico County and Norfolk both recognized the necessity for performing all four levels of assessment on the refugees. Likewise, Prince William recognizes the need to do more in terms of refugee services. In the Thomas Jefferson district, there was a prior perception that the reimbursement money was too little, and thus the director did not appear to have to push the refugee program. Now she is interested because the “money is so good.” Virginia Beach responded that there’s a need for better education on the agency’s part as far as TB is concerned and the BCG vaccine. It has tried to address this problem by making the refugees feel welcome and to establish their trust so they will come back. The remaining 4 health districts did not respond to this question.

Inter-District Collaboration:

The final interview question addressed the issue of collaboration among health departments in terms of refugee services. In response, nine replied that there is no collaboration. One health district did not respond, one indicated that there’s only collaboration when they are attempting to locate refugees, and Prince William stated that they have a good repoire with area health districts in terms of TB control in the form of a TB Elimination Committee of Northern Virginia. Henrico County mentioned that there is a Refugee Coalition in the Richmond area, which allows for communication across health departments as well as other service providers involved with refugees.

The interviewees were then asked how they were similar or different to adjacent districts in terms of the refugee services they do/do not provide. Of those that responded,

Alexandria stated that Fairfax and Arlington have different funding sources than it does. Arlington stated that the surrounding jurisdictions don't seem to provide refugee services to the extent that it does and do not coordinate with other refugee providers in their areas. Fairfax indicated that Prince William only offers TB tests but is a smaller district with not as many resources. Norfolk stated the belief that it is funded better than Virginia Beach and mentioned a difference in attitude between the two health districts. It believes that unlike Virginia Beach, which is seen as minimalistic, it "bends over backwards for its patients to make sure they receive good care." Prince William replied that it believed Fairfax only offered level I assessments as it does, whereas Roanoke responded that it had heard that it provides one of the most thorough assessments in the state compared with some other departments. Virginia Beach indicated that Norfolk does have a refugee clinic and much greater funding than it has.

Chapter 6—Discussion of Interview Results

In order to discuss the interview results of this thesis, it is important to reflect on the original research questions identified at the beginning of this paper: What types of services and procedures do the health departments provide for refugee populations? Do they offer the range of services as recommended by the federal and state guidelines and receive reimbursement for them? And if not, how and why do the individual health department policies differ from one locale to the next, and how can these differences impact the health of the refugees being resettled in those particular health districts?

An overwhelming 10 out of the 13 health districts interviewed provide Level Four assessments on the refugees being resettled in their areas and are reimbursed with RMA funds for these services. Since the vast majority offer the range of services recommended by the state and hence, federal, refugee health program, it is imperative to focus on the three health districts that reportedly do not follow the recommended guidelines: Virginia Beach, Prince William, and Alexandria. What is different about these three districts that results in their offering only the required minimum in terms of refugee health assessments when the other districts are offering so much in comparison? The next sections of this chapter will focus on each of these three health districts in further detail in the attempt to discover an answer to this question.

Virginia Beach Health District:

The Virginia Beach Health District is located in the easternmost portion of the Tidewater region and is adjacent to the Norfolk and Chesapeake Health Districts. It

performed only 8 health assessments in the year 2000, and received an average reimbursement of \$164.75, the third lowest percentage of RMA funds for the state during that year. Virginia Beach was included in the study to determine if districts that receive a small number of refugees offer as many services as those who receive larger numbers. When compared with the other health districts that performed the same number of health assessments or fewer in 2000, Virginia Beach was the only one that fell below the state average in terms of RMA reimbursement per refugee.

The Virginia Beach office performs the mandated TB screening on refugees, and children receive the additional levels of assessment at the department's pediatric clinic. The interview conducted for this district involved a conference call with two of the public health nurses who work with the refugees resettled in their area. The respondents indicated that in terms of deciding what services their district will provide that it is ultimately the health director's decision but in collaboration with the nurse manager and department administrator. They both felt that lack of staffing and financial resources play a large role in why they do not offer more services for refugee adults beyond the mandatory Level One assessment.

In contrast with Prince William and Alexandria, the Virginia Beach refugee resettlement agency does contact the health department to schedule an appointment for a TB screening. The two resettlement agencies in the Virginia Beach area are Refugee and Immigration Services (RIS) and Church World Services. The respondents believe that RIS seems to have more limited health resources whereas Church World Services appears to be a better help to refugees in terms of health needs by having its own physicians within churches that can see the refugees. The interviewees also feel that there is a need

for better education on the agency's part as far as TB is concerned, especially with TB in children and the misunderstanding about the reliability of the BCG vaccine.

Both nurses feel that the RMA reimbursement is not enough to allow them to perform all four levels of assessment because "it's more time consuming to provide services to non-English speaking patients." In terms of staffing, the respondents stated that they have a very small communicable disease area that consists of 6 nurses for over half a million city residents. With these 6 nurses, they have to provide TB, HIV, STD, refugee, and reportable disease work for all of Virginia Beach. And in addition, they only have one nurse practitioner and one physician for the family planning clinic. The respondents both strongly contend that they would like to provide all levels of assessment on the refugees, but they "are stretched thin and have no time or staffing for refugee health assessments" and cannot sacrifice staffing that is already at a bare minimum to further refugee services.

The respondents indicated that the adjacent Norfolk Health District does have a complete refugee clinic but also recognized that it has much greater funding than Virginia Beach. When asked how funding works and why Norfolk is able to provide so much more, the nurses stated that it's a very political issue. They explained that there is a state formula for determining state allocation of funds which is "very archaic and should be changed." Additional funding comes from federal and local resources, and health departments vary in the amount of local funding they receive depending on the political climate, recognition of need, and available money and resources in the locality.

Prince William County Health District:

Prince William County is located in Northern Virginia, adjacent to the Fairfax County Health District. Of all of the 19 health districts that performed refugee assessments in 2000, Prince William was reimbursed the least amount of RMA funds, \$77.84 per refugee, \$178.27 below the state average. In terms of the number of health assessments performed for that same year, it ranked 9th in the state, providing a total of 53 assessments. The interview data indicate that the decision as to what services the district provides is a collaborative one between the health department director and staff, based on the needs of the community and the priority of these needs. The respondent, the TB program coordinator for the county, stated that Tuberculosis is by far the county's biggest and most consuming problem. Prince William, a county of 280,000 residents, has experienced a 188% increase in TB disease over the past few years, going from 2.8 to a case rate of 8 per 100,000 in 2001. The number of cases increased from 9 to 26, and 17 of the 26 were in the foreign-born population.

The health district is comprised of two health departments with 2 laboratory technicians in each department and about 20-30 nurses for the whole county. The respondent noted that the county itself has seen a significant population increase in the past few years and that the health department staff are "pushing it just to meet the goals of treatment for TB disease." In addition to the TB problem, their second largest impact and drain on the department is in the area of maternity services which is heavily accessed by the illegal immigrant population. When asked if the reimbursement money would help to enable them to provide more services, the interviewee replied that the RMA

funding was not enough since one has to complete all portions of each level to receive reimbursement, and they would need more staff to be able to do this.

Refugees in Prince William County are not scheduled for an appointment but receive their screenings as walk-ins during the regular TB clinic hours. This is different from other districts where health assessments are scheduled by appointment (with the exception of Alexandria where walk-ins also occur). In addition, the resettlement agencies do not notify the Prince William Health Department when a refugee has been settled in its district, and if the refugee does not show up during the TB clinic, the health department has to locate him. There does not appear to be a lack of desire to provide services to refugees or a feeling that they are unimportant, instead, the respondent indicated that there's "no staffing and no time. It would be nice to move on and provide more services, but we can't. We're not trying to short-change refugees, we're trying to equalize services."

The City of Alexandria Health Department:

Like Prince William, the Alexandria Health Department is also located in Northern Virginia, and it is adjacent to the Arlington and Fairfax County Health Districts. It is the largest anomaly in the state in terms of the number of refugees resettled in its district and the level of services it provides to them. In 2000, 215 refugees, 9% of the state's total, were resettled in its locality, resulting in Alexandria being the third largest health district in terms of the number of refugees resettled there. And yet, it accessed the second lowest amount of RMA funds, \$78.55 per refugee, representing only 3% of the total RMA funds utilized for the state. Alexandria performed the fifth largest number of health

assessments in 2000, totaling 164, but ranked 18th out of the 19 health districts in terms of reimbursed RMA funds. What is it about this health district that it is accessing so little monetary funds compared to the other districts in the state, even those in its immediately surrounding locale?

The interview respondent is the TB/HIV services supervisor for the health district. She stressed that her health department *wants* to perform the Level One, TB assessment on the refugees, since their district has such a high percentage of TB in the foreign-born population. When asked directly why Alexandria does not do more of the other services recommended by the state, her response was that they would like to do more but do not have the staff to do so. She stressed that the health director decides what services they will provide and that a health department has to prioritize according to the health demands in the immediate community in addition to performing what's mandated first.

In Alexandria, TB was noted to be one of its biggest concerns. "Our refugee program is small, but TB is booming," was the initial response. In addition, the interviewee replied that their district's general medical clinic is its biggest financial draw in terms of available resources. Different from Prince William and Virginia Beach, which do not have general medical clinics at all, Alexandria has the services in its district and the ability to perform all four levels of assessment, which could be done at its medical clinic. And yet, to the knowledge of the respondent, refugees are not accessing these services. "The refugees have other services available to them but it's difficult to help them through the system. We tell the refugees where to go for further services but aren't sure if they actually go or not."

This response then poses the question: Whose responsibility is it to see that refugees are utilizing the services that are available at the health department: the refugee, the health department, or the resettlement agency? The respondent implied that she believed it was up to the resettlement agencies to help refugees through the system. She stated: “The agencies don’t seem to have a clear idea of what should be done in terms of health. They don’t bring the refugees in like they should.” But once the refugee has arrived at the health department, is it then up to the health department staff to ensure that the refugee accesses the resources available there? There appears to be a lack of collaboration not only with the resettlement agency but also within the health department itself. For health assessments in Alexandria, it seems like it should be a simple solution for the health department staff and resettlement agency to work together to insure that the refugee receives the full health screening at the available medical clinic.

The purpose of the RMA funds is to offer a monetary incentive for health departments to perform more in-depth assessments on the refugees. But the respondent in this interview stated that the “reimbursement is not worth the trouble of doing the other levels.” How can this opinion vary so much from the other health districts that claim the reimbursement amount to be “very generous?” The next section of this chapter will therefore focus on the issues that have emerged as the most prominent reasons for not offering more services to refugees: low levels of reimbursement, high rates of Tuberculosis, lack of staff, funding, and resources, and collaboration with the resettlement agency as well as with the decision-makers within the department itself.

Funding and Resource Allocation:

To better understand the aspects of health department funding, I interviewed Dr. Molly Odell, director of the Alleghany Health District. She explained that the funding formula for the state is historically based and districts are funded predominantly on the locality's ability to pay, partly according to the population of the area, in addition to other factors. Overall, the locality never pays more than 45% of the total budget. Funding typically comes into a health district in three ways: the state budget, the local revenue, and grants, with poorer areas typically receiving more grant money. Each district can distribute money from one locality to the next within that district, depending on the needs of each individual locality. Some districts are only made up of one county, such as Arlington, whereas other districts might be made up of several localities, such as the Thomas Jefferson Health District, which is comprised of Albemarle, Fluvanna, Greene, Louisa, and Nelson Counties in addition to the city of Charlottesville. Dr. Odell provided data she received from the Virginia Department of Health's main office that was used to construct Table 6.1. This table shows the budgeted funds for each health district for 2001 and the percentage and amount of the funds the state and locality each pay.

To help further clarify this information, Table 6.2 was developed based on Census 2000 population data for each health district. In addition to population, the median income and the percentage of individuals living below the poverty level was also observed for each district. Based on the information in Table 6.2, if one predicted which health districts would receive a higher percentage of funding from the state in terms of population, one would choose Fairfax, Virginia Beach, Prince William, and Peninsula districts.

If one focused on the poverty level of the locality, the Richmond, Norfolk, Roanoke, and Central Shenandoah districts all have a significant number of individuals living in poverty when compared to the average level for the state. There does not appear to be a relationship between heavily populated areas and poverty, as the five most populated health districts all exhibited poverty levels below the state average of 9.6%. However, there does appear to be a relationship between areas of lower population and poverty. Of the five least populated health districts, all except one (Arlington) have a higher than average number of individuals living below the state poverty level. Interestingly, when one looks at the median income of these 5 health districts, Alexandria and Arlington both have median incomes above the state average, which implies a larger gap between those with money and those living in poverty in these two districts.

Table 6.1
2001 Health District Budgets
(Not including funding from grants)

Health District:	State Funding:	Local Funding:	State Percentage:	Local Percentage:
Norfolk	\$5,159,654	\$3,148,566	62.10%	37.90%
Central Shenandoah	\$2,682,639	\$1,682,353	61.45%	38.54%
Roanoke	\$1,605,849	\$1,086,721	59.64%	40.36%
Thomas Jefferson	\$2,015,518	\$1,421,715	58.63%	41.36%
Richmond	\$3,425,049	\$2,440,765	58.39%	41.61%
Peninsula	\$3,641,063	\$2,620,182	58.15%	41.85%
Chesterfield	\$2,149,365	\$1,625,751	56.29%	43.71%
Prince William	\$2,122,637	\$1,703,001	55.49%	44.52%
Alexandria	\$2,876,396	\$2,353,415	55.00%	45.00%
Arlington	\$2,628,332	\$2,150,453	55.00%	45.00%
Fairfax	\$7,951,294	\$6,505,604	55.00%	45.00%
Henrico	\$1,476,906	\$1,208,378	55.00%	45.00%
Virginia Beach	\$2,567,132	\$2,100,381	55.00%	45.00%

Source: Odell, 2002

Table 6.2
Population and Income by Health District, 2000

Health District:	Population (2000)	Median Income	% Below Poverty
Richmond	197,790	\$29,234	24.9%
Norfolk	234,403	\$31,815	19.4%
Roanoke	94,911	\$30,719	15.9%
Central Shenandoah	258,789	\$34,154	13.1%
Thomas Jefferson	199,648	\$41,705	11.2%
Alexandria	128,283	\$51,052	10.2%
Peninsula	308,113	\$49,632	9.3%
Arlington	189,453	\$57,244	8.1%
Henrico	262,300	\$44,122	7.9%
Prince William	326,238	\$52,841	7.7%
Chesterfield	299,177	\$48,419	6.8%
Virginia Beach	425,257	\$48,705	6.5%
Fairfax	1,001,624	\$65,525	4.7%
State:	7,078,515	\$46,677	9.6%

Source: Census, 2000

In Table 6.1, the local and state percentages give rise to closer scrutiny. If one examines which districts pay the least percentage of funds in comparison to the state funds allocated to them, in descending order, Norfolk, Central Shenandoah, Roanoke, Thomas Jefferson, and Richmond pay the lowest percentages. All five of these health districts have the highest percentage of residents living below the average poverty level for the state. One would expect for Richmond to pay the lowest percentage as its poverty level is the highest when compared to the other 13 health districts, but perhaps there are other factors that contribute to the state formula such as the age, ethnicity, and gender of the residents involved.

Those health districts that pay the 45% maximum percentage of funds include Alexandria, Arlington, Fairfax, Henrico, and Virginia Beach districts with Prince William

closely behind them paying 44.515% of the total annual funds. Of these 6 districts, Alexandria is the only one with a poverty level that exceeds the state average. Also, Alexandria, Virginia Beach, and Prince William were the only districts that do not perform all levels of the refugee health assessment. Each contended that they did not have the funding or the staffing to allot time for further refugee services, and all three pay the maximum percentage of funds each year for the operation of their health districts, further backing their arguments for reduced refugee services. Alexandria could also be inundated with additional services based on its higher poverty level than the other 5 health districts mentioned. Since Virginia Beach and Prince William have the second and third highest district populations in the state, this is another possible contributing factor to their decreased refugee services.

When considering population, one could argue that Fairfax should also have difficulty in providing services because it has the overwhelmingly highest population of all the health districts. Perhaps the difference is that it is one of the three locally administered districts (with Arlington and Richmond being the other two) in the state, which may enable it to spend its money in different areas that might otherwise be mandated by the main office. When asked how the locally administered district differs from the others, the Fairfax respondent replied that when the state changes a mandate and “says that it won’t pay for a chest x-ray, we don’t have to worry about this because Fairfax County does pay for it.”

Tuberculosis in Virginia:

During the interviews, Tuberculosis disease and infection appeared as one of the biggest health problems associated with refugees resettled in the Commonwealth. Also, the three health districts performing only Level I assessments, mentioned Tuberculosis as a “big problem” in their locales. I therefore thought it important to examine the number of cases of TB disease for the state and the health districts they were located in. Table 6.3 shows TB cases by health district for the year 2000, which was obtained from the Virginia Department of Health, Office of Epidemiology.

Table 6.3
Reported Cases of TB Disease by Health District, 2000

Health District:	Number of cases:	Case rate per 100,000
Arlington	32	16.89
Alexandria	15	11.69
Fairfax	89	8.89
Norfolk	13	5.55
Richmond	10	5.06
Roanoke	4	4.21
Central Shenandoah	10	3.86
Thomas Jefferson	7	3.51
Henrico	9	3.43
Virginia Beach	14	3.29
Prince William	9	2.76
Peninsula	8	2.60
Chesterfield	6	2.31
State Total:	292	4.13

Source: VDH, 2000

According to the table above, the health districts that experienced the highest case rates of TB disease in 2000 were Arlington, Alexandria, Fairfax, Norfolk, and Richmond. Alexandria’s response that “TB is booming” does correspond with its second highest case rate in the state. Prince William’s case rate does not appear to be too much of a problem

in 2000, however, according to the interview respondent, they went from the 2.8 case rate in 2000 to a rate of 8 in 2001, and from a total of 9 to 26 cases. This indeed is a significant increase and time-consuming problem, especially in addition to Prince William's complaints of low staffing and resources. Because of the highly infectious nature of TB disease, health department staff have to keep a close watch on those patients infected with it. In addition, the rates of TB infection are not indicated in the surveillance report, and issuing medication and monitoring patients with TB infection can be extremely time consuming as well.

Department/Agency and Inter-Department Collaboration:

During the interview with the Alleghany Health District director, Dr. Molly Odell, I inquired about the authority of the health director in terms of decision-making in deciding which services the health departments will or won't provide. Dr. Odell stated that the health department director does have the final say in the decision-making process, but he is so inundated with responsibilities (especially if there are several health departments within his district that must be visited on a regular basis) that he relies on the staff to know what's happening in the community and inform him of it. This implies a close relationship between the director and staff within the health district. In terms of their own refugee program in Alleghany, which is located in the Roanoke City Health Department and has the highest average in terms of RMA reimbursement for the state, Dr. Odell stated that her staff came to her initially with the desire to operate a refugee clinic. They felt they had the time and staffing to do it and had found a physician to perform the exams on a voluntary basis. This initiative, in addition to the RMA

reimbursement, enabled Dr. Odell to agree with and support the refugee clinic. She also noted that the participation of the resettlement agency has played a vital role in their clinic's success.

Both Alexandria and Prince William County report little or no collaboration with the resettlement agencies in their health districts. With the other 11 respondents, the resettlement agency contacts the health department for an appointment for the health screening. In Alexandria and Prince William's case, the refugee is not scheduled for an appointment and is expected to arrive as a walk-in during the regular TB clinic hours. The process of having to locate the refugees who do not show up for the clinic can be costly and time-consuming, especially when the respondents already indicate lack of time and staffing as their biggest reasons for not offering more refugee services. The interesting case with Alexandria and Prince William is that they are both located in Northern Virginia where Fairfax and Arlington districts do not seem to have a problem with agency interaction—the same agencies (indicated below) that Alexandria and Prince William are dealing with as well:

- Catholic Diocese of Arlington Refugee Services (Arlington)
- Ethiopian Community Development Council, Inc. (Arlington)
- Lutheran Social Services (Falls Church)
- Virginia Council of Churches Refugee Resettlement Program (Manassas)

Whether the lack of interaction is the fault of the agency, health department, or a combination of both is difficult to discern. Dr. Odell stressed the determination and perseverance of the local resettlement director in addition to a few of the health department staff as being key to the success of their program. The respondent for the

Thomas Jefferson Health District noted that the health director delegated to the staff to decide if they had the available time and motivation to do a refugee program. She stated that “there was one nurse in particular who was really motivated to work with refugees and she sort of took it over.” She had a good collaboration with their local resettlement agency, and it “has been more strained [with the agency] since she has been gone.” It is feasible that the resettlement agencies in Northern Virginia do not collaborate with Alexandria and Prince William because they only provide TB testing and not complete assessments. Many of the resettlement agencies I have spoken with state that they too are often overwhelmed with their responsibilities to refugees and are short on funding, staffing, and time. Knowing that the health department is required to seek the refugee out for a TB screening, it is possible that the agency leaves this responsibility up to Alexandria and Prince William Health Departments since they will not be bringing the refugees there for any further services.

Chapter 7—Conclusions

In accordance with the concepts of health geography reviewed earlier, the research for this thesis is an example of both structure and agency at work, or rather, the structuration perspective. I have examined the structure behind the refugee health assessments such as the RMA reimbursement and the funding allocations to each health district, both at the state and local level, which have played a role in the ability of health districts to provide refugee services. In addition, human attitudes and actions, or agency, has also influenced the levels of assessment made available by each locale. In some districts, the health director's decision is influential and in others, personal motivation and involvement of health department staff and the resettlement agency have been the key to the refugee program's success. These examples can be seen as a lack of positive agency in the health districts that are providing such reduced services. In addition, other issues include inundation with individual district problems (such as high rates of Tuberculosis), the need to provide mandated services first before offering additional ones, and finally, lack of staff motivation and interaction with the resettlement agency. In addition to agency, structural problems exist in the form of varied funding allocation at the state and local levels.

I have discussed the issues of tuberculosis and time-consuming areas of concern such as the maternity clinic in Prince William. This thesis has examined the topics of resource allocation among the individual health districts as well as looked at population and income levels for each locale. The issue of staff motivation and agency collaboration remains speculative. The interviewees provided their own personal insights and opinions

into their responses that have been useful and informative. But undoubtedly, additional causes underlie the reduced refugee services in Alexandria, Virginia Beach, and Prince William County. They demand further research.

These interviews have provided beneficial and useful insights into the individuality of Virginia's health districts, each with their own unique problems in their own unique *spaces*. This thesis began to look at the refugee health assessments from the larger, statewide scale, and has instead, found the answers to most of the problems to be at the smaller-scaled, local level. Each health district in the state is singular not only in its geographic location, but also in relation to the individuals and problems within each locale. It is therefore reasonable to expect that each health district makes decisions according to its own position in the Commonwealth. Roanoke Health District cannot operate identically to Fairfax for obvious reasons such as population patterns and congestion. Subtler factors may also operate such as specific environmental problems, or varied communicable diseases.

For the individual refugee being resettled in a particular health district however, there is no choice in the services he will or will not receive. Those refugees with known or undetected physical ailments that are resettled in Virginia Beach, Prince William, or Alexandria, may experience a more difficult resettlement and adjustment period as they deal with their own health problems later in the resettlement process. However, if resettlement agencies know that refugees will not receive certain services in particular districts, they could resettle them in adjacent districts if health services there are more accessible.

Further research on this topic could include interviewing more staff at each health district as well as delving further into the role of participating resettlement agencies in those areas. In addition, interviews with refugees themselves regarding their overall state of health could be a key in determining if those who have been resettled in the areas of low levels of assessment actually suffer increased physical or mental health problems as a result.

This thesis addresses one of the many factors that affect the health and well-being of refugees resettled in the United States. The Virginia case-study demonstrates that much more can be done to ensure that refugees gain wider access to and make greater utilization of the four levels of physical examinations that Virginia's health districts can provide. Additional research can lead to more appropriate policies that will better protect and enhance the health of both refugees and the entire American public.

Appendix 1—The Health Department Questionnaire

1. Does your clinic perform refugee health assessments? And if so, what level of assessment do you perform?
2. Do you perform the same level of assessment on every refugee? If not, what factors determine which level? Are there policies or guidelines which you must follow?
3. *Who* decides what services you provide? Is it a collaborative decision, or completely up to the health department director? What factors influence this decision?
4. Who administers the services available to refugees?
5. Approximately how many refugees have you administered assessments to in the past several years (esp. 1999 and 2000)? Have the services you've provided changed over time, and if so, how?
6. Where were most of these refugees from?
7. What types of tests are administered? TB? Parasites? HIV, STDs, and malaria? Immunizations? Are there certain policies or guidelines you follow for these tests?
8. What other types of services, if any, are provided to the refugees (i.e. do you check for chronic as well as infectious health problems)? Is there a dental program? Provide interpreters?
9. Do you perform health assessments on a particular schedule? i.e. weekly, biweekly, monthly, etc.
10. Who administers the health assessment? i.e. doctor, physician's assistant, public health nurse, etc.
11. Do you have laboratory facilities on-site (for blood tests, etc.)?

12. Are you reimbursed for providing health assessments? If so, with RMA funds or Medicaid? Do you feel like the reimbursement amount is sufficient?
13. Does the refugee resettlement office schedule the appointment for the assessment or does your department seek the refugee out?
14. What have you learned from your experiences in working with refugees? Have these had any practical influence in deciding what services you provide?
15. What do you consider is the most important aspect of refugee health, from a public health standpoint and for successful resettlement?
16. What have been the most serious health problems you've encountered?
17. Do you feel the refugee services you provide are adequate and meet the refugee's needs?
18. Is there anything that you don't provide that you would like to, or vice versa?
19. Are there any barriers/obstacles that prevent your department from offering or providing increased refugee services? If so, what are they?
20. Do you collaborate with, or are you aware of the refugee services other health departments provide in adjacent districts? If so, how are they similar or different to what your clinic provides?

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