
Nicholas Lee Rummell

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RESETTLED REPRODUCTION: A HISTORY AND ANALYSIS OF FAMILY PLANNING OPPORTUNITIES AMONG REFUGEES IN TENNESSEE.

by

Nicholas Lee Rummell

A Dissertation
Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Liberal Studies

Major: Liberal Studies

The University of Memphis
August 2024
Dedication

This dissertation is dedicated to my family for all of their support and understanding. To my wife, Nicole, thank you for allowing me to undertake the strenuous journey that is a doctoral degree, and supporting my dreams throughout the process. I love you. To my daughter, Persephone, thank you for being understanding and accepting that sometimes daddy just had to get some work done. I love you. To my stepsons, thank you for helping out so I had time to read, research, and write. To my mother, Theresa, thank you for raising me to appreciate education, and for helping me through life. To the rest of my family, thank you for the support, encouragement, love, laughter, and for being the best family one could ask for!

I would also like to dedicate this to all of the refugees around the world who are struggling to have a better, safer, and healthier life.
Acknowledgments

This dissertation would not have been possible without the assistance and guidance of many individuals and organizations. I would first like to acknowledge all of the refugees in Tennessee, and across the United States, with whom I have met, had discussions with, listened to their stories and struggles, and built friendships with. Without refugees striving to create a better life for themselves and their families, this research would not exist.

I would also like to acknowledge all of the resettlement agencies, nonprofit organizations, and healthcare providers in Tennessee who work with refugees. Also to the Tennessee Department of Health and the Tennessee Office for Refugees, your assistance in survey design, distribution, and participation helped to form the bulk of the original research for this study. Although we may not always agree on policies and procedures, it is your work that is key in helping refugees access and utilize the healthcare they need and deserve.

Numerous other organizations and societies also deserve acknowledgement for their assistance in guidance in all phases of this work. Thank you to the American Public Health Association, the Tennessee Public Health Association, and the Community College Humanities Association for giving me the opportunity to present early research from this study at national conferences. Each of these forums provided an opportunity for feedback and discussion of the data, and for fine-tuning of the research questions. Thanks to the Tennessee Justice Center, the Society of Family Planning, and the Society of Refugee Healthcare Providers for helping to connect me with other organizations, providing research support and expertise, and for giving me a forum to share my research with other stakeholders.

I would also like to thank the staffs at the University of Memphis and Pellissippi State Community College libraries for assistance in finding resources and data, and the College of
Liberal and Professional Studies and the School of Public Health at the University of Memphis for providing me the opportunities to undertake this study. Also, the University of Memphis Graduate Student Association deserves thanks for the small grant to help perform research and present preliminary finding of the work.

To my dissertation committee: Dr. Colin Chapell (Chair), Dr. Jennifer Turchi (unofficial co-chair), Dr. Beverly Tsacoyianis, and Dr. Courtenee Melton-Fant; thank you for agreeing to share this journey with me and for constantly providing me with education, support, inspiration, and motivation on this project, and throughout my entire doctoral program. Dr. Chapell, your guidance and support has made this daunting task somewhat easier and less stressful. Your wisdom and feedback has made this dissertation better. Dr. Turchi, you have been a great instructor, mentor, classmate, colleague, and friend. I have learned so much about public health, research, community engagement, and scholarship from talking with and learning from you. Dr. Tsacoyianis, your guidance and instruction has made me a better historian, researcher, and professor. Dr. Melton-Fant, your support and expectations have been driving me to be a better scholar throughout this dissertation. Finally, a quick thanks to Dr. Meredith Ray, for showing me that I could, in fact, succeed in Biostats.

Last but not least, I would like to acknowledge my family and friends for their support and assistance. I must acknowledge my wife, for her support and for taking care of things when I needed to travel, research, or write. To my daughter, thank you for keeping me sane and reminding me there is much more to life than a doctoral program. To all of my family and friends, your words of encouragement and belief have made this an easier process. If I have not properly shown my appreciation to any of you, allow these thanks and acknowledgements to make up for that, if only ever so slightly.
Abstract

Refugee women face a myriad of barriers to health after resettlement, including access to family planning services. They often have little knowledge of available family planning or contraception options, or where to obtain them after resettlement. As a result, refugee women in Tennessee suffer from high rates of unintended pregnancies, stemming from limited access to family planning services, and unmet family planning needs after resettlement.

This dissertation combines the disciplines of history, public health, and public administration/policy to better understand why refugee women in Tennessee have had limited access to family planning services. To achieve this, it was necessary to illuminate the barriers to sexual and reproductive health they face in order to better support their family planning needs and desires. A secondary purpose of this study was to examine the role male partners play in supporting or limiting refugee women’s access to family planning services after resettlement, by attempting to determine if male partners in Tennessee exert the same impact on refugee women’s family planning decision-making that is shown in the literature.

This study found that the barriers resettled refugee women in Tennessee face are similar to those faced by other refugee women. Cultural and linguistic barriers were found to be the greatest barriers faced by refugee women when trying to access and utilize family planning and contraception services. Political and policy barriers also created numerous challenges for reproductive healthcare access and utilization. Additionally, this study found that the role of male partners was not as influential in the reproductive decision-making process. Finally, the most significant finding from this research shows that organizations that are specifically in place to help refugees end up constructing more barriers than they eliminated, due to religious affiliation among them.
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<th>Description</th>
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<tr>
<td>ACA</td>
<td>Affordable Care Act (Obamacare)</td>
</tr>
<tr>
<td>BCS</td>
<td>Bethany Christian Service</td>
</tr>
<tr>
<td>CARES Act</td>
<td>Coronavirus Aid, Relief, and Economic Security Act</td>
</tr>
<tr>
<td>CDC</td>
<td>Center for Disease Control and Prevention</td>
</tr>
<tr>
<td>CWS</td>
<td>Church World Service</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<tr>
<td>ECDE</td>
<td>Ethiopian Community Development Council</td>
</tr>
<tr>
<td>EMM</td>
<td>Episcopal Migration Ministries</td>
</tr>
<tr>
<td>ERD</td>
<td>Ethical and Religious Directives for Catholic Health Care Services</td>
</tr>
<tr>
<td>HIAS</td>
<td>Hebrew Immigration Aid Society</td>
</tr>
<tr>
<td>HHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>IRI</td>
<td>Immigration Research Initiative</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>KFF</td>
<td>Kaiser Family Foundation</td>
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<tr>
<td>LARC</td>
<td>Long-Acting Reversible Contraception</td>
</tr>
<tr>
<td>LIRS</td>
<td>Lutheran Immigration and Refugee Services (now Global Refugee)</td>
</tr>
<tr>
<td>LMIC</td>
<td>Low- and Middle-Income Countries</td>
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<tr>
<td>MCI</td>
<td>Male Contraceptive Initiative</td>
</tr>
<tr>
<td>MPI</td>
<td>Migration Policy Institute</td>
</tr>
<tr>
<td>NPWF</td>
<td>National Partnership for Women and Families</td>
</tr>
<tr>
<td>ODPHP</td>
<td>Office of Disease Prevention and Health Promotion</td>
</tr>
<tr>
<td>ORR</td>
<td>Office of Refugee Resettlement</td>
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<tr>
<td>PRAMS</td>
<td>Pregnancy Risk Assessment Monitoring System</td>
</tr>
<tr>
<td>PRM</td>
<td>Bureau of Population, Refugees, and Migration</td>
</tr>
<tr>
<td>RHTAC</td>
<td>Refugee Health Technical Assistance Center</td>
</tr>
<tr>
<td>RMA</td>
<td>Refugee Medical Assistance</td>
</tr>
<tr>
<td>RPC</td>
<td>Refugee Processing Center</td>
</tr>
<tr>
<td>SDOH</td>
<td>Social Determinants of Health</td>
</tr>
<tr>
<td>SEM</td>
<td>Social-Ecological (of Socioecological) Model</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>TOR</td>
<td>Tennessee Office for Refugees</td>
</tr>
<tr>
<td>TPS</td>
<td>Temporary Protective Status</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNCRSR</td>
<td>United Nations Convention Relating to the Status of Refugees</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNPF</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNRA</td>
<td>United Nations Relief and Rehabilitation</td>
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<tr>
<td>USCCB</td>
<td>United States Conference of Catholic Bishops</td>
</tr>
<tr>
<td>USCRI</td>
<td>United States Committee for Refugees and Immigrants</td>
</tr>
<tr>
<td>VOLAG</td>
<td>Voluntary (Resettlement) Agency</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>WR</td>
<td>World Relief</td>
</tr>
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</table>
1. Introduction

The world is constantly in motion, and globalization has changed the way individuals experience the world. Much of this motion comes from individuals who are forcibly displaced due to political, economic, environmental, or military factors, and at present the world is seeing the highest number of displacements ever recorded. The United Nations High Commissioner for Refugees (UNHCR) estimates that at the end of 2021 there were 89.3 million people forcibly displaced from their homes due to persecution, conflicts, violence, or human rights violations.¹ By May of 2022 that number had surpassed 100 million, with 27.1 million classified as refugees.² The primary and universal definition of a refugee was codified in the 1951 Convention Relating to the Status of Refugees and amended by the 1967 Protocol to the Convention. Accordingly, a refugee is someone who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.”³

Refugees face a plethora of challenges and struggles throughout their period of displacement, and they continue to face numerous issues once they have been resettled in a new country, even in developed countries, such as the United States. It is commonly acknowledged

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that human rights exist in every aspect of refugee issues. One major area of concern for resettled refugees is in the realm of healthcare. Language and cultural barriers make accessing care in an already difficult U.S. healthcare system potentially life-threatening.

Women make up over half of the refugees resettled in the United States, and they have specific healthcare needs that often require visits to specialists. Sexual and reproductive healthcare are some of the major issues that impact refugee women, and they consistently endure circumstances that are in violation of the Reproductive Justice framework, and which disregard their human rights. In fact, a lack of sexual and reproductive health is one of the leading causes of death, disease and disability among displaced women and girls, both during flight and after resettlement. One of the most significant issues that resettled refugee women face is a high number of unintended pregnancies. Unintended pregnancies can lead to worse health outcomes, lack of reproductive self-determination, and also play a major role in maternal mortality rates. With this knowledge, it is imperative to understand why refugee women have such high numbers of unintended pregnancies after resettlement. All women, including resettled refugee women, have the right to decide on the number, spacing, and timing of their pregnancies, and they deserve to have proper and adequate information to do so.

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Overview of Problem

Fundamental to the protection of refugee women is the promotion of their rights to reproductive self-determination and reproductive health. Access to sexual health services and information is critical to realizing the highest attainable standard of sexual health. Governments and the international community must honor all relevant legal obligations to protect and promote the rights of refugees, including reproductive rights. Refugees often have little knowledge of available contraception options, or where to obtain them after resettlement. Studies have also showed that unmet family planning needs “are higher in refugee populations owing to lack of access to contraception, lack of knowledge about various methods, and having other priorities.” As a result, refugee women in Tennessee also suffer from high rates of unintended pregnancies, stemming from poor and limited access to family planning services, and unmet family planning needs after resettlement.

Refugees and Resettlement

Refugees have been coming to the United States to avoid threats and persecutions since the U.S. was established. Organization of the resettlement phenomena, however, did not start until after World War II ended, and the plight of millions of uprooted people led President Harry S. Truman to issue a special directive to spread up the admission of tens of thousands of individuals displaced by the war. From 1946 until the passing of the 1980 Refugee Act, the refugee admission and assistance programs were piecemeal, and did not represent any well-

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formulated policy of acceptance or resettlement. Thus, even before the current guidelines and policies set forth in the 1980 Refugee Act, the U.S. became a leading country for refugee resettlement due to its status as a global power, its freedoms and relative security, and, arguably, its role in creating or expanding the conflicts around the world that led to individuals becoming displaced.

Ever since the 1980 Refugee Act was passed, the United States has continually been the leading country in refugee resettlement, with an average of nearly 96,000 refugee resettlements a year from 1980 to 2016. However, the U.S. resettlement policy is also one of the strictest and longest processes of any country, averaging over two years from identification to resettlement. Refugees hoping to be resettled in the U.S. have to be identified and approved through the United Nations High Commissioner on Refugees (UNHCR), then screened and interviewed, pass a background check, and then undergo a medical screening before being accepted for resettlement. Once approved, they are assigned to one of only ten VOLAGs, or voluntary resettlement agencies, that are supported and funded by the U.S. federal government for resettlement. Through the Office of Refugee Resettlement (ORR), housed within the United States Department of Health and Human Services (HHS), and the Bureau of Population, Refugees, and Migration (PRM) in the State Department, the U.S. government only recognizes

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ten resettlement agencies who receive funding to support refugee resettlement activities.\textsuperscript{12} Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices to help with resettlement. It is those ten agencies, or their sub-contracted affiliates or subsidiaries, that are then responsible for finding a location for resettlement in the U.S. and assisting with the technical and logistical aspects of resettlement.

<table>
<thead>
<tr>
<th>US Resettlement Agencies (VOLAGs)</th>
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<tbody>
<tr>
<td>Bethany Christian Services (BCS)</td>
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<tr>
<td>Church World Service (CWS)</td>
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<td>Episcopal Migration Ministries (EMM)</td>
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<tr>
<td>Ethiopian Community Development Council (ECDC)</td>
</tr>
<tr>
<td>Global Refugee (Formerly Lutheran Immigration and Refugee Service (LIRS))</td>
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<tr>
<td>Hebrew Immigrant Aid Society (HIAS)</td>
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<tr>
<td>International Rescue Committee (IRC)</td>
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<tr>
<td>United States Committee for Refugees and Immigrants (USCRI)</td>
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<td>United States Conference of Catholic Bishops (USCCB)</td>
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<td>World Relief (WR)</td>
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\textit{Figure 1: List of U.S. Resettlement Agencies}\textsuperscript{13}

**Refugee Resettlement in Tennessee**

Tennessee is not often considered a state that resettles many refugees. Although refugees have a long history in Tennessee, dating back to the 1790s when Irish refugees came in large number to Knoxville.\textsuperscript{14} More recently, however, Tennessee has been seen as a fairly hostile place for resettling refugees. This began in 2008, when Tennessee decided to opt-out of the federal

---

\textsuperscript{12} Previously, the U.S. government only recognized nine voluntary resettlement agencies, or VOLAGs, which received funding to support refugee resettlement activities. During the writing of this dissertation, the U.S. government added a tenth VOLAG, Bethany Christian Services, to the list of approved resettlement agencies, in November 2022.


\textsuperscript{14} A “refugee,” Peter Kern, was even elected as the mayor of Knoxville in 1890, although there is some debate over whether he should be considered a “refugee” or an “immigrant.” See Jack Neely, “Refugees Helped Create Knoxville as We Know It,” \textit{Knoxville History Project} (2017, 16 March). \url{https://knoxvillehistoryproject.org/2017/03/16/refugees-helped-create-knoxville-know/}.
resettlement program, which took resettlement activities and funding away from the state
government, and gave it to a “contractor.” ORR selected Catholic Charities of Tennessee as the
new contractor for Tennessee, and they have been the official governmental contractor ever
since. The hostile atmosphere for refugees grew stronger in Tennessee in 2015, when Governor
Bill Haslam joined twenty-nine state governors who “rejected” the Obama Administrations’
refugee relocation program, and Haslam sent a formal letter to the President asking him to stop
sending Syrian refugees to Tennessee. 15 Republicans in Tennessee pushed even further, calling
for Tennessee to stop resettling nearly all refugees, and that Syrian refugees already in Tennessee
be “rounded up” and removed from the state. 16 Finally, in 2017, the State of Tennessee filed a
lawsuit against the federal government to stop refugee resettlement in the state. 17 Although this
lawsuit was dismissed, the recent history of politics and policies in Tennessee have cast a
shadow across the states resettlement program. 18

Even with all of the contentious policies and negative press surrounding resettlement in
Tennessee, it still is a common state for resettlement. Although numbers tend to vary yearly,
Tennessee usually ranks in the top twenty of states resettling refugees and was the eighteenth
ranked state for total number of refugee resettlements in both 2022, and over the past ten years. 19

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15 Paul James Pope, “Constructing the Refugee as Villain: An Analysis of Syrian Refugee Policy Narratives Used to

16 Dave Boucher, “Tennessee GOP Leader: Round up Syrian Refugees, Remove from State,” The Tennessean (2015,
refugees-remove-state/75936660/.

17 Don Barnett, “Do States Have a Say in the Refugee Resettlement Program?” Center for Immigration Studies

https://scholar.google.com/scholar_case?case=12900204091596686133&hl=en&as_sdt=6,43.

19 Immigration Research Initiative, “Refugee Resettlement per Capita: Which States Do the Most?” Immigration
Research Initiative (7 Mar 2003), https://immresearch.org/publications/refugee-resettlement-per-capita-which-
Refugees resettling in Tennessee are placed in one of the four major cities of (or the areas surrounding) Nashville, Memphis, Knoxville, or Chattanooga. They refugees are sent to cities based on the city’s availability to settle them and based on the current refugee populations in the cities, as the resettlement program tried to resettle refugees in areas or neighborhoods with similar populations. In Tennessee, Nashville has received the most refugees, over half of those resettled in the state, with the largest numbers coming from Myanmar (Burma), Somalia, and Bhutan. Memphis and Knoxville have received about 20% of the resettled refugees each, with refugees from Iraq and the Democratic Republic of Congo being prevalent in both cities. Chattanooga receives about 10% of the refugees in Tennessee, and the majority of those arrive from Iraq, Sudan, and Ukraine.

Figure 2: Map of Resettlement Areas in Tennessee

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Overall, since 2010, more refugees from Iraq, Myanmar (Burma), and Somalia have been resettled in Tennessee than from any other country, but more recently, since 2015, the Democratic Republic of Congo has provided the most refugees to Tennessee, with more than double those from any other country. As a result, Tennessee has large refugee populations across its four major cities, and has become a common resettlement location, especially for refugees from the Democratic Republic of Congo, Iraq, and Myanmar (Burma), among others.

<table>
<thead>
<tr>
<th>Top Six Countries of Origin for Refugees Resettled in Tennessee</th>
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<tr>
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</tr>
<tr>
<td>1. Iraq</td>
</tr>
<tr>
<td>2. Somalia</td>
</tr>
<tr>
<td>3. Myanmar (Burma)</td>
</tr>
<tr>
<td>4. DRC</td>
</tr>
<tr>
<td>5. Bhutan</td>
</tr>
<tr>
<td>6. Sudan</td>
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</table>

Figure 3: Top Six Countries of Origin for Refugees Resettled in Tennessee

Refugee Pregnancy Intention in Tennessee

Within the United States, women make up more than half of the number of refugees resettled, and in Tennessee, that number is only slightly smaller, at 48.5%.

Resettled refugee populations also have high pregnancy rates, especially in their first three months of resettlement, possibly due to feelings of comfort, security, or relief.

In Tennessee, a growing number of refugees come from Sub-Saharan Africa. Nationally in 2019, refugees from the Democratic

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Republic of Congo far outnumbered those from other countries. This national trend was mirrored in Tennessee, with the Tennessee Office for Refugees reporting that over 58% of refugees in Tennessee since 2017 have been resettled from countries in Sub-Saharan Africa, with the DRC being the leading country of origin, but countries such as Ethiopia, Somalia, South Sudan, and Sudan are also well represented. In addition, it is estimated that closer to 70% of the refugees resettled from sub-Saharan Africa are women and children.

![Map of Country of Origin for Refugees Resettled in Tennessee](https://www.mapchart.net/index.html)

**Figure 4: Map of Country of Origin for Refugees Resettled in Tennessee**

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With such a large number of resettled refugees being female and black, and the holes in the maternal health and unintended pregnancy literature for Tennessee, national data disaggregated by race provides information that can substitute for specific data. According to the 2019 PRAMS report, birth and fertility rates for 2019 are very similar between the U.S. in general, and Tennessee as a state (birth rate 11.4 for U.S. and 11.8 for Tennessee; fertility rate 58.3 for U.S. and 60.3 for Tennessee). The nationwide rates by race show that black women in the U.S. have significantly higher birth and fertility rates than white women (13.4 compared to 9.8, and 61.4 compared to 55.3 respectively). Further, Tennessee had a larger rate of unintended pregnancies (31.1%) than the average U.S. rate (25.8%), and the unintended pregnancy rate in Tennessee among non-Hispanic black women was 1.6 times higher than that of all women in Tennessee (78.8% unintended for black women, 49.5% for all women). The fact that nearly 60% of resettled refugees in Tennessee are from Sub-Saharan Africa, that women in Tennessee have higher unintended pregnancy rates than the U.S. average, and that African American women in the U.S. and Tennessee have higher birth, fertility, and unintended pregnancy rates than white women all suggest that the unintended pregnancy rates of resettled refugee women in Tennessee, although missing in scholarly literature and research, are likely quite high.


Study Purpose

This dissertation aims to combine the disciplines of history, public health, and public administration/policy to determine and better understand how and why refugee women in Tennessee have historically, and continually, had poor and limited access to family planning services. To achieve this, it is necessary to examine what extent the limited access to family planning services has led to unintended pregnancies, and to illuminate the barriers to sexual and reproductive health in order to better support the family planning needs and desires of resettled refugees in Tennessee.

A secondary purpose of this study is to examine the role male partners play in supporting or limiting refugee women’s access to family planning services after resettlement. Gender norms across many societies that refugees resettle from often allow men key decision-making power. As a result, although family planning programs are directed at women, and women bear the burden of uptake for family planning, men often continue to be the primary decision makers on whether to use contraception of family planning services, and what type to use. The support and opinions of men directly affect the “choice, adoption, continuation and correct use of family planning methods” in many of the refugees’ home countries, and continues after resettlement. This study also attempts to determine if male partners in Tennessee exert the same impact on refugee women’s family planning decision-making that is shown in the literature.


**Definition of Key Terms**

To better understand the goals and purposes of this study, a few key terms need to be defined regarding their use in this work. These key terms include refugee, resettlement, contraception, family planning, unintended pregnancy, VOLAG, and nonprofit organization.

**Refugee**

According to the 1951 Convention Relating to the Status of Refugees and amended by the 1967 Protocol to the Convention, a refugee is someone who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.”

It is important to distinguish between refugees and asylees, migrants, and immigrants, and those with Temporary Protected Status (TPS). For U.S. classification, the official international definition of refugee is used, but it has also been further codified in the United States Code with the same definition. For U.S. classification as a refugee, a displaced individual must be outside of their country of origin, outside of the United States, and they must apply for refugee status with an official entity, such as a national government or the United Nations Refugee Agency (UNRA).

**Resettlement**

Refugee resettlement is defined by the UNHCR as “the selection and transfer of refugees from a State in which they have sought protection to a third State that has agreed to admit them – as refugees – with permanent residence status. The status provided ensures protection against

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refoulement (the forcible return of refugees to a country where they are liable to be subjected to persecution) and provides a resettled refugee and his/her family or dependents with access to rights similar to those enjoyed by nationals.”

Resettlement also carries with it the opportunity to eventually become a naturalized citizen of the resettlement country.

Contraception

Contraception, also known as birth control, is the act of preventing pregnancy. This can be a device, a medication, a procedure or a behavior. Contraception allows a woman control of her reproductive health and affords the woman the ability to be an active participant in her family planning. Contraception is often divided into two categories, traditional and modern. Traditional methods, also referred to as “natural” methods, are those that do not use modern contraceptives or require a surgical procedure. They include fertility awareness methods, withdrawal (periodic abstinence), prolonged breastfeeding, and different body function methods. Modern contraception methods can be defined as any product or medical procedure that interferes with reproduction from acts of sexual intercourse. These include oral pills, implants, injectables, patches, IUDs, condoms, sterilization, vaginal rings, and other products or devices. Abortion is not considered contraception, as it does not prevent pregnancy, however, abortion is a very common and important family planning procedure.

Family Planning

Family planning, according to the World Health Organization (WHO), is “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing


and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.”

In many locations, cultures, and situations, abortion is accepted as a family planning service, as it allows individuals to conform to their desired number or spacing of children when other options are not viable or available.

**Unintended Pregnancy**

Unintended pregnancies are pregnancies that are “unwanted” (when no [more] children were desired) or “mistimed” (occurring early than desired). Intended pregnancies are defined as happening at the correct time, or later than originally desired (due to infertility or difficulty conceiving).

A concept similar to unintended pregnancy is unplanned pregnancy. Often this is a pregnancy that occurred when using a contraceptive method. Intentions are often only measured for pregnancies ending in live births, as those ending in abortion are generally assumed to have been unintended. All of these definitions assume the pregnancy is a conscious decision.

Many studies also include a category of “unsure” regarding intention. For the data presented in this study, unintended pregnancy will be used the majority of the time, and unless otherwise noted, unintended pregnancy rates include those that were unwanted, mistimed, unplanned, and/or unsure.

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**VOLAG (Voluntary Agency)**

VOLAG is an abbreviation for “Voluntary Agency,” which refers to any of the ten agencies that have cooperative agreements with the U.S. State Department to provide reception and placement services for refugees resettling in the United States. These are also often simply referred to as “resettlement agencies.” The VOLAGs are responsible for meeting and picking up refugees at the airport, providing them with housing, and helping with necessities and cultural orientation for the refugees’ first ninety days in the United States.⁴⁰

**Nonprofit Organizations**

A nonprofit organization is an entity that is created and operated for charitable or socially beneficial purposes rather than to make a profit. They may serve many or multiple purposes, such as religious, scientific, charitable, educational, literary, health, or animal welfare purposes. In the context of this study, a “refugee-serving” nonprofit organization is an entity that only serves refugees (or in some cases refugees and immigrants). The most common example of refugee-serving nonprofits are the resettlement agencies, but those will usually be referred to as VOLAGs or simple as “resettlement agencies.” The other refugee-serving nonprofits can be varied, but they are ones that solely serve refugees, and can be in the fields of education, language acquisition, job training, or acculturation, among others. These refugee-serving nonprofit organization are distinct from nonprofit organizations that could/can serve refugee clients, but also serve other populations. In this study, organizations that can serve refugees or others are referred to as “general” nonprofits.

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Assumptions

Certain assumptions and expectations were held in this study based on previous experience and knowledge, and the review of the literature. The first assumption was that the cultural and linguistic barriers to accessing family planning services would be the greatest faced by refugees in Tennessee. While this assumption may seem quite obvious, it was also born out by the literature review, which indicated that cultural and linguistic barriers were the most significant according to both the refugees themselves, and those practitioners who work with them.41 While there is little research on refugees specifically in Tennessee, and the literature focuses on healthcare in general, the assumption that cultural and linguistic barriers are the most significant is extended to both refugees in Tennessee and to family planning services here.

The second assumption is that although there are numerous cultural and linguistic barriers, politics and policies of the resettlement countries will also create barriers to sexual and reproductive health, including family planning services. Due to Tennessee’s laws and restrictions on sexual and reproductive health, it is possible that the political and policy barriers may be more important in Tennessee than in other states that resettle refugees. While the expectation is that these barriers may not be as significant as the cultural and linguistic ones, they still will provide problems.

Third, this study assumes that the refugee-serving nonprofit organizations in Tennessee will provide the greatest assistance in alleviating the barriers that refugees face. These

organizations are specifically designed to assist refugees in all aspects of their resettlement, so healthcare in general, and family planning services specifically, should be easier to access with their assistance.

Finally, this study assumes that the role of male partners in the access and utilization of family planning services of refugee women resettled in Tennessee will show little to no change from their pre-resettlement lives. This is mostly due to the cultures of the refugees mostly being patriarchal, and the belief that the continuity of culture will outweigh the desire for acculturation into American society.

**Limitations**

The first major limitation of this study is the general difficulty that comes with researching refugees. Resettled refugees often become a “hidden group,” whose members are hard to identify and locate. Once a refugee is resettled, they are essentially “fast-tracked” to naturalization. As a result, after resettlement refugees have no requirements to classify themselves as refugees unless they are seeking assistance specifically designed for refugees. Consequently, it is often difficult to determine if someone is a resettled refugee from employment or medical records, or from school or census records. In addition, unlike when the U.S. resettlement system began forty years ago, many refugees resettled in the U.S. today have family or friends already living in the country, and secondary migration has become more significant for refugees. The secondary migration makes it harder to track refugees, and thus harder to research and study them.

A second limitation, very closely related to the first, is the limited responses to the primary research surveys. The difficulty “finding” refugees led to a very limited response in the survey created for this study. The second research survey also had limited responses from those who work with refugees. This could be due to the sensitive nature of the questions on family planning and/or to confidentiality concerns.\textsuperscript{43}

Another limitation in this study was that it was almost completely done in the English language. Only having the surveys available in English limited who could participate, especially because of the lack of proficiency in English by many resettled refugees. In addition, there has been much research on refugees and refugee healthcare in languages other than English that could have illuminated other trends if included.

My positionality, as a straight, white, middle-class male may also be viewed as a limitation. Most of the research on family planning focuses on women, and in particular, the target population (refugees) often possess cultural beliefs that limit unrelated male interaction with women, especially on more delicate topics. Consequently, the current research surveys were designed as online surveys in order to limit researcher interaction, and to limit any possible impacts on feasibility or participation. However, there still remains the possibility of researcher bias as a limitation, as however well-intentioned, some of the research on refugee women and family planning may have been limited by a non-refugee, male researcher.

In addition to possible limitations from the researcher’s positionality, there were other limitations in the research and studies. To begin with, there exists a major hole in the public health and historical literature concerning refugee women, unintended pregnancy, and family planning in the United States. This is especially true for Tennessee in particular. The original

\textsuperscript{43} The full breakdown of limitations for each of the case study surveys can be found in the two case-study chapters later in this work.
research in this study attempted to overcome this void. In addition, extrapolation from other studies on similar populations outside of Tennessee were used to help fill in some of the gaps.

A final limitation was the religious affiliations of the resettlement agencies and other nonprofit organizations that are in place to help refugees. Many of the organizations that assist refugees in Tennessee are affiliated with Christian churches and are unwilling to discuss contraception and family planning with their clients. Steps were taken to overcome these limitations as much as possible, but they still exist and need to be acknowledged.

**Delimitations**

Certain parameters were consciously chosen for this study to manage the size and scope of the research. The historical and policy aspects for the research begin with the current resettlement scheme, implemented with the passage of the 1980 Refugee Act in the United States. In addition, the research for this study focused solely on resettled refugees who currently reside in Tennessee, regardless of where in the United States they may have originally been resettled. Although refugees have the right to move within the U.S. after resettlement, the numbers of secondary or internal migration are usually fairly low. Furthermore, refugees from certain countries, such as Bhutan and the Democratic Republic of the Congo, two of the largest groups resettled in Tennessee, are the least likely to relocate, suggesting that there may be less secondary migration among refugees resettled in Tennessee. Also, research has shown that refugees who undertake secondary migration after resettlement do so due to cost of living conditions.

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expenses, moving from places with a higher cost of living to those that are lower.\textsuperscript{46} Since Tennessee usually falls in the bottom ten states for cost of living, this also suggests that Tennessee might see fewer refugees leave as a result of secondary migration.\textsuperscript{47} Although research from areas outside the state was necessary to create understanding of the full situation, refugees in Tennessee were chosen as the main focus for this research due to their proximity and connections to the researcher. Furthermore, refugees currently living in Tennessee are the only ones directly impacted by the laws and policies of the state, which is the major focus of this work. Practicality was also a factor, as looking at a larger group of refugees from multiple states would not have been possible under the scope and time constraints of this study. Once Tennessee was selected for the study, all refugees were included in an attempt to get the broadest possible knowledge and information. The research was not limited to a refugee population in a certain city, or a population from a specific country of origin due to the wide variety of refugees in Tennessee. Ultimately, the study population was broad in an attempt to better understand what barriers and challenges all refugees in Tennessee face in accessing family planning services, and how those challenges compare to refugee populations in other states.

The original research surveys also had different, specific delimitations. The first survey (Case Study 1 – Chapter 6) opened on 1 April 2022, which was notably before the U.S. Supreme Court Decision in the \textit{Dobbs v. Jackson Women’s Health Organization} decision that overturned \textit{Roe v. Wade}. There was the potential that the decision in \textit{Dobbs} may affect the survey results, however no responses were recorded before the \textit{Dobbs} decision on 24 June 2022. After the


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Dobbs decision, the survey remained open until 1 December 2023. The survey was open to any individuals, male or female, who were resettled in the United States as refugees, were at least eighteen years old, could read and understand English, and who lived in Tennessee at the time of the survey. The second survey (Case Study 2 – Chapter 7) ran from 25 June 2023 until 1 March 2024. The research survey opened on 25 June 2023, notably after the U.S. Supreme Court Decision in the Dobbs v. Jackson Women’s Health Organization decision that overturned Roe v. Wade. This is significant because due to the decision in Dobbs, the survey had to be worded to avoid any potential fear of consequences. For any question about abortion, the question clarified that the survey was asking about views and approaches to abortion “before the overturning of Roe v. Wade.” The study was open to any individuals who worked or volunteered with refugees, were at least eighteen years old, and who lived in Tennessee at the time of the survey.

**Organization of Study**

This dissertation takes an interdisciplinary approach to better understand the reasons that resettled refugees in Tennessee face barriers to the access and utilization of family planning services. The disciplines of history, public health, and public administration/policy are intertwined to uncover trends that have persisted from the past and continue to impact refugee women. The multidisciplinary approach allows for theoretical approaches and paradigms from the diverse fields to converge on the most complete understanding of the roles different elements play to limit access to sexual and reproductive health, and specifically family planning services, for resettled refugees in Tennessee.

Following the introduction of the topic, research questions and approaches, chapter two will set out the methodology used within each of the disciplines for the study, including a discussion of the limitations and the author’s positionality. Chapter three consists of an
exhaustive review of the literature on the topic. This includes an examination of the literature surrounding refugees and resettlement from the disciplines of history, public health, and public administration, as well as a review of sexual and reproductive health and maternal health through a public health lens. The review also consists of an analysis of the literature considering the role of men in family planning access. Finally, there is an inspection of the literature surrounding refugee healthcare and the roles of religion, nonprofit organizations, and the media.

Chapter four looks at the historical background of refugees and resettlement in the United States, including how refugees are classified and measured. It then continues with a public health analysis of refugee health in relation to social determinants of health (SDOH), cultural aspects, and the role of male partners in healthcare decision-making. This is followed by an analysis of policy through the lens of the Social Construction Theory in chapter five. The policy analysis examines the policies governing refugees and resettlement in general before focusing on refugee healthcare policies, including those during COVID-19, those under President Biden, and those directly related to sexual and reproductive health, especially in the U.S. South.

Chapters six and seven are case studies of original research based on research surveys. Case study one (chapter six) focuses directly on refugees themselves. This research survey sets out to better understand the family planning knowledge and practices of refugees in Tennessee by asking them directly about their understanding and experiences. Case study two (chapter seven) expands upon the previous study by seeking to better understand the perspectives that refugee healthcare and service providers have on family planning services. The concluding chapter (chapter eight) brings together the findings from the entire study, providing some answers to the research questions, some additional challenges and barriers that were uncovered, and provides suggestions for avenues of further study.
2. Methodology

Introduction

All women, including resettled refugee women, have the right to decide on the number, spacing, and timing of their pregnancies, and they deserve to have the information to do so. This dissertation attempted to better understand the numerous barriers resettled refugees face regarding access to and use of family planning services. It attempted this by examining the history behind the barriers and the policies that inform them, the public health approaches to circumvent them, and the role that providers and nonprofits play in both creating and reducing the barriers. It also endeavored to illuminate ways that refugee men and women can increase their knowledge and use of family planning methods. The research was conducted through the disciplines of history, public health, and public administration/policy, which all intertwine to provide a more complete picture of the barriers faced by resettled refugee women when trying to access and utilize family planning services in Tennessee.

Historical Methodology

A historical background was used to develop an understanding of the refugee resettlement process and how refugees have been treated in society and in policy after resettlement. The historical approach used cultural and social history lenses, with influence from both modernization and feminist theories. The social-historical method allows for the research to go beyond the traditional historical purpose of narrating events “as they happened.”¹ Further, social history permits the inclusion of a critical analysis that puts

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historical events into a broader social and cultural context. As the main purpose of social history is to recover parts of history that have often been overlooked or neglected, a social history approach to refugees and their access to healthcare provides an ideal lens to illuminate how these challenges have evolved and changed over time.

This research also borrows many aspects from modernization theory as a way to examine the place and role of refugees in their new societies. Although modernization theory is a broader concept that looks at the social variables that contribute to social progress and development of societies, individual refugees who have resettled in the United States often find themselves in a position of personal modernization. Many refugees come from locations that are less developed and less modern than the society they are resettled into, which means adapting to a number of changes. They are also challenged by the internal dynamics of their new location while adapting to new cultures and technologies. Historians often link modernization to the processes of urbanization and industrialization and the spread of education, all processes that refugees are experiencing in their new homes. On a larger scale, when modernization increases within a society, the individual becomes increasingly important, eventually replacing the family or community as the fundamental unit of society. Thus, when refugees resettle in the United States, they often find their culture and traditions diminishing in their everyday lives, and they undergo a process of modernization at the individual level. As a result, an “individual” modernization lens is useful to understand the challenges that refugees face after resettlement, and how they attempt to cope with, understand, and navigate their more

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“modern” lives.

Feminist theory examines both women's and men's social roles, experiences, interests, choices, and politics. The goal of feminist history is to explore and highlight the female viewpoint of history in order to recover and demonstrate the significance of women's voices and their choices in the past. While many refugee women originate from cultures and countries where they have less control over their own lives and reproductive choices, an examination of their new-found freedoms and opportunities after resettlement through a feminist lens allows a better understanding of their agency and the responses they have in their new positions.

The position of resettled refugee women as individuals facing multiple discriminations also calls for an examination of reproductive justice, social reproduction theory, and reproductive racism. Reproductive justice combines reproductive rights and social justice, which creates a more inclusive approach. Social Reproduction Theory adds a connection between class struggle and the oppression of women to traditional Marxist theory, examining how oppression is linked to capitalist production. Reproductive racism shows how the framing of social justice issues as “demographic” ones can avoid dealing with issues of

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reproductive rights under the guise of “saving” and “preserving” the national identity.\(^8\) The result is less access to contraception and family planning for those groups desired to produce more workers for society, while rolling back rights for those who are outsiders, such as refugees, preventing an undesirable shift in the demographics of society.

**Public Health Methodology**

The public health discipline supplements the historical background to examine social determinants of health that impact the knowledge of family planning methods and barriers to receiving reproductive health care. Social Determinants of Health (SDOH) are the conditions and the environments in which people are born, live, learn, work, play, worship, and age. Combined, these factors affect a wide range of health, functioning, and quality-of-life outcomes and risks.\(^9\) As to family planning of refugees, there are numerous SDOHs that contribute to barriers to knowledge, access, uptake, and utilization that must be fully understood to help overcome these challenges. In addition, a needs analysis survey, using a socioecological model similar to the adapted socioecological model used by Hawkins et al., informed by social-cognitive theory, will serve as a case study to look at current knowledge and access to family planning methods by refugee women and men in Tennessee.\(^10\) The socioecological model argues that health behavior and promotion occur through the interplay

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of individual, interpersonal, institutional, community, and policy factors. This makes it useful for identifying, understanding, and describing how factors across multiple levels of society influence health. Social cognitive theory focuses on an understanding of interactions that occurs between an individual and their environment. This approach provides an opportune design to fully explore the SDOHs and how both individual and environmental aspects coalesce to both create and overcome barriers to family planning services. A second study will use a survey of refugee providers and practitioners to get the perspective of the experiences and barriers of those within the system that are trying to aid and assist refugees. This study will be extremely important to better understand how the refugee-supporting providers work with, against, and around the systems that they have to face on a daily basis.

Public health will also combine with the discipline of history to examine how the sexual and reproductive health policies instituted by federal, state, and local government have changed over time and the impact they have had on refugee populations. As for refugees in Tennessee, this policy lens is extremely important due to the refusal of the state government to expand Medicaid as allowed under the Affordable Care Act (ACA). Research shows that states which did not expand Medicaid have additional barriers to affordable coverage, especially for

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refugees. In addition, a policy analysis was used to evaluate the course of policy changes through the lens of the Social Construction Theory. The social construction of target populations is a theory that examines characteristics or popular images of groups who are affected by public policy. This approach allows for the combination of history and public health to not only examine policies, but also the historical contexts behind them. This also provides an opportunity to evaluate the challenges created by the recent Supreme Court decision in Dobbs v. Jackson, which overturned Roe and Casey, and opened the door for a reconsideration of Griswold, directly threatening access to contraception. This policy analysis also benefits from the historical and public health approaches of feminist theory, social history, and reproductive justice and racism.

**Public Administration Methodology**

The public administration discipline will help to highlight the role of nonprofit organizations in the resettlement, education, and healthcare of refugee populations. The role of nonprofit organizations will be evaluated in the context of their missions and how they interpret their beliefs and religious principles in relation to their purposes and aims. While usually viewed through Weisbrod’s public good theory, refugee-serving nonprofits can only be fully understood by combining this with interdependence theory and the theory of impure altruism. Although public health and social sciences play a vital role in refugee and healthcare studies, there is a need to include historical analyses to help engage in interdisciplinary connections to enable shifting paradigms and to grasp the full picture of the situation.

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Finally, the historical, public health, and policy approaches will combine to examine the role of men in family planning decision making, access, and acceptance. Modernization theory from the historical discipline will be the basis for the changing experiences of men in regards to their views and beliefs on family planning, while social construction theory explains much of the “modernization” they are undergoing. The attempt of this section was to find ways to address male-partners as one of the many barriers to family planning access for resettled refugee women.

**Case Study Methodology**

The bulk of the research for this work was based on historical analysis of primary research studies, policies, and reports on refugee access to family planning services. In addition, an analysis of literature reviews and other secondary sources complemented the research. As for the original research, it was obtained from two surveys: first a needs analysis survey of resettled refugees in Tennessee, and second, a survey with resettlement agency employees, nonprofit staff and volunteers, medical and clinical practitioners, and others who work with resettled refugees. The needs analysis survey was used to create a baseline of knowledge on the perceived needs and barriers from the refugees themselves. The second survey provided a prospective from providers to integrate with the data gathered through the needs analysis survey. Getting the views and opinions of individual stakeholders on all sides of the resettlement, assistance, and medical process not only allows for greater understanding of the issues, but also provides opportunities to directly remedy any misconceptions with regard to thoughts and perceptions. The detailed methodology of each research survey is included in the (2020).
Positionality and Limitations

My positionality, as a straight, white, middle-class male may be viewed as both a challenge and an opportunity for the survey research. I am well aware that much of the research on family planning focuses on women, and in particular, the target population (refugees) often possess cultural beliefs that limit unrelated male interaction with women, especially on more delicate topics. However, I do believe that my positionality provided an opportunity for me to be able to connect with male refugees and use their cultural beliefs as a benefit to communication with them. In addition, I believe that having the refugees (both male and female) experience someone like me being interested in their culture, experiences, barriers, and reproductive health often gave them a feeling of significance and/or “importance” that will drive further participation and possibly even trust in the process. I am not too naïve, however, to realize that the challenges of my positionality may have caused more headaches than benefits, but the research is too important to not be carried out. Ultimately, I do not believe that the challenges produced any bias or limitations in the design or impact of the study, and the current studies were designed as online surveys in order to limit researcher interaction, and to limit any possible impacts on feasibility or participation. Although the gender of the researcher was also a limitation, research advisors and assistants helped overcome some of the challenges created by gender by assisting in the design, recruitment, and distribution of the surveys.

In addition to possible limitations from the researcher’s positionality, there were other limitations in the research and studies. To begin with, there exists a major hole in the public health and historical literature concerning refugee women, unintended pregnancy, and family planning in the United States, and in Tennessee in particular. The original research in this study
attempted to overcome this void, but it did not limit comparisons nor prevented a full depth of analysis. Further, the current inability to have the surveys translated into different languages, and thus only being in English, provided another limitation on the study and results.

A final limitation was the religious affiliations of the resettlement agencies and other nonprofit organizations that are in place to help refugees. More than half of the refugee-serving organizations in Tennessee are affiliated with Christian churches and are unwilling to discuss contraception and family planning with their clients. Of the twelve organizations approached to help distribute the needs analysis survey, four specifically stated that their religious views would not allow them to participate – or even mention – the survey due to its focus on family planning. Two additional organizations were unwilling to distribute the survey and hinted at religious reasons without being direct about it, while four of the organizations did not reply when approached. Notwithstanding these limitations, other organizations, direct outreach to refugees, snowball sampling, and the second survey targeting practitioners helped provide additional data to better understand the resettled refugee populations in Tennessee, and the barriers to family planning services they face.

**Conclusion**

The interdisciplinary methods for the research of this dissertation are designed to provide multiple angles of analysis, and to develop a fuller picture of the history of family planning knowledge, access, and policy for resettled refugees in Tennessee. The overall analysis ranges from the institution of the United States Refugee Act of 1980 to the present, with more focus and emphasis on modern developments. This dissertation also examined the role that men play in family planning decision making, while noting opportunities to increase knowledge and access for resettled refugees.
In sum, the history of resettled reproduction and refugee access to family planning services in Tennessee required a multidisciplinary approach to examine all of the interconnected aspects that play a role. As a result, it was necessary to review the relevant literature produced by multiple disciplines to come to a more complete understanding. By combining the disciplines of history, public health, and public administration/policy, the barriers to reproductive health care access faced by refugees are illuminated, and gaps are identified to be examined and filled to support the family planning needs and desires of resettled refugees in Tennessee.
3. Literature Review

**Introduction**

The history of refugee access to family planning services in Tennessee requires a multidisciplinary approach to examine all of the interrelated aspects that are involved. As a result, it is necessary to review the relevant literature produced by multiple disciplines. The history of refugee resettlement will be reviewed first, followed by an overview of the literature on sexual and reproductive health, family planning, and unintended pregnancies. The review then turns to social and cultural determinants on refugee health care, including a detailed review of the role of male partners’ involvement in family planning. After examining the historical and public health literature on refugee health care, the review takes a policy approach to touch on resettlement policy, the Refugee Medical Assistance (RMA) program, and other healthcare policies. Race, gender, ethnicity, and discrimination are then reviewed from the perspectives of refugees, including a brief look at reproductive justice and reproductive racism. Next, a review of the literature concerning religion in health care and nonprofit organizations, and how the role of religion in these organizations is important and relevant from a public administration standpoint. Finally, a brief look at the role of the media in shaping opinions about refugees provides some insights into the perceptions and policies that are important to refugee acceptance and as a result, their access to assistance. By combining the disciplines of history, public health, and public administration/policy, the barriers to reproductive healthcare access faced by refugees are illuminated. These gaps are identified to be examined and filled in order to support the family planning needs and desires of resettled refugees in Tennessee.
History of Refugees

Refugees have long been a part of the world and have contributed to many shifts in population throughout time. Commercial, political, economic, environmental, and military stimuli have all contributed to the movement of people around the globe, and many of these movements are by individuals who have been forcibly displaced. At present, the world is seeing the highest number of displacements ever recorded. The United Nations High Commissioner for Refugees (UNHCR) estimates that at the end of 2021 there were 89.3 million people forcibly displaced from their homes due to persecution, conflicts, violence, or human rights violations.¹ By May of 2022 that number had surpassed 100 million, aided by the war in Ukraine.² Of those displaced, 53.2 million are classified as Internally Displaced Persons (IDPs), 4.6 million are asylum seekers, and 27.1 million are classified as refugees.³

The definition of refugee is often confusing and complex in American society, however this should not necessarily be the case. Within public discourse, refugees are often grouped together with asylum seekers, internally displaced people (IDP), immigrants (both legal and “illegal” or undocumented), migrants, and individuals with Temporary Protected Status (TPS). The generic “migrants” label often encompasses all of these groups, which leads to many issues within American society. Moreover, discussions in American politics and society often lump all of these groups together, especially when it comes to public health, doing a major disservice to refugees in particular. Unfortunately, this is also the case when it comes to organizations and scholarship


³ UNHCR, 2022.
as well, however this is more due to the difficulty in separating refugees from other migrants in real-world practice.\textsuperscript{4} As a result, research on refugees in the United States often fails to appreciate the unique situation of refugees compared to other immigrants and migrants. This results in less access to healthcare, more blaming of refugees for societal issues, and an overall added level of discrimination for refugees, who are guaranteed more rights after resettlement than most other categories of immigrants and migrants.

It is clear that in the United States the definition and classification of refugees is not fully understood by many individuals. Refugees often get confused with asylum seekers, individuals with TPS, and with immigrants or migrants. Consequently, many individuals incorrectly believe that immigrants and migrants are the same, and often refugees, asylum seekers, immigrants, and migrants are all grouped together and generically referred to as immigrants. However, when it comes to official U.S. policy and what constitutes a refugee and refugee resettlement, there is a strict and single definition which guides how the U.S. classifies and measures them.

David W. Haines points out in his work \textit{Safe Haven?} that much of the refugee experience in the U.S. parallels that of other immigrants (language, education, and occupation barriers), but also reminds that refugees are different for distinct reasons, most notably trauma, forced displacement, and years spent in refugee camp limbo.\textsuperscript{5} One of the major differences seen between refugees and other classifications of “immigrants” is in the process of resettlement versus that of immigration. Both processes are long and often complicated, but they are based on


different situations and result in different rights and opportunities after resettlement. Finally, discussions surrounding immigrants and refugees often group all immigrants or refugees into a monolithic whole, with programs, planning, and assistance being the same for everyone. This is true even when looking at just immigrants or just refugees. The discussions in America politics often fail to recognize or understand that all refugees are different because they come from different backgrounds and countries, have different traumas and vulnerabilities, and require different health care services. The generic “catch-all” policies are especially damaging to refugee women and children, as they have more specific needs. Although basic health services are provided to many, the discussion around more specialized care, especially things like sexual and reproductive health, are often overlooked due to financial constraints. Monica A. Onyango and Shirin Heidari give a good overview of this aspect in their “Care with Dignity in Humanitarian Crises,” where they note that advances have been made but there are still enormous gaps between what is provided, and what is needed.⁶

**Resettlement Policy**

Refugee resettlement is shaped by international, national, state, and local politics and environments. These policies and environments are constantly changing and evolving to fit the humanitarian needs and political agendas of the times. The United States has traditionally been the leading country in refugee resettlement, with an average of nearly 96,000 refugee resettlements a year from 1980 to 2016.⁷ However, the U.S. resettlement policy was also one of

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the strictest and longest processes of any country, averaging over two years from identification to resettlement. Refugees hoping to be resettled in the U.S. had to be identified and approved through the United Nations High Commissioner on Refugees (UNHCR), then screened and interviewed, pass a background check, and then undergo a medical screening before being accepted for resettlement. Once approved, they were assigned to one of only ten resettlement agencies that are supported and funded by the U.S. federal government for resettlement. Those ten agencies, or sub-contracted partners, were then responsible for finding a location for resettlement in the U.S. and assisting with the technical and logistical aspects of resettlement.

**Sexual and Reproductive Health in Resettlement**

Resettlement leads to many challenges for refugees overall; those that are especially apparent in healthcare in general, and in sexual and reproductive health specifically. Sexual and reproductive health are intricately linked with maternal health as well. One of the most important aspects of maternal health that is directly related to maternal mortality and poor maternal health outcomes are unintended pregnancies. *Healthy People 2020* aims to help eliminate these healthcare disparities, and one major concern id the prevention of unintended pregnancy. In the United States, racial and ethnic minorities experience a greater proportion of unintended pregnancies than white women, and U.S. nativity status was found to also contribute to racial and ethnic disparities in unintended pregnancies. Studies have shown that unintended pregnancies can lead to a myriad of physical and mental health issues. Khajehpour et al. found that women

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with unintended pregnancies had lower scores for health status, less prenatal care, and higher rates of risky health behavior during pregnancy. In addition, Brown and Eisenberg found that unintended pregnancies led to more abortions, while Abbasi et al. found evidence that unintended pregnancies led to higher rates of postpartum depression. Study results have also shown that maternal suicide rates are higher among refugees compared to host populations. Brown and Eisenberg also found that unintended pregnancies led to higher rates of infant and neonatal mortality rates, especially in lower-income women, and Dehingia et al. found that unintended pregnancy was associated with pre-eclampsia, postpartum hemorrhage and postpartum pre-eclampsia, which may contribute to higher maternal mortality rates. These studies support other research linking unintended pregnancies to higher maternal mortality in the UK, as well as in lower-income countries. Unfortunately, many of these deaths are preventable and avoidable with proper maternal care along with proper and appropriate family planning knowledge and practices, which can help to reduce many of these unintended pregnancies.

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Family planning plays a significant role in reducing the incidences of infant, child, and maternal morbidity and mortality. Family planning empowers individuals to make informed choices about the timing, spacing, and number of pregnancies and birth, and allows for less physical, emotional, and economic challenges that may arise from unplanned pregnancies. Research in low- and middle-income countries (LMICs), and with refugees who originate from those countries, shows that smaller families with well-spaced children have better health outcomes compared to those of larger family sizes within the same socioeconomic status.16

Expanding access to contraception and family planning resources not only helps limit unintended pregnancies, but are also a key component in many international initiatives, such as the Millennium Development Goals, Every Woman Every Child, and Family Planning 2020.17 These initiatives are also considered the “cornerstone” for achieving the United Nations’ Sustainable Development Goal 3.18 Unfortunately, even with these goals and research, unmet need for family planning and contraception services within those populations continues to persist.

As of 2019 there were over 162 million women with unmet need for contraception worldwide, and the United Nations Population Fund (UNFPA) estimates that there are over 257 million women globally who have unmet need for modern contraception.19 Even in the United

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States it is estimated that 7% of married women, and 9% of unmarried women have unmet needs for family planning services.\textsuperscript{20} Studies show that reducing unintended pregnancies through addressing these unmet needs would “reduce the number of maternal deaths by about 76,000 per year.”\textsuperscript{21} In addition, the use of family planning to reduce unmet contraception needs would save money, and could have significant impacts on reducing poverty and hunger, increasing access to clean water and sanitation, improving education, and lead to economic growth for communities and countries.\textsuperscript{22} Studies have also shown that improving access to family planning creates a positive impact on women’s contraception use, and can help to reduce fertility rates overall.\textsuperscript{23} With all of its potential benefits, access to family planning has been clearly shown as a low-cost way to help decrease unintended pregnancies, which in turn would lessen the medical, social, and economic burdens that can develop as a result.

**Maternal Health**

Resettled refugee women are a group that are particularly vulnerable to healthcare barriers, especially in regard to maternal health.\textsuperscript{24} Maternal health services in general are essential in


reducing morbidity and mortality in populations. In the United States in general, and in Tennessee in particular, there is a major hole in the public health literature concerning refugee women, unintended pregnancy, and family planning. In fact, very few studies have been undertaken on the health of women in general with regard to either intended or unintended pregnancies. Fortunately, studies from other Western countries on refugee maternal health, and research on pregnancy intention in lower-income countries provides a window into these same struggles and challenges that resettled refugee women in Tennessee face.

According to Declercq and Zephyrin, maternal mortality is responsible for roughly seventeen deaths per 100,000 pregnancies in the United States. Although there is limited data on resettled refugee women in the United States, additional studies have shown that migrant and refugee women have a higher risk of maternal mortality, higher risk of unintended pregnancy, higher rates of induced abortion, and higher risk of obstetric complications than mothers from the host countries. In fact, Pedersen determined that as many as nine additional maternal deaths per

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100,000 (a 53% increase) occur within these populations. In addition to health risks, unintended pregnancies also carry increased healthcare costs, including antenatal and delivery services and postpartum care for the mother, and routine healthcare for the infant. Research in Western countries has also shown that refugees from lower income countries have higher unmet contraceptive needs, which also leads to more unplanned or unwanted pregnancies.

**Cultural Considerations**

Language and cultural differences are some of the most obvious, but crucial, barriers to family planning. Not speaking the language of their new country can lead to problems finding, accessing, and understanding medical care for refugees. Practitioner-patient communication can be difficult in all medical encounters, but the added language and cultural barriers make practitioner communication with refugee patients more difficult and important. In numerous studies, the communication barriers are cited as the most significant issues in treating refugees.

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31 Jonathan D. Alpern, Cynthia S. Davey, and John Song, “Perceived Barriers to Success for Resident Physicians Interested in Immigrant and Refugee Health,” *BMC Medical Education* 16, no. 178 (2016); 3; Patricia Shannon Maureen O’Dougherty, and Erin Mehta, “Refugees’ Perspectives on Barriers to Communication About Trauma Histories in Primary Care,” *Mental Health in Family Medicine* 9 (2012), 48; Meghan Morris, Steve T. Popper,
These communication barriers can be multifaceted, including language differences, limited literacy, and cultural differences (such as nonverbal cues and expressions) that add layers to the communication disadvantages.32 One study discovered that “minority patients, especially those not proficient in English, are less likely to engender empathic response from physicians, establish rapport with physicians, receive sufficient information, and be encouraged to participate in medical decision making.”33

Although medical practitioners are required to provide interpreters for services, this does not always overcome the barrier. To begin with, often there are issues with finding interpreters who speak the specific language or dialect needed. Many studies show that patients lament the limited availability of interpreters and the type of interpreter. Maternal patients have complained about being provided with young girl interpreters who were “unfamiliar with women problems,” or even worse, male interpreters, with whom the women feel uncomfortable discussing private reproductive health issues.34 Furthermore, many interpreters can often only translate the “words,” not the meaning or the point, of technical medical vocabulary, which often leads to a false sense of patient understanding. The lack of interpreters is a problem, but even when they are available, they often arrive late, which delayed appointments, and the interpreters left early, before the appointment was over, to get to another patient. Phone and video interpretation has also been


used, becoming more popular with providers, but patients often complain about the distant, impersonal feel of them, and find it more difficult to understand and build relationships with these interpreters. Compounding issues with interpreters, materials provided in the refugee patient’s language is also usually lacking. In one study mothers reported that they “received insufficient information in their language to make informed decisions.” In others, the lack of translated materials prevented women from gaining a deeper understanding of the issues, and that the incomplete information impacted on their ability to make informed decisions about what type of contraception or family planning services were available or appropriate for their own care. In many cases, the refugee women were “not literate even in their own language,” so information and instructions translated and written into their own language were of little help. This provides yet another barrier, and helps to emphasize the importance and necessity of quality interpreters. One way that this can be improved is by providing interpreters to establish a working relationship with the women before they engage with the health system, thereby building trust, understanding, and connections.

In addition to the language barriers, cultural differences provide many opportunities for challenges. Many refugee mothers are not familiar with the cultural norms and policies of the United States, and many more American practitioners are not aware of the cultural practices of


37 Summer Awad (Preferred Communities Case Manager, Knoxville Office, Bridge Refugee Services, Inc.) in interview and discussion with author, June 2021.

their refugee patients. Maintaining the culture of one’s homeland can provide comfort to refugees, but it can also make accessing and navigating family planning options more difficult. Morris and her colleagues found that “culture directly affected refugees’ concept of prevention services, independence, expectations of care and stigma around health conditions.”\(^{39}\) In addition, in many refugee cultures, the role of family and friends is extremely important in family planning decision-making, along with other maternal preparation and care. Resettled refugee women have limited social support and “role models” from within their own culture or ethnic group, and the inability to discuss reproductive health care often leads to feelings of isolation, depression, and disengagement from the family planning process.\(^{40}\) Another issues is that many of the cultures and religions of the refugee women require that females only be seen and treated by female practitioners. This also provides more comfort for the patients, as they are more willing to discuss family planning options with other women. After resettlement, however, due to the language and cultural barriers, many times women are accompanied to their appointments by their husbands and/or children. Although the husbands and children often speak better English, their presence often prevents the female patients from being as open and honest, and male partners or children often dominate the conversation, “leaving women unable to disclose their SRH (sexual and reproductive health) needs in the presence of their partners.”\(^{41}\)

\(^{39}\) Morris et al., 2009: 535.


Continuity of care is another major issue and barrier that relates to language and cultural challenges. In fact, a study by Brandenberger, showed that continuity of care was the second most important issue discussed concerning refugee health care, behind only communication issues. Many refugees (and most patients in general) prefer to see the same practitioner on each visit. In addition to building comfort, it also does not force the refugees to recount or revisit traumatic experiences with each new practitioner. “Seeing the same doctor each time was felt to be important because the doctor then knew their, often complex, medical history.” This helps to reduce both the revisitation of trauma and subdue fears of confidentiality. Nearly every article discussing refugee healthcare discusses the importance of, and desire for, continuity of care, and the practices of family planning often increase this desire due to the private and culturally diverse aspects of sexual and reproductive health. The same is true of using the same interpreter each time if possible. However, given financial and logistical issues, this can be difficult, and for some refugee patients privacy concerns developed if the interpreters were members of the patient’s community, which are often small, localized, and prone to talking and information sharing. This, coupled with the previous issues discussed about limited and poor interpreters, creates further issues for continuity of care.

42 Julia Brandenberger, Thorkild Tylleskär, Katrin Sontag, Bernadette Peterhans, and Nicole Ritz, “A Systematic Literature Review of Reported Challenges in Health Care Delivery to Migrants and Refugees in High-Income Countries – The 3C Model,” *BMC Public Health* 19 (2019): 756. In this literature review, communications issues were discussed in 83% of the studies and continuity of care was discussed in 80%.


Logistical Considerations

Logistical issues also create barriers to healthcare access. Logistical issues include arranging and getting transportation, limited office hours of clinics and provides, scheduling and wait times, and securing childcare for other children during appointments. Many refugee women do not have driver’s licenses or vehicles, and they must rely on public transportation or friends and family. Most public buses and trains/metros do not have instructions or stops translated into the languages of the refugees, and often times they are unreliable and inconsistent. Even in situations where refugee-serving organizations help organize and provide transportation, either through public or volunteer means to attend appointments, consistency and reliability are still issues. In one survey, women were the “least satisfied” with the assistance they received in accessing transportation with 68% being less than “at least somewhat satisfied.”

Furthermore, long wait times and limited appointment availability often leads to refugee women leaving offices before they are seen, or in some cases, not even going to appointments. A general study of missed appointments by Pesata, Pallija, and Webb found that the majority of missed appointments were families headed by young single mothers, and that transportation issues, and wait times were the two biggest barriers. Also, many refugee women must focus more on securing housing, food, and education for their families rather than focusing on their own healthcare, including family planning and contraception. As a result, the time required to


46 Deacon and Sullivan, 2009: 279.

schedule, travel to, and wait for an appointment was often seen as a barrier not just to healthcare, but also to the health, nutrition, education, and well-being of their children, and not worth the hassle.

Relatedly, not having access to free or low-cost childcare often led to missed appointments. Many refugees reflected on the difficulty of finding someone to watch their children in order to make medical visits.\textsuperscript{48} Refugee women often are confused about the American daycare system because they typically relied on family to watch their children before resettlement. One study of refugee women in a Midwestern U.S. city showed that only 12\% of women were comfortable leaving their children with non-family members, and only 7\% had ever placed their children in day care.\textsuperscript{49} Additionally, lacking childcare, coupled with not having the financial freedom to miss time at work, adds to the barriers and missed opportunities because most clinics and practices are only open during traditional business hours.

**Role of Men**

Furthering cultural barriers are the roles played by men in the cultures of the refugees. Family planning has traditionally been seen as a responsibility of women in most societies, and family planning programs are often directed towards women.\textsuperscript{50} Although biologically both males and females are usually needed to create a pregnancy, the fact that females have more of a

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\textsuperscript{49} Deacon and Sullivan, 2009: 279.

physical investment in having or preventing children has led to more of a focus on the roles and desires of women in family planning. In most family planning programs, the presence of men is “negligible,” even when the role of men in family and healthcare decision-making is usually supreme. Gender norms across many societies from which refugees originate often allow men key decision-making power. Some research has also shown that mothers-in-law have more control over family planning decisions than mothers do, as the mothers of male partners can influence and control their sons, leading to limited family planning access, and sometimes this even progresses to the point of reproductive coercion. As a result, family planning programs are directed at women, who bear the burden of uptake for family planning, while men continue to be the primary decision makers on whether to use contraception or family planning services, and what type to use.

Although in most countries sexual and reproductive health services, especially family planning services, are predominantly female centered, the support and opinions of men directly affect the “choice, adoption, continuation and correct use of family planning methods” in many of the refugees’ home countries and this continues after resettlement. Further, male partner influence is complex, and not only directly influences choice, but also has indirect effects in both

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biological and social ways.\textsuperscript{55} It has also been shown that when men understand the method of family planning, couples are more likely to use it correctly and are more likely to communicate better.\textsuperscript{56} Nevertheless, there really is no general accepted understanding of what men’s involvement in family planning actually means, even as male engagement has become more common with regard to family planning strategies and interventions since the 1994 International Conference on Population and Development in Cairo.\textsuperscript{57} The 1994 Cairo conference did lead to the creation of working groups and developmental targets, but family planning initiatives continue to focus on women, with less attention paid to men.\textsuperscript{58} Indeed, some even argue that increased male involvement may interfere with women’s ability to make their own decisions and undermine women’s autonomy.\textsuperscript{59}

Recent studies, however, have started to examine the role of males in family planning and contraception decision-making. Although much of this research is just beginning, it is often split between examining the attitudes and determinants of male participation and that of developing interventions to expand their involvement.\textsuperscript{60} Furthermore, without an accepted definition of what


\textsuperscript{59} Adamou et al., 2019.

\textsuperscript{60} For example, concerning attitudes and determinants, see Luiza A. Hoga, Juliana R. Rodolpho, Priscila M. Sato, Michelly C.M. Nunes, and Ana L.V. Borges, “Adult Men’s Beliefs, Values, Attitudes and Experiences regarding Contraceptives: A Systematic Review of Qualitative Studies,” \textit{Journal of Clinical Nursing} 23 (2013), and Lundgren et al., 2012. Concerning Interventions to expand involvement see Miriam Hartmann, Kate Gilles, Dominick Shattuck, Brad Kerner, and Greg Guest, “Changes in Couple’s Communication as a Result of Male-Involvement in Family Planning Intervention,” \textit{Journal of Communication} 17, no. 7 (2012), and Margaret E. Greene and Andrew
male involvement actually means, it is difficult to research, and even more difficult to understand. Adamou et al. encountered this issue in their exploration of monitoring and evaluating male engagement in family planning, where they ultimately had to develop their own working definition of male engagement, adapted from a consensus of studies and organizations. Their study defined male engagement as the inclusion of men as clients of family planning services, as supportive partners, and as agents of change in the family and the community.\textsuperscript{61}

Fortunately, male involvement in family planning among resettled refugees is another area that is starting to receive more attention. Although comparative studies examining the role of male involvement are usually limited to comparisons between LMICs, and often do not compare these countries to the U.S., it is still possible to take a preliminary look at some of the differences.\textsuperscript{62} Somewhat surprisingly, there is a dearth of literature examining the role of American male involvement in family planning. Often in the U.S., male involvement has been simply defined as the importance of, and utilization of, vasectomies and condoms, especially since these are male-directed methods which appeal to them as decision makers.\textsuperscript{63} Although numerous studies from the 1970s found that both married and unmarried men in the U.S.

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\textsuperscript{61} Adamou et al., 2019.
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believed both sexes should share responsibility for family planning, there is limited research and investment in the biological, social, and technological factors concerning male contraception and male aspects of family planning.\textsuperscript{64} Many in the U.S. still view family planning and contraception decisions as those of women. Often men fear getting too involved would infringe on their partner’s autonomy, or that contraception is something that they just do not know enough about it and should not be their concern.

Much of the literature on the role of men in family planning in the U.S. also focuses on couple communication and the aims of gender equality. Although gender-related power dynamics may give males more decision-making power as the “heads of households,” therefore giving them more control over contraception utilization, research has shown that couple communication is often a more important factor in these decisions.\textsuperscript{65} However, in the absence of direct discussion and communication among couples, there is evidence that women sometimes incorrectly assume their partner is opposed to contraception use and family planning.\textsuperscript{66} In fact, there is strong evidence that women tend to be inaccurate in the perception of their partner’s


\textsuperscript{65} Lundgren et al., 2012.

\textsuperscript{66} Hartmann et al., 2012.
views on family planning.\textsuperscript{67} Regardless of men’s actual views, other studies show that women’s perception of men’s opinions is a much more significant determinant of contraception use.\textsuperscript{68}

One reason for the lack of literature on American male involvement could also be a result of couple communication in a different way: due to social and gender norms in the U.S., many couples could officially discuss ideas and preferences about contraception and utilization, but the women may make the final decision. This could result in the appearance that there is less involvement because if couples agree, the women are still practicing in ways that they would have even without male involvement in the decision-making process. As a result, it is possible that male voices, and thus male involvement, gets lost due to good couple communication and the fact that often females acquired the family planning services alone. This could also account for the apparent “over-focus” on vasectomy and condoms within male engagement since those physical aspects are more directly related to male choice and anatomy. Also, views of men in the United States have been trending towards equal and shared responsibility for contraception over the last fifty years. According to a study in the 1980s, using data from the 1970s, only around one-third of men felt shared responsibility regarding contraception and family planning decisions.\textsuperscript{69} In the late 1980s, the percentage increased to two-thirds, and by the late 1990s, to over three-quarters.\textsuperscript{70} A 2019 study found that over eighty percent of men in the U.S. believed


\textsuperscript{70} Samuel D. Clark, Laurie S. Zabin, and Janet B. Hardy, “Sex, Contraception and Parenthood: Experiences and Attitudes among Urban Black Young Men,” \textit{Family Planning Perspectives} 16 (1984); William R. Grady, Koray
that men and women shared equal responsibility concerning contraception decisions. Further, the more egalitarian views that men hold, the more likely they are to view contraception utilization as a joint decision, and American male educational attainment plays a major role in their involvement. Interestingly, men who are more educated than their female partners were more likely to view their own role in contraception decision-making as more important, while those men who have partners with equal or higher education are more likely to view it as a joint responsibility. A lot of the literature about male involvement in the U.S. tends to reflect the findings of Masters et al.’s survey study. This study found that the most important factors concerning male intention to discuss, and be engaged in, contraception decision making was affected by male attitudes and norms: the more strongly men endorse “traditional” masculinity, the less likely they are to discuss, let alone engage in, family planning decisions.

Although men may have personal, financial, or practical reasons to support family planning, many times barriers exist for them at societal levels that impact their own decision-making. Norms around childbearing, religious beliefs, and perceived adverse health effects are major

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72 Grady et al., 1996.

73 Grady et al., 1996.

74 N. Tatiana Masters, Diane M. Morrison, Katherine Querna, Erin A. Casey, and Blair Beadnell. “Correlates of Young Men’s Intention to Discuss Birth Control with Female Partners.” *Perspectives on Sexual and Reproductive Health* 49 (2017).

75 Masters et al., 2017.
motivations to prevent male support of family planning. Other recent studies have shown that men’s lack of knowledge about family planning, including misinformation on side-effects, lack of experience with contraception, and fears of “loss of masculinity” due to fewer or no children, were major barriers to support. Throughout the literature, male partner objection to family planning was found to be a significant barrier, and men’s poor knowledge about sexual and reproductive health and family planning emerged as the most common issues. Unfortunately, some of the main reasons for the lack of male knowledge comes from the fact that most men often receive their information from friends or television and radio, rather than medical professionals.

Other research does provide a more positive outlook for the role of men in family planning decision-making processes. In many studies the male “acceptance” rate for their partner to use contraception is around 40-60%, however, when men are more knowledgeable and involved, that

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79 Bag et al., 2022; Mistik et al., 2003.
percentage increases.\(^{80}\) Hartmann’s study showed that increasing male involvement through education and communication positively influenced family planning acceptance, use, and continuation. A Pillai and Kelley study showed further increases in acceptance with education, and both Yue’s and Mosha’s work echoed the findings that greater couple and partner communication led to higher male acceptance rates.\(^{81}\) Eqtait and Abushaikha also argue for intensive education for men, but also note that when religious leaders were involved it increased the effectiveness of male participation.\(^{82}\) Further research has emphasized the need to include males in family planning policies and programs, which would increase their knowledge and interest. In 1994 the International Conference on Population and Development highlighted areas where men’s inclusion in women’s reproductive health was critical, yet there are still few interventions aimed at addressing how to better include men.\(^{83}\) As early as 1996, Ringheim lamented family planning program’s failure to acknowledge the crucial role of men in contraception decision-making, and Timmermans reported that men were “only considered when male family planning methods” were involved.\(^{84}\) More recently, Nasir et al. showed that men who were more “aware” of family planning were thirty-seven times more likely to practice

\(^{80}\) Hartmann et al., 2012.


\(^{83}\) Ali and Mukasa, 2016: 58.

All in all, the current research tends to support the claim that male involvement in family planning can be a useful avenue to increase the use of family planning and contraception, which would reduce unintended pregnancies regardless of location.

Unfortunately, most of the research on male refugee involvement in family planning and contraception decision making is limited to evidence from the countries of origin for many refugee populations, or from refugee camps before resettlement. Although information from countries of origin and refugee camps are important and provide some context on the role of males, the post-resettlement period in the United States has many more factors that can influence and determine both contraception and family planning acquisition and utilization. Most of the research on the engagement of males in family planning, regardless of location and culture, laments the fact that there is still “a long way to go” to account for, and then improve, male involvement in family planning. However, it is still possible to gain some valuable insights from the current literature.

Although partner communication was key to male involvement in U.S. residents, studies of refugees have shown that less than half of women, and less than a third of men, “named their

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85 Nasir et al., 2010.

86 For example, studies have been done on the role of male partners in India (Bag et al., 2022), in DRC (Hernandez et al., 2022), in the Philippines (Lantiere et al., 2022), in Ethiopia (Smith et al., 2022), and in South Sudanese refugees in Northern Uganda (Singh et al., 2022), and in refugee camps (Aselefech Seyife, Grimasion Fisseha, Henock Yebyo, Gebreamlak Gidey, and Hadgu Gerensea, “Utilization of Modern Contraceptives and Predictors among Women in Shimbelba Refugee Camp, Northern Ethiopia,” PLoS ONE 14, no. 3 (2019)). However, little to nothing been found in the literature for male partners of refugees resettled in the United States.

partner/spouse as a person whose opinion related to family planning mattered to them.”88

Further, as noted previously, many women suffered from “false negative” errors, where they perceived disapproval from partners, but the partners (in matched surveys) actually approved.89 Overall, almost half of the females in the study were incorrect in their perception of their partner’s opinions, and the majority were false negative errors. As the authors surmised, this was probably a product of culture and serotyping, but also showed a lack of communication, and created a situation where there could be an unnecessary, unmet family planning need. Refugees that resettle in the U.S. have many cultural and traditional attributes that they bring with them, however, due to the U.S. Resettlement Program and the desire of the refugees to be accepted, integration into American culture also becomes a factor in establishing their new lives.

Regarding knowledge about the family planning practices of refugees in the U.S., there are many gaps and unknowns.

**Refugee Men after Resettlement**

While there has been an increase in studies of resettled refugees’ knowledge and attitudes about contraception in their new countries, much of it is too broad, looking at “refugees” in general, and focuses on the most stressful periods of displacement and flight. In fact, as of 2020 there was only “a single qualitative study evaluating family planning among refugees after resettlement to the U.S.,” which only focused on female Bhutanese refugees.90 Since 2020 there

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88 Elisabeth Costenbader, Seth Zissette, Andres Martinez, Katherine LeMasters, Nana Apenem Dagadu, Prabu Deepan, and Bryan Shaw, “Getting to Intent: Are Social Norms Influencing Intentions to Use Modern Contraception in the DRC?” *PLoS One* 14, no. 7 (2019); Hernandez et al., 2022.

89 Hernandez et al., 2022.

have been further studies, and some of the gaps are slowly being filled in, but there is still more unknown than understood. These broader studies offer some generalizations about the role of men in family planning decision-making but are far from complete. Chalmiers et al. showed that many of the studies highlight that most refugee women come from cultures that value large families, but also that resettlement often transformed familial power dynamics and offered women new avenues for negotiating contraception use with husbands. Royer and colleagues also noted that these transformed gender norms made some refugee husbands more supportive of joint decision-making and contraception use. This aligns with an earlier study by Royer, who also found that opinions of partners of some refugee women were influential in contraception preference.

Refugee men still viewed their opinions on contraception as important and significant after resettlement, which interestingly contrasts with American Black men, who have been shown in studies to be more likely to view contraception as almost solely a woman’s responsibility and choice. Ultimately, most of the evidence in the literature shows that refugee women still tend to undergo fewer decision-making changes after resettlement than their male counterparts, and most of these changes are based simply on their perception of their partner’s beliefs. However,

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92 Chalmiers et al., 2022.

93 Royer et al., 2020.


95 Grady et al., 1996.
opposed to the refugee situation in the 1980s and 1990s, where most women were resettled in the
U.S. as dependents of male kin and with inferior class resources, the situations that created
refugees in the last twenty years were drawing more men into conflicts, thereby causing or
allowing more women to resettle alone or with children, and without male partners. But even
with many refugee women serving as “heads of households” after resettlement, many women
still tend to desire large families with many children, still view modern family planning as
“acceptable,” but rarely use it, and still prefer traditional methods for birth spacing.96 There is
some evidence that refugee women are more open to possibly using modern contraception to
limit births due to the new cultural norms they are acclimating to in the U.S. Still, this belief was
not widely held, and more frequently, it is not necessarily due to fewer male partners being
resettled.97 Instead, similar to their beliefs before resettlement, refugee women tend to put the
most weight behind their perceived views of their partner’s opinions. Even though there has been
an increase of women resettling without men, many do not even think about their own health, let
along family planning because they are focused on their children, their economic situation, and
assimilation.98 As a result, many refugee women are just not concerned with contraception, and
they can “justify” their own decisions to not use modern contraception or family planning

96 Royer et al., 2020; Agbemenu et al., 2022.
97 Royer et al., 2022.
98 See, for example, Anita J. Gagnon, Lisa Merry, and Cathlyn Robinson, “A Systematic Review of Refugee
Women’s Reproductive Health,” Refuge 21, no. 1 (2002); Anna Perez-Aronsson, Georgina Warner, Anna Sarkadi,
and Fatumo Osman, “‘I’m a Mother Who Always Tries to Give My Children Hope’—Refugee Women’s
Experiences of Their Children’s Mental Health,” Frontiers in Psychiatry 10 (2019); and Sarah Yeo, Yuae Park,
Deborah Jean McClelland, John Ehiri, Kacey Ernst, Priscilla Magrath and Halimatou Alaofè, “A Scoping Review of
services based on their often-inaccurate perceptions of their partner’s views or a lack of necessity.\textsuperscript{99}

Interestingly, even with the barriers and beliefs of resettled refugee women, certain groups of refugees, such as those from African countries who have resettled in the U.S. tend to experience more favorable reproductive health outcomes compared to U.S.-born groups.\textsuperscript{100} This finding by Agbemenu suggests that the “healthy immigrant effect” extends to the reproductive health of African refugee women. This “success” coupled with traditional cultural beliefs and the well-reported fact that refugee women are often hesitant to use “new” (modern) contraception methods due to a fear of negative side effects and infertility, reinforces the belief in these women that they do not need to change their family planning ways, regardless of the level or nature of male engagement.

Although the literature on male involvement in family planning decision-making is limited, it is a growing field of study, and most research points to increasing male engagement as a way to reduce unmet family planning needs, increase contraception utilization, and reduce unintended pregnancies for all demographic sub-groups. However, the current literature points to a trend that at least for the present, refugee women and their own perceptions of their partner’s beliefs and opinions are the most significant factor in family planning decision-making. In the end, there is very limited research on the role of male partners of resettled refugee women in the United States, but examination of studies does provide some clarity for the struggles and challenges faced.

\textsuperscript{99} Hernandez et al., 2022.

Policy Aspects

Beyond the cultural and social aspects, there are also numerous political and policy aspects that need to be considered. Although refugees resettling in the United States are eligible for the Refugee Medical Assistance (RMA) program, the program only covers refugees for the first eight months of their resettlement.\textsuperscript{101} After the initial eight months, resettled refugees are expected to obtain their own health insurance either through their employment or through the healthcare marketplace. Thus, most research and work on resettled refugee healthcare focuses on “the period immediately following arrival in the US, and funding for longer-term health care services is limited.”\textsuperscript{102} However, since the United States prioritizes “victims of torture or violence; physically or mentally disabled persons; [and] persons in need of urgent medical treatment not available in the first asylum country,” refugees resettled in the US often need healthcare and insurance that will go well beyond those first eight months.\textsuperscript{103} Unfortunately, many refugees work in low-income jobs that do not offer health insurance, and they do not have the income to afford private insurance. They also do not have the ability to take time off of work for healthcare appointments due to fear of losing their already meager wages, or possibly even losing their jobs altogether.

In Tennessee, this is further complicated because the state did not expand Medicaid as allowed under the Affordable Care Act (ACA). This has added costs and barriers compared to other states that have expanded Medicaid, and it has led to more refugees resettled in Tennessee


not obtaining health insurance.\textsuperscript{104} As of 2016, the twenty states that had not expand Medicaid experienced more negative health outcomes, higher unintended pregnancy rates, and higher healthcare costs.\textsuperscript{105} This especially impacts refugee women and their maternal health, as is evident in studies that have shown that nearly half of refugees were uninsured after their RMA ended. Not having insurance was the most cited reason for postponing or missing maternal and sexual healthcare appointments, including visits for contraception or family planning procedures.\textsuperscript{106} Although increasing access to insurance does not guarantee one will obtain insurance, and having insurance does not guarantee access to contraception, many studies have shown that compared to women with insurance, those without have a lower likelihood of contraception use and care.\textsuperscript{107} Furthermore, studies have shown that although the number of uninsured contraception visits declined after implementation of the ACA, the gap in uninsured visits widened, with the decline in uninsured visits greater in states that expanded Medicaid compared with those states that did not.\textsuperscript{108} It is no surprise, then, that most studies find that


\textsuperscript{105} Kim et al., 2016

\textsuperscript{106} Yun et al., 2012: 938; Banke-Thomas et al., 2019: 948.

\textsuperscript{107} Kate E. Beatty, Nathan Hale, Alam J. Khoury, Michael G. Smith, Jusung Lee, and Liane M. Ventura, “Association of Health Insurance with Contraceptive Use and Interpersonal Quality of Contraceptive Care in the Southeast United States,” \textit{Southern Medical Journal} 116, no. 4 (2023); Nathan Hale, Michael Smith, Katie Baker, and Amal Khoury, “Contraceptive Use Patterns among Women of Reproductive Age in Two Southeastern States,” \textit{Women’s Health Issues} 30, no. 6 (2020); Agrawal and Venkatesh, 2016.

expanding Medicaid in states that have not yet done so, such as Tennessee, is key for “enhancing contraception access and population health outcomes.” As a result, even though refugees theoretically have the ability to be covered by health insurance, they still are at a very high risk of being uninsured, or at least underinsured, in Tennessee and throughout the United States.

**Discrimination**

Resettled refugees find additional barriers to healthcare due to racial and cultural discrimination. Refugees in general are often viewed as outsiders, and they are often placed in countries that view them as minorities, or “others,” due to their culture and race. This “othering” and discrimination can lead to issues obtaining both health insurance and family planning services, which, in addition to other barriers, means that refugees must navigate a healthcare system that already contains perceived and actual disparities. A Kaiser Family Foundation study showed that 29% of physicians and 47% of non-physicians believed that the U.S. healthcare system treats people unfairly based on their race or ethnicity. Similarly, the Institute of Medicine found evidence that suggests “bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.” Other studies have consistently shown that healthcare providers are “tempted to discriminate” against refugees, while doctors “view refugees as unwanted and a burden,” and have even turned them away despite these

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109 Beatty et al., 2023.


actions possibly being violations of the Human Rights Act.\textsuperscript{113} Of course, refugees themselves notice the disparities and discrimination in healthcare when visiting providers. A Nigerian refugee reported that as a result of being a refugee, “people look at you as if you’re not a human being [but] you’re something different.”\textsuperscript{114} In the same study, a female Afghan refugee lamented that once a nurse realized her family were refugees, the nurse “started not listening to us and treated us differently.”\textsuperscript{115}

In addition to ethnicity and refugee status, the majority of refugees resettled in the U.S. have typically been women, and they are usually minority women of color. As women, many resettled refugees have specific and unique health care needs that often require specialist practitioners. Even though their position as women may be better in the United States than it was in their home country, they still are restricted by systemic sexism present in the United States. The well-documented issues of the gender wage gap, women having less access to opportunities, being judged for career choices, and expected to carry out more “domestic” responsibilities that are all present for refugee women as well.\textsuperscript{116} Being women in the U.S., coupled with cultural and social beliefs of their often-traditional home societies, adds to female refugees’ precarious situation.


\textsuperscript{114} Bhatia and Wallace, 2007: 51.

\textsuperscript{115} Bhatia and Wallace, 2007: 51.

These dual intersections of race and gender, and policy and discourse have further implications for refugee women in the U.S., especially because many are racial minorities. The history of medicine and health care in the United States is marked by racial injustice, and this injustice is more prominent in the U.S. South, including Tennessee. Throughout history, non-dominant racial groups in the United States have received inferior medical treatment, either by law or by custom. The history and legacy of slavery and Jim Crow laws were just the beginning of racial injustice in medicine. This injustice has also led to research and healthcare inequity, and to the creation of “race-based medicine,” which has been described as exemplifying the racist legacy found in the field. Unethical research such as the Tuskegee Study and the “HeLa” cells taken from Henrietta Lacks without consent are two of the major examples that highlight these racial injustices. Further, the work of James Marion Sims, often considered the founder of U.S. gynecology, came to many of his discoveries by experimenting on enslaved black women without their consent.


120 Vickie M. Mays, “The Legacy of the U.S. Public Health Service Study of Untreated Syphilis in African American Men at Tuskegee on the Affordable Care Act and Health Care Reform Fifteen Years after President Clinton’s Apology,” *Ethics and Behavior* 22, no. 6 (2012); Diane R. Brown and Meral Topçu, “Willingness to Participate in Clinical Treatment Research among Older African Americans and Whites,” *Gerontologist* 43 (2003); Baptiste et al., 2022.

These traumatic memories haunt both gender and racial experiences in the South, but they are more than just relics of the past. A 2012 study found that African Americans are still concerned about substandard healthcare, and believe that providers are more likely to treat them like guinea pigs, or withhold information about their healthcare. In addition, many studies have shown that Black Americans’ pain is routinely underestimated by providers, and as a result, undertreated. In a recent study, physicians and non-physician healthcare workers were shown to have more implicit and explicit prejudice against Blacks and Arab-Muslims than the general population, which shows that situations have not improved, and may have possibly gotten worse, since the seminal 2009 study that found physicians were at least as prejudiced against Blacks as the general population. Even to this day, race is used in clinical tools, formulas, and algorithms that adjust or “correct” their outputs based on patient’s ethnicity or race. This has led to practitioners denying black patients access to certain treatments and diverting resources away from black patients. All of this evidence supports the conclusion of Williams and Rucker, who determined that “racism appears to be a technological hazard in the practice of

122 Mays et al., 2012.


These challenges and burdens have led to greater gaps in care and coverage for racial and ethnic minorities, and specifically have caused greater burdens of unintended pregnancy in the U.S., further supporting the need for improved refugee access to family planning.

In the United States, race is also a social determinant of health (SDOH), as social disadvantages and inequities are often related to race, and issues such as structural racism impact many aspects of health and healthcare. Structural racism, or what Dubal et al. term an *infrastructural determinant of health*, is a result of the larger historical and political frameworks and underlies experiences of health and illness. In combination with other SDOH, race operates to create disparities in health outcomes by increasing discrimination, reducing access, enabling mistrust, and putting different racial groups in difficult situations preventing them from receiving the necessary care. Race operates to create disparities in health in the U.S. because racism is a fundamental cause of disparities in socioeconomic status, and socioeconomic status is a fundamental cause of health inequalities. However, racism operates more significantly to create indirect impacts on health. In the literature, this is often referred to “upstream” determinants, as they often occur further up in the levels of determining health. For example, race and racism can lead to discrimination in housing, and the lack of adequate housing is often considered a SDOH. The role of housing as a social determinant of health is well-established,

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128 Kim et al., 2016.
and a lack of adequate housing, tenants’ experience of property quality, limited access to affordable housing, and aspects of neighborhood are all demonstrated to be significantly correlated with measures of health and wellbeing and are all littered with racial discrimination.\(^\text{131}\)

Racial discrimination is also ever-present in education. Mickelson found that racial discrimination in education arises from “actions of institutions or individual state actors, their attitudes and ideologies, or processes that systematically treat students from different racial/ethnic groups disparately or inequitably.”\(^\text{132}\) As a result, lower education levels also limit employment opportunities, which then causes lower incomes, and less access to housing. All of these factors are important SDOH, which are all put into motion by race being an upstream, indirect catalyst. Bharmal et al. diligently shows how all of these factors that are impacted by race combine to lead to multiple diseases and risk factors, through the Social Disadvantage Theory. For example, racial residential segregation is an example of institutional racism that produces and perpetuates social disadvantage in resource-challenged neighborhoods, low-quality and under-resourced schools, and inadequate and unsafe housing.\(^\text{133}\) Many of these “upstream” determinants are extremely prevalent in Tennessee, as well as in other parts of the U.S. South.

This persistent racism affects refugees who have been resettled in the U.S., and especially in the South. The South is the location of the majority of states that did not expand Medicaid under the Affordable Care Act, as eight of the twelve states that did not expand Medicaid are located in


\(^{133}\) Nazleen Bharmal, Kathryn Pitkin Derose, Melissa Felician, and Margaret M. Weden, \textit{Understanding the Upstream Social Determinants of Health}, (RAND Health: RAND Social Determinants of Health Interest Group, 2015).
the U.S. South.\textsuperscript{134} Since refugees often rely on Medicaid for health care – especially after the expiration of their Refugee Medical Assistance – many refugees in the South have a higher likelihood of interrupted healthcare coverage, and are more likely to be uninsured completely.\textsuperscript{135} Overall, states that did not expand Medicaid end up with more refugees not obtaining any health insurance, and in Tennessee specifically, a Case Manager from Bridge Refugee Services echoed this saying that the lack of Medicaid expansion in Tennessee was a “major barrier” for refugee clients, and one of the biggest obstacles the organization was fighting to overcome.\textsuperscript{136}

The position of resettled refugee women as individuals who face multiple discriminations also calls for an examination of reproductive justice through the lens of the Social Reproduction Theory and Reproductive Racism. Reproductive justice is the belief that women and girls should have complete physical, mental, spiritual, political, social, and economic well-being based on the full achievement and protection of women’s human rights.\textsuperscript{137} It combines the concepts of reproductive rights with those of social justice movements to form a more inclusive approach to better articulate the realities of women of color regarding sexual and reproductive health issues.\textsuperscript{138} Much of this developed because historically nearly all of the discussions about reproductive justice centered around abortion, rather than taking a holistic approach. This push

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\textsuperscript{134} Matthew Buettgens and Urmi Ramchandani, \textit{3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility}, (Urban Institute. United States of America, 2022).

\textsuperscript{135} Buettgens and Ramchandani, 2022, and Jessica Stephens, Samantha Artiga, and Julia Paradise, “Coverage and Care in the South in 2014 and Beyond,” \textit{Kaiser Family Foundation Health} (13 November 2018).

\textsuperscript{136} Agrawal and Venkatesh, 2016; Awad, 2021.


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was led by bell hooks, who argued that highlighting abortion rather than reproductive rights as a whole “reflected the class biases of the women who are at the front of the movement,” and that there are “other reproductive issues that were just as vital… to keeping reproductive rights a reality for all females.” A recent study using a reproductive justice framework in a large and diverse refugee population supported this idea, as it found that even through the diversity of the refugees, there was a consistency of refugee women’s experiences with sexual and reproductive health, and that “systemic change” was needed to improve refugee women’s access to increasing and exercising agency regarding reproductive health.

**Theoretical Approaches**

Social Reproduction Theory takes a more developed look at Marxist Theory, but draws a connection between class struggle and women’s oppression. This approach examines how female oppression, especially concerning limitations and restrictions on reproductive health, derives directly from “women’s involvement in processes that renew direct producers.” In essence, the elite classes have sought to limit constraints on reproduction, especially in lower classes, in order to make sure that there are enough “new” individuals in the next generation to drive production in capitalist societies. The concept of Reproductive Racism aligns itself with Social Reproduction Theory, but it expands who is allowed to reproduce beyond class.

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Reproductive Racism shows how those individuals who are viewed as “demographic threats” have experienced a rollback in reproductive rights, lest they threaten the “purity of the nation.”  

This idea has become fairly mainstream in the United States (especially as a far-right conspiracy theory) known as the Great Replacement Theory. The Great Replacement Theory contends that certain groups, mostly left-leaning domestic or international elites, are attempting to replace white citizens with nonwhite immigrants. They fear that an increased presence of immigrants, including refugees, in the United States will enable new nonwhite majorities to take control of national political and economic institutions, dilute or destroy their host countries’ distinctive cultures and societies, and eventually eliminate the host countries’ white populations. Due to this belief, many policy makers and politicians are trying to limit reproductive choice in order to make sure the native population of the United States is not suffering from a decline. This agenda has been supported by the fact that the United States is more than willing to help support family planning and contraception access abroad, through international aid, while further limiting access domestically. In fact, the United States is the most significant donor to international aid for family planning and contraception, being involved in more than thirty countries. This is especially true in countries that are politically unstable, which often account for situations creating the refugees that resettle in the United States. The goal is


increased and improved access to family planning and contraception for those in the developing world, while increasing the domestic population with increased birth rates, limited access to contraception and family planning, and severe punishment and restrictions on abortions to guarantee the survival of “traditional” populations that are “American.”

This is taken even further when social and ecological crises are redefined as demographic ones, thus allowing for the “status quo of systemic social relations,” including inequality and racism. Once refugees resettle in the United States, since they are supposed to become “Americanized” and self-sufficient as soon as possible, they become part of the desired workforce. Refugees often fall into the lower classes of American society, but their children often succeed and become prominent members of society. However, they are still often considered outsiders because of the racial, ethnic, and cultural aspects that remain after their acculturation, and they are still considered a threat through the Replacement Theory beliefs. Thus, reduced access to contraception and family planning for those “desired” to produce more workers, while rolling back rights for those who are outsiders, such as refugees, helps to prevent an undesirable shift in the demographics of society.

**Sexual and Reproductive Health Barriers**

Prior to 2022 most of the barriers to refugee sexual and reproductive health were similar to the general barriers to health care discussed above, falling into cultural, social, and linguistic realms. One of the biggest issues refugee women face specifically concerning sexual and


reproductive health is not being able to fully utilize traditional means that may have been common in their home cultures, but are seen as strange, primitive, or inappropriate by American medicine and culture.\textsuperscript{149} An example of this is the tendency of refugees to desire large families and numerous children. After resettlement many refugee women are caught between their traditional beliefs of having large families, and the more American cultural ideal of smaller families and fewer children. This often leaves many refugees feeling forced to use contraception or other family planning practices that they may not wish to use.\textsuperscript{150} This is often the case because of the stigma that is attached to women in the United States who have numerous children. They are often viewed as lazy, promiscuous, poor, and relying on governmental assistance. Since refugees are encouraged and expected to integrate into society as quickly as possible after resettlement, this pressure often leads refugee women to unwillingly reduce the number of children they have.

A second example of pre-2022 issues for refugee women is the desire for vaginal (natural) births. Many refugee women complain about having to deliver through cesarean section rather than naturally. Although the rates of cesarean section in refugee populations are unknown, they are thought to be much higher than the national averages.\textsuperscript{151} These higher rates of cesarean section in refugee populations are often attributed to the lack of cultural competency by


American practitioners, and to erroneous preconceived beliefs about black and refugee pregnancy outcomes. In addition, some refugee women lack trust in American medical providers and even believe that doctors in the U.S. might try to find medical problems in order to charge more. This reasoning also informed refugee women’s beliefs in the high rates of cesarean sections that were requested or required by doctors in the U.S. after resettlement. Abortion, while legal in the United States prior to the 2022 Dobbs decision that overturned Roe v. Wade, was also a challenge for refugee women due to access barriers such as cost, location, transportation, and understanding of the American medical infrastructure. Another concern was the negative stigma that was associated with abortion by many in the United States.

After the Supreme Court decision in Dobbs v. Jackson Women’s Health Organization in the summer of 2022, policy and discourse on sexual and reproductive health changed dramatically. Although the ultimate impact of the Dobbs decision on family planning in general, and for resettled refugees in the United States, is still evolving, the overturning of Roe completely eliminates the option of abortion as a means of family planning in Tennessee. The Court’s decision also enacted Tennessee’s “trigger law” against abortion in the state. Although abortion is only one aspect of family planning, the content of Justice Thomas’ concurrence also leaves open (or even hopes for) a reevaluation of, and possible limitations on, contraception rights.

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153 Agbemenu et al., 2020.


155 Dobbs v. Jackson Women’s Health Organization, 945 F. 3d 265.
Overall, while the ultimate impacts and consequences of *Dobbs v. Jackson* will take years to fully play out, the implications and fears caused by it have already created a chilling effect on all reproductive and family planning rights, especially for vulnerable resettled refugees.

**Role of Religion**

Another factor that contributes to the rates of unintended pregnancies in refugee women in Tennessee is the religious affiliations of the resettlement agencies and other nonprofit organizations who are in place to help refugees. All four of the federally recognized and supported resettlement agencies in Tennessee have religious affiliations.\(^{156}\) Although the religious affiliations vary (Episcopal, Evangelical, and Catholic), they are all Christian based and all have religiously influenced views on contraception. This is significant, because research has shown that practitioners at religiously affiliated VOLAGs and other nonprofit organizations must navigate a “complex environment of pressures” when serving refugee clients, especially surrounding sexual and reproductive health, family planning, contraception, and abortion, due to the organizations’ religious views and beliefs.\(^{157}\) All three Christian affiliations share the belief that “all human life is sacred,” but their direct approaches to contraception differ. The Episcopal Church does support the use of contraceptives and affirms “responsible family planning.”\(^{158}\) However, this “responsible” view does not allow for freedom of family planning choice, rather

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\(^{156}\) The U.S. government only recognizes ten resettlement agencies who receive funding to support refugee resettlement activities. Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement. Nine of the ten agencies are religious/faith-based organizations (eight Christian, one Jewish), thus the majority of refugees being resettled in the U.S., and all of the refugees being resettled in Tennessee, must go through these faith-based, religiously affiliated organizations.


just when it is necessary for financial or other reasons. Evangelicals are somewhat split on family planning and contraception, but most members support similar “responsible” family planning practices.\(^{159}\) Finally, the Catholic Church, and Catholic hospitals, health centers, and charities are required to comply with the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), which are promulgated by the U.S. Conference of Catholic Bishops. The ERDs prohibit all birth control methods, sterilization, abortion, some miscarriage management techniques, and oral emergency contraception pills, even for pregnancy resulting from sexual assault.\(^{160}\)

Since all of the resettlement agencies in Tennessee are connected to, and funded by religious organizations, they often ignore or refuse to even discuss contraception or sexual and reproductive health. This has led to many of them not routinely providing information or referrals for sexual and reproductive health needs, and “only a minority of resettlement offices (nationwide) are directly helping refugee women and couples plan for their futures by planning their pregnancies and families, or linking-them to SRH services.”\(^{161}\) In addition to the official resettlement agencies in Tennessee, there are six additional nonprofit organizations and four health clinics that are dedicated fully, or in large part, to assisting refugees. Of these ten organizations, half of them (three nonprofits, two health clinics) are also faith-based and have direct connections to Christian religious denominations. Even a majority of hospitals in Tennessee are religiously affiliated, thus adding more barriers. Because Catholic hospitals must


follow the aforementioned ERDs, they often do not provide common reproductive services that are critical to women’s sexual and reproductive health, and are creating an environment that is less safe than other medical settings.\textsuperscript{162} Across the United States, the number of just Catholic-owned or affiliated hospitals increased by 22\% from 2001 to 2016.\textsuperscript{163} As a result, four of the ten largest healthcare systems, and one in every six hospital beds are in Catholic facilities.\textsuperscript{164} The problems regarding family planning and contraception are exacerbated because many studies have shown that most women are unable to correctly identify the religious affiliation of their hospital, and they all anticipated comprehensive reproductive healthcare regardless of religious affiliation.\textsuperscript{165} Wascher also found that women with lower annual income were less likely to identify that their hospital was religiously affiliated, and that although most patients choose a hospital for reasons other than religiosity, women of color have greater odds of delivering in Catholic hospitals, due to other upstream determinants.\textsuperscript{166} As a result, many refugees, who often fall into the categories of lower income and women of color, find these additional barriers through the religious hospitals. All in all, over two-thirds of the individual refugees resettled in

\textsuperscript{162} Lori Freedman, \textit{Bishops and Bodies: Reproductive Care in American Catholic Hospitals}, (New Brunswick, New Jersey: Rutgers University Press, 2023).


Tennessee are placed by a resettlement agency that does not share their religious affiliation, and they must rely on nonprofits and hospitals who do not share their religious (and as a result, often cultural) views. This is extremely significant for all aspects of resettlement and acclimation, but especially for healthcare, which often has very religious and cultural foundations.

**Role of Nonprofit Organizations**

An additional religious issue arises outside of hospitals and healthcare centers. For example, in Tennessee, in order to have “access” to the resettled refugees all of the organizations must be aligned with the four resettlement agencies, so even if they are not explicitly a faith-based organization, they must at least be aware of the opinions and directives of the church-based resettlement agencies. Technically, all of the nonprofit organizations must be non-proselytizing to secure their government funding and relationships, but there is a history of churches coercively proselytizing, expecting the refugees to convert in exchange for assistance.167 As a result, most of the religious organizations avoid any ethical or moral conflict over contraception and family planning by simply not discussing it, so that their religious beliefs do not appear to be influential. Rather, they just direct any health care concerns from their clients to the health clinics or hospitals, who are arguably less-directly influenced by their religious positions, unless they are a Catholic hospital or clinic, as noted above.

When examining the role nonprofit organizations play with regard to refugee reproductive health, the literature discusses the role of nonprofit giving through the Interdependence theory, which offers the most insight into the reasons for nonprofit existence.168 This theory shows the


“symbiotic relationship” between nonprofits and the government and argues that voluntary action arises out of a sense of moral obligation (often from religion), even if that moral obligation needs economic “assistance” from the government.\(^{169}\) The refugee-serving nonprofits usually also fall under Weisbord’s Public Good Theory, which shows how the nonprofit sector’s existence is based on needs unmet by the market or government.\(^{170}\) This theory, however, tends to neglect or overlook how and why certain individuals, such as those with a strong religious affiliation, give to organizations that do not directly benefit themselves. Thus, the addition of the Theory of Impure Altruism provides more evidence. The Theory of Impure Altruism explains how donors may gain benefits from giving, such as status, relief of guilt, the “warm glow,” or promoting their own agenda.\(^{171}\)

The religious nature and affiliations of the refugee-serving nonprofits allows for religious individuals to provide support to vulnerable populations and meet their charitable “obligations” while making sure their religious beliefs – in this case views on contraception and abortion – are still honored. Since philanthropic studies show that individuals with religious affiliations give away several times as much each year than non-religiously affiliated individuals, and local church congregations provide “most of the day-to-day help that resettles refugees” in the U.S., religiously affiliated nonprofits such as those in Tennessee, have somewhat cornered the market on providing aid for refugees.\(^{172}\) As a result, practitioners of these religiously affiliated nonprofits


nonprofits must navigate a “complex environment of pressures” coming from their donors and their organizations’ beliefs when working with refugee clients.\textsuperscript{173} In this way both the “paradox of giving” (giving one’s own money to make others better off), and the barriers to contraception and reproductive health, in the religious-refugee context can be explained by Halfpenny’s economic analysis, which shows that donors advance their own well-being – in this case by promoting and disseminating their views on contraception and reproduction – through their giving.\textsuperscript{174} However, the fact remains that many of the organizations that are specifically designed to help refugees are doing the opposite; refugees are starting their new lives without access to the services and care they need because the nonprofits are limiting access to contraception and family planning services, among other health services, due to their own religious beliefs.

**Role of the Media**

Finally, the role of the media can have a significant impact on how refugees are perceived by the American public, and that perception can impact their access to healthcare. Recent studies have examined the role of the media, using the lens of communication science, to better understand how refugees are portrayed in the media and how these portrayals can help shape public opinion. In 2013, Victoria Esses, Stellan Medianu, and Andrea Lawson found that the negative portrayals of refugees in the media could result in effectively dehumanizing them amongst local populations.\textsuperscript{175} This dehumanization can further exacerbate the discrimination and othering that refugees already experience. Looking more specifically at Europe, but with many

\textsuperscript{173} Christensen and Ebrahim, 2006.


parallels to the United States, Leen d’Haenens, Willem Joris, and Francios Heinderyckx edited a volume which shows that those who control the media control how refugees are portrayed. 176 Separate studies show that in most of Western Europe the authorities and politicians “dominate the press coverage” about refugees and are given a forum in the media while “refugees remain voiceless.” 177 Because authorities and politicians tend to influence the perception of immigrants and refugees in the media (according to the director of the Ethnical Journalism Network) journalists who report on refugees often “fail to tell the full story and routinely fall into propaganda traps laid by politicians.” 178

D’Haenens’ work attempts to remedy this by focusing an entire chapter on reflecting on the perception of refugees in the media by speaking to refugees themselves. In this chapter, the researchers not only recognize the issue, but through their interviews and focus groups they “move beyond the traditional analysis of media content” to examine how refugees specifically experience the media representations of themselves and other refugees in the news media. 179 They find that the refugees were neither thrilled nor impressed with how they are portrayed, and they were specifically critical of the two main tropes in the media: those of refugees as threats, and those of refugees as victims. 180 Through this analysis, the researchers argue for a shift in the gatekeeping to allow refugees themselves to have more control over the media representation of


177 d’Haenens et al., 2019: 41. See also pages 95, 160, 161 of the same work.


179 d’Haenens et al., 2019: Chapter 10, pp. 177-198.

180 d’Haenens et al., 2019: 178.
them, leading to a paradigm shift in approaches to refugees in the media from that of pity to that of empathy. Overall, the value of this work comes from the concluding recognition that whether or not the news media are part of the problem, “there is a real potential for them to be part of the solution” through the concept of shifting gatekeepers.

The parallels between European and American media outlets were examined and confirmed by Tambi Farouk Issac, who undertook a content analysis of the portrayal of refugees in U.S. media. Issac found that American media outlets, like their European counterparts noted above, often did not include the views of the refugees in their coverage. This further supports the earlier research of Sarah Steimel, who studied refugee media coverage in the U.S., and concluded that refugees are seen as the least favored group living in the United States and are often not given the opportunity to speak for themselves in the media. Since the news media represent an important source of information for the American public about refugees, and the portrayal of refugees is often dominated by politicians and authorities, the information about refugees that makes it “through the mysterious mazes of gatekeeping,” provides the backdrop to “shape the public debate and the policy agenda.” The negative portrayals are the ones that often shape discussions, adding yet another layer of discrimination and barriers to refugees attempting for access healthcare.

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181 d’Haenens et al., 2019: 190.


185 d’Haenens et al., 2019: 199.
Conclusion

Overall, there is an abundance of literature on the many cultural, social, logistical, political, and organizational factors that contribute to healthcare disparities in resettled refugees. However, much of the literature is more general and examines all refugees and all aspects of healthcare. While there has been an increase in the study of refugee women, and in sexual and reproductive health specifically, there are still large voids. Unfortunately, there are limited references in the literature about refugees who settle in Tennessee, even as the state ranks as a fairly common resettlement location for refugees. Further, there is almost no literature at all about refugee women and sexual and reproductive health, contraception, or abortion in Tennessee. The lack of research on both refugees in general and sexual and reproductive health in Tennessee can best be explained by the religious and political nature of the state. This is a major void that needs to be filled. The existing literature shows that the risk factors faced by refugees are often accompanied by the other “general” barriers that must be overcome to achieve the health, welfare, and pregnancy intentions they desire and deserve.

Refugee women in the U.S. face multiple discriminations around reproductive health care access. They are often “triply marginalized” due to economic, racial or ethnic, and gender issues. Refugee status, race, ethnicity, gender, and barriers to healthcare coverage all combine to limit sexual and reproductive health resources for refugee women. When combined with the


general barriers faced by all refugees, such as language, cultural, logistical, and geographical barriers, refugee women in the United States are fighting an uphill battle just to get access to the sexual and reproductive health care they need and deserve as a human right. All women, including resettled refugee women, have the right to decide on the number, spacing, and timing of their pregnancies. Moreover, they deserve to have the information to do so. The possible outcomes of unintended pregnancies, including abortion, poor infant and maternal health, and elevated risks of infant and maternal mortality can be limited and reduced. This requires more research, straightforward, cost-effective interventions that are culturally responsible and acceptable to women of varying backgrounds, and policy changes that no longer view refugees as outsiders, but as common members of American society.
4. Historical Background and Public Health Analysis

Introduction

The definition of a refugee is often confusing and complex in American society, politics, and history. However, this should not necessarily be the case. Within public discourse, refugees are often grouped together with asylum seekers, internally displaced people (IDP), immigrants (both legal and “illegal” or undocumented), migrants, and individuals with Temporary Protected Status (TPS). The generic “migrants” label often encompasses all of these groups and leads to many issues within American society. In the United States, discussions often lump all groups together when it comes to these groups and their role in history and society, doing a major disservice to refugees in particular. Unfortunately, this is also occurs in academic scholarship and among nonprofit organizations as well, but this is often due to the difficulty in separating refugees from other migrants in real-world practice.¹ As a result, the history and position of immigration and refugee status have been tied to discussions in America in a way that often discounts the unique situation of refugees compared to other immigrants and migrants, and results in less access to healthcare, more blaming of refugees for issues, and an overall added level of discrimination for refugees, who are guaranteed more rights after resettlement than most other categories of immigrants and migrants.

¹ To illustrate, see World Health Organization (WHO), Improving the Health Care of Pregnant Refugee and Migrant Women and Newborn Children, (Copenhagen: WHO Regional Office for Europe, 2018), Clemence Due, Damien W. Riggs and Martha Augoustinos, “Diversity in Intensive English Language Centres in South Australia: Sociocultural Approaches to Education for Students with Migrant or Refugee Backgrounds,” International Journal of Inclusive Education 20:12, (2016), and Ramin Asgary, Clyde Lanford Smith, Blanca Sekell, and Gerald Paccione, “Teaching Immigrant and Refugee Health to Residents: Domestic Global Health,” Teaching and Learning in Medicine 25, no. 3 (2013), just to name a few. [My emphasis added].
**Classification of Refugees**

To set the stage for better understanding, a brief discussion of the differences between “immigrants” in general, and refugees is needed. A refugee is someone who, due to a well-founded fear of being persecuted due to religion, race, nationality or social group, cannot remain or return to their home country. Immigrants are individuals who make a conscious choice to leave their homes and move to a foreign country, while migrants are those who are purposefully on the move in search of a better life/work but have not made a decision on officially moving or settling. Further, “illegal” immigrants/migrants are individuals who are in the United States inappropriately, usually as a result of overstay a migrant visa. Each of these different groups have different rights when it comes to rights and health care in the United States, so when they are lumped together, as they often are in the literature, the “special” benefits that refugees should get as a result of their trauma, vulnerabilities, and long and legal vetting process often are threatened, if not lost. As a result, it is important to discuss the background of refugees and resettlement in the United States before fully examining the role of public health and the impacts on refugee family planning.

Refugees are individuals who are forcibly displaced due to political, economic, environmental, or military factors, and at present the world is seeing the highest number of displacements ever recorded. The United Nations High Commissioner for Refugees (UNHCR) estimates that at the end of 2021 there were 89.3 million people forcibly displaced from their homes due to persecution, conflicts, violence, or human rights violations. By May of 2022 that

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2 Migrant visas including visas for temporary work, tourism, education, medical procedures, etc.

number had surpassed 100 million, aided by the war in Ukraine.\textsuperscript{4} Of those displaced, 53.2 million are classified as Internally Displaced Persons (IDPs), 4.6 million are asylum seekers, and 27.1 million are classified as refugees.\textsuperscript{5} Unfortunately, the numbers have continued to rise as a result of the Hamas-Israel conflict starting in 2023, and from continuing crises in Colombia, Ethiopia, Haiti, Sudan, and others, with the UNHCR estimating that the figure stood at 110.8 million people by June 2023.\textsuperscript{6} The different classifications are important for policy measures and agenda setting, as different countries and organizations take different approaches to the different groups. Although definitions and classifications can vary internally by country, the United States has a codified system for classifying refugees and other displaced peoples. This system, although not well understood by the general public, is important for an understanding of what constitutes refugee resettlement in the United States, how refugees are measured, and what these measurements can illuminate.

The primary and universal definition of a refugee was codified in the 1951 Convention Relating to the Status of Refugees and amended by the 1967 Protocol to the Convention. Accordingly, a refugee is someone who “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling

\textsuperscript{4} UNHCR, \textit{UNHCR: Ukraine, Other Conflicts Push Forcibly Displaced Total over 100 Million for First Time}, United Nations High Commissioner on Refugees, 2022. \url{https://www.unrefugees.org/news/unhcr-ukraine-other-conflicts-push-forcibly-displaced-total-over-100-million-for-first-time/}.

\textsuperscript{5} UNHCR, 2022.

to avail himself of the protection of that country.” 

In comparison, an IDP is someone who meets most of the same requirements as a refugee, but is still within the borders of the country of her nationality. While these are the official accepted international legal definitions, many countries, leaders, and scholars are not as precise in their usage. In the United States, a refugee usually refers to the international definition, but specifically someone in a “third” country (neither their home country nor the United States). Those who fit the definition of a refugee but are in the United States, or at a U.S. port of entry, are officially defined as asylum seekers. In most countries in Europe the classifications are similar, but the term asylum seeker, or asylee, is more commonly used to describe all who would be called refugees and asylum seekers in the United States. This is most likely due to the fact that “refugees” can officially become “asylum seekers” if they reach a country within which they would like to resettle, and the geographic proximity of Europe to many refugees, compared to the U.S., is much closer. As a result, many “refugees” can make it to a European country to become asylum seekers much more easily than they can reach the United States. This can also help to clarify why European countries officially resettle fewer “refugees” than places like the U.S., Canada, and Australia, because many of the refugees who wish to resettle in Europe arrive in the countries and become asylum seekers. Unfortunately, in more common parlance, the terms migrant or immigrant are often used as general “catch-all” terms to describe anyone not a citizen.

In the United States many citizens, and too many experienced politicians, often do not fully understand the importance of these definitions and classifications. Instead, refugees often get confused with asylum seekers, individuals with Temporary Protected Status (TPS), and with

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immigrants or migrants. For U.S. classification, the official international definition of refugee is used, but it has also been further codified in the United States Code with the same definition.\(^8\)

For U.S. classification as a refugee, a displaced individual must be outside of their country of origin, outside of the United States, and they must apply for refugee status with an official entity, such as a national government or the United Nations Refugee Agency (UNRA). That entity will then investigate the situation to determine if the individual meets the criteria, and also looks to understand and prove the “well-founded fear.” As a result, the official definition and classification of a refugee by the United States is fairly clear and straightforward, even if not well-understood by the general public. Confusion in the U.S. classification system starts to develop when other groups of migrants and forcibly displaced individuals are included. Asylum seekers, according to the U.S., fit all of the same requirements as refugees, with the exception of the geographic location. An asylum seeker is someone who has been forcibly displaced, but rather than applying for refugee status with a government or the UNRA, they arrive in the U.S., or at a U.S. port of entry, and request asylum, rather than refugee status.

A further level of complication in the classification system comes from the newer Temporary Protected Status (TPS) designation. TPS was introduced the by U.S. in 1990, and it is a temporary immigration status provided to nationals of specifically designated countries that are suffering from a current and ongoing conflict or disaster.\(^9\) This system is more closely related to asylum, as TPS status is offered to individuals who are already in the United States (for whatever reason, and by whatever means) when the designation is made. TPS recipients get some benefits,

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but they are only temporary, and receiving this status does not provide any path towards naturalization or citizenship. Finally, all of these groups are distinct from immigrants and migrants. Immigrants are individuals who make a conscious decision to leave their home to move to a foreign country. Individuals hoping to immigrate to the United States must undergo a lengthy vetting process and apply for an Immigrant Visa. A migrant, opposed to an immigrant, is an individual who is purposefully on the move in search of a better life, but has not made a decision to try to move to the United States (or any other country). To arrive as a migrant in the U.S. an individual must obtain a Non-Immigrant Visa, which can be obtained for numerous purposed, including tourism, temporary employment, and education. Many individuals incorrectly believe that immigrants and migrants are the same, and often refugees, asylum seekers, immigrants, and migrants are all grouped together and generically referred to as immigrants. However, when it comes to official U.S. policy and what constitutes refugees and refugee resettlement, there is a strict and single definition which guides how the U.S. classifies and measures refugees.

**Measuring Refugees**

Because of the strict and official definition of refugees according to U.S. law and policy, it is fairly easy to measure refugees and refugee resettlement. This is especially true during the pre-resettlement period, and the period directly after resettlement in the United States. Due to the extensive vetting and background checks, and the government supported resettlement, there is a plethora of knowledge and data, which provides numerous strengths in measurements and classifications. These strengths include detailed demographic data of all who are resettled, including family information, countries of origin, location before resettlement, and how long they have been displaced. In addition, all refugees being resettled in the U.S. are required to
receive a pre-departure and post-arrival (officially optional, but highly recommended) health screenings by the CDC (or authorized providers). This data is all collected, recorded, and kept by the United States government for all refugees. Thus, there are many strengths when it comes to the collection and measurement of refugee resettlement data in the United States for the pre-arrival and immediate post-arrival periods.

However, there are also some major weaknesses when it comes to measurements and data clarity surrounding resettled refugees. These weaknesses arise after refugees have resettled in the United States. To begin with, once a refugee is resettled, they are essentially “fast-tracked” to naturalization. Upon arrival they are given a social security number, they can start working immediately, and they can apply for legal permanent residency one year after arrival. As a result, after resettlement refugees have no requirements to classify themselves as refugees unless they are seeking assistance specifically designed for refugees. Consequently, it is often difficult to determine if someone is a resettled refugee from employment or medical records, or from school or census records. Once refugees are resettled, most of the focus on assistance is directed at emphasizing self-sufficiency as soon as possible.\(^\text{10}\) This push for self-sufficiency, including at least partial integration, if not complete acculturation, leaves refugees in a position where they often do not wish to self-identify as refugees, and prefer to remain “statistically invisible” for fear of stigma, discrimination, or even loss of benefits.\(^\text{11}\) This “data paradox” leads to further issues in tracking refugees after resettlement, and further reinforces inadequate resources and


services being provided by governmental and nonprofit entities.\textsuperscript{12} In addition, unlike when the U.S. resettlement system began 40 years ago, many refugees resettled in the U.S. today have family or friends already living in the country. As a result, secondary migration has become more significant for refugees. This is often due to economic conditions and conational networks, which are in attempt to maximize successful self-sufficiency.\textsuperscript{13} One study found that over 15\% of refugees resettled in the United States undertook secondary migration within a year of arrival, even as resettlement agencies are discouraging the moves.\textsuperscript{14} The secondary migration makes it harder to track refugees, and thus harder to administer services for them. Resettled refugees often then become a “hidden group,” whose members are hard to identify and locate.\textsuperscript{15} This difficulty in identifying refugees without their own self-reporting becomes the major weakness when it comes to data collection and clarity.

A further weakness, albeit an acceptable one due to safety, privacy, and confidentiality, is that governments and resettlement organizations, who are the most suited to find these “hidden groups,” often will not provide data to others for reasons of confidentiality.\textsuperscript{16} Furthermore, data that is released by governments is often not disaggregated sufficiently to be of much use. This lack of ability to collect and find data to better understand resettled refugees also extends to the

\bibitem{davis2017}

\bibitem{mossaad2020}

\bibitem{bloem2017}

\bibitem{bloch2004}

\bibitem{bloch2004a}
Bloch, 2004: 139.
resettlement agencies themselves. Although the government does compile a “referral for resettlement” document for each refugee to be resettled, including family, education, employment, and health information, those documents are often not even shared with the resettlement agencies before the refugees arrive if they are ever shared at all.\textsuperscript{17} Because of this, resettlement agencies and refugee-serving nonprofit organizations often have limited information to help in the resettlement and integration process, and data availability and clarity are often missing before the process even begins. These tensions between the need for data to inform decision and the need to protect vulnerable refugee populations leaves large gaps of understanding within the data of refugee and resettlement measurements.

A further cause for the weaknesses related to data collection and clarity comes from the federal policies and funding of refugee programs. Even since the codification of refugee policy in the U.S. Refugee Act of 1980, federal funding has been reduced for research, resettlement activities, and integration support. The original plan for the resettlement program was supposed to be mostly funded by the federal government, and costs shared by the states were supposed to be fully reimbursed by the federal government.\textsuperscript{18} However, by 2008, federal contributions were only equaling 39\% of the total costs, and states and nonprofit organizations were forced to cover the rest, without guarantees of reimbursement.\textsuperscript{19} These shortcomings are not only financial in nature. According to Section 3 of the U.S. Refugee Act of 1980, the Office of Refugee Resettlement (ORR) – the federal government resettlement office housed in the Department of Human Services – is required to compile and maintain certain data on resettled refugees.

\textsuperscript{17} Brown and Scribner, 2014: 115.
\textsuperscript{18} Brown and Scribner, 2014
\textsuperscript{19} LIRS (Lutheran Immigration and Refugee Service), \textit{The Real Cost of Welcome: A Financial Analysis of Local Refugee Reception}, (Baltimore: Lutheran Immigration and Refugee Service, 2009).
However, this data is difficult to collect, often not collected appropriately, if at all, and when it is collected and distributed properly, it is usually so delayed that the information is no longer valid or useful.20

When it comes to understanding refugee and resettlement in the United States, definitions and classifications are clear, useful, and standardized. Pre-resettlement and immediate post-resettlement, the traditional way that refugees, asylum seekers, and other people on the move are categorized and measured are great and beneficial. It enables a picture of the movements of people from vulnerable situations to their resettlement location and helps officials and scholars to better understand the causes and catalysts of flight, the importance of refugee hosting and resettlement countries, and provides insight into the needs, desires, and motivations of refugees and host countries. However, once resettlement is complete, numerous factors at the personal, institutional, national, and international levels limit the full understanding of refugees and resettlement practices and policies. These challenges make it difficult to follow how refugees map onto the world in motion, by giving an incomplete picture, where information and data usually end before the plight of vulnerable refugees is complete.

**Refugees in the United States**

The United States has traditionally been the leading country in refugee resettlement, with an average of nearly 96,000 refugee resettlements a year from 1980 to 2016.21 However, the U.S. resettlement policy is also one of the strictest and longest processes of any country, averaging

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20 Brown and Scribner, 2014

over two years from identification to resettlement. Refugees hoping to be resettled in the U.S. have to be identified and approved through the United Nations High Commissioner on Refugees (UNHCR), then screened and interviewed, pass a background check, and then undergo a medical screening before being accepted for resettlement. Once approved, they are assigned to one of only ten VOLAGs that are supported and funded by the U.S. federal government for resettlement. Those ten agencies, or sub-contracted partners, are then responsible for finding a location for resettlement in the U.S. and assisting with the technical and logistical aspects of resettlement.

United States resettlement numbers are set each year by presidential proclamation. From the passing of the U.S. Refugee Act of 1980 through the end of the Obama administration, the annual resettlement ceiling was set at an average of 95,500 per year. After Trump was elected president, the annual resettlement ceiling dropped drastically to average only 35,750 per year during Trump’s four years in office. This dramatic decline started well before other issues, like the COVID-19 Pandemic, and created challenges to refugee resettlement throughout the United States. As a result of Trump’s policy changes and fewer refugees being resettled in the U.S., all nine resettlement agencies had to close offices. By April 2019 “around 100 offices have either

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23 The U.S. government only recognizes ten resettlement agencies who receive funding to support refugee resettlement activities. Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement. Nine of the ten agencies are religious/faith-based organizations (eight Christian, one Jewish), thus the majority of refugees being resettled in the U.S., and all of the refugees being resettled in Tennessee, must go through these faith-based, religiously affiliated organizations.

24 MPI, 2022.

25 MPI, 2022.

26 As noted, the U.S. government recognizes ten resettlement agencies, however, the tenth – Bethany Christian Services – was only recognized as of November 2022. Thus, as of the research in 2019, there were only nine recognized VOLAGs.
closed entirely or suspended their refugee resettlement program, a third of offices nationwide.”

These closures were required because funding for resettlement offices is directly tied to the number of refugees resettled in a given year. Trump’s limitations on refugee resettlement were part of his “Muslim Travel Ban” that sought to prevent individuals from Muslim majority countries from entering the United States. President Trump signed Executive Order No. 13,769 in 2017 titled “Protecting the Nation from Foreign Terrorist Entry into the United States.” The order officially lowered the number of refugees to be admitted into the United States, suspended the U.S. Refugee Admissions Program for 120 days, and suspended the entry of all Syrian refugees indefinitely, in addition to banning travel from seven Muslim-majority countries. The administration was attempting to use the fears of previous attacks in the U.S. and in Europe to support its policies to reduce refugee resettlements and ban specific refugee groups altogether.

The healthcare of refugees resettled in the United States has long been tied to their ability to resettle. Refugees must pass health screenings prior to departure to make sure they are “healthy” enough for resettlement, and so that they do not bring foreign, tropical, or communicable diseases into the United States. These pre-departure screenings are required as part of the resettlement application process to the United States, which is one of the strictest in the world. Upon arrival in the United States, refugees are expected to also undergo a medical screening in the U.S., but this is not officially required. Unfortunately, after resettlement, much of the focus on refugees omits their health and instead focuses on their ability to gain English language proficiency, obtain employment, and to become self-sufficient. Most refugee


29 Appleby, 2022.
resettlement agencies, which are the sole organized form of support for the newly resettled refugees, do little more than provide blanket referrals for healthcare, as they usually do not have the funding, knowledge, or ability to provide more regarding health. As a result, most resettled refugees are forced to focus on education and self-sufficiency, and often ignore or put off health related issues themselves. With the focus on assimilation and self-sufficiency, many rules and policies concerning refugees avoid public health as well.

The most significant way that policies of immigration and refugee status are tied to public health discussions are through the immigrants and refugees as a “burden” claim. This centers around the concept of the “public charge.” Immigrants who wish to come to the U.S. must be able to provide for themselves in order to get a visa. Those who cannot are considered a “public charge” and will not be admitted to the U.S., and those who are already in the U.S. and lose their ability to provide for themselves could be deported. This public charge requirement was never designed to be considered for refugees, as due to their circumstances, they are not expected to be able to provide for themselves. Instead, refugees are expected to gain self-sufficiency as soon as possible after resettlement, but they are given access to governmental resources to help this happen. However, as Donald Kerwin and Heide Castaneda have noted, this idealized American concept of self-sufficiency contradicts the fact that refugees were selected for resettlement due to their vulnerability, rather than their ability to achieve self-sufficiency.30 This often leads to an undue burden on refugees to “prove” they belong and can provide for themselves. This situation became more burdensome under the Trump administration, when there were discussions and drafts proposed that would extend the public charge limitation on refugees as well. Stroup noted

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that this would have major negative effects on refugees, as many would avoid registering for governmental services they needed, for fear of being deported.\footnote{B. Stroup, “Immigration Policy Changes May Affect Your Nonprofit Regardless of Mission,” Independent Sector (27 June 2018), \url{https://independentsector.org/news-post/immigration-policies-may-affect-your-nonprofit-regardless-of-mission/}.} This issue was further complicated by the fact that although refugees do have access to specialized Refugee Medical Assistance (RMA), they can only access that if they do not qualify for Medicaid. Use of Medicaid was one of the governmental services that was “proof” of being a public charge, so many refugees felt that they could not apply for Medicaid for fear of being considered a “public charge,” and without applying for Medicaid, they could not apply for or receive RMA benefits either.

Trump’s anti-migration rhetoric did not see distinctions between immigrants and refugees and believed that all were a burden on American society, and thus those who needed government support should not be allowed to enter, or remain in, the United States. Thus, discussions about public health were often connected to the ideas of (illegal) immigration, but the Trump administration tried to pass strict policies that would not stop with immigrants, but also include refugees. Of course, as noted by Castañeda, if this were to go into effect (and thankfully it did not) this would be the equivalent of deporting refugees for the same reasons they were accepted in the first place.\footnote{Castañeda, 2023.} Furthermore, the beliefs of the Trump administration, and by extension many of his followers and supporters, were not only extreme, but also unfounded.

Due to the Trump administration’s gutting of the U.S. resettlement policy, the U.S. was no longer the leading resettlement country, and Canada emerged as the new country resettling
the most refugees by 2018. Canada’s role as a resettlement leader was further solidified when Prime Minister Justin Trudeau “emphasized on Twitter that refugees are welcome” in Canada in response to Trump’s issuance of the “Muslim Ban.” As a result, when the COVID-19 pandemic hit, the refugee resettlement policies of the United States had already undergone a seismic shift.

When the World Health Organization officially announced COVID-19 as a global pandemic on 11 March 2020, governments faced many challenges to protect their countries and citizens. One attempt made by many countries to prevent further spread of the pandemic was to limit travel and close borders. These often “blanket” border closures prevented most refugee resettlements from occurring, even those who had already been identified, screened, and approved. This also led to some arguments that the pandemic closures were violations of international humanitarian laws, and organizations such as the UN and WHO called for using quarantines and health measures so that refugees could still be resettled in their destinations, rather than having them completely shut out and confined to locations that were not safe for their physical, mental, and emotional safety. However, with all of the border restrictions in place, the UNHCR had no other option but to officially decide to temporarily suspend resettlement departures on 17 March 2020. With this temporary suspension, the UNHCR was basically aiding President Trump’s desired policies in the United States. President Trump used fear during


– and well before – the pandemic to create policies that further restricted resettlement, including targeting refugees as potential health risks, security threats, and economic burdens. President Trump even willingly rejected and ignored a study by his own Department of Health and Human Services that showed the positive impact of refugees on the United States, in order to preserve the narrative of refugees as terrorists and threats.37

The changes in resettlement policies in the U.S. had some major implications for the health and well-being of refugees. To begin with, the policy changes, coupled with the UNHCR’s temporary suspension of settlements created a situation where refugees were stuck in limbo, often in camps and unable to continue or finish their resettlement processes. This created major challenges to refugee health as many of the camps were extremely vulnerable to outbreaks of COVID-19 due to their overcrowding and poor medical infrastructures.38 Further, longer times in camps have been shown to increase overall health risks and increase poor health outcomes. The COVID changes also resulted in delayed family reunifications, possibly contributing to additional mental health issues.39 Although the precarious situation of refugees was present before the pandemic, all health issues, including physical health, depression, post-traumatic stress disorders, and other mental and emotional health concerns became more prominent and relevant in the COVID-19 pandemic both in camps and in resettlement countries.40 Within the


39 Abu Alrob and Shields, 2022.

U.S., pandemic policies such as social distancing and stay-at-home orders had a major impact on refugee health and well-being. Most refugees could not access healthcare providers due to closures, and although telehealth options were expanded, many resettled refugees did not have the money, technology, or language skills to access virtual medicine. Even with those attempts to see patients virtually, more significant socio-cultural and structural barriers existed for refugees compared to non-refugees. All of the traditional barriers to health care that refugees already faced, such as language barriers, cultural issues, lack of insurance, and logistical barriers were further exacerbated by the pandemic. However, on the rare occasions that telehealth was available and accessible for refugees, it did lead to fewer missed appointments, and fewer transportation and childcare issues.41

Conversely, however, there were some policies in the U.S. that ended up benefitting refugees, at least to a degree. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) did allocate $350 million to provide services, including health care, for refugees both domestically and internationally.42 In addition, the need for medical workers due to healthcare employee burnout as a result of the pandemic, led to a collaboration where the International Rescue Committee identified foreign-trained refugee medical practitioners to see if they could meet requirements for temporary medical licenses, and help relieved the overburdened healthcare force.43 Resettlement agencies were impacted by the COVID-19 pandemic as well, with the loss of funds and limited opportunities to make a difference virtually, as many of their responsibilities


42 Grant, 2020.

43 Grant, 2020.
require hands-on assistance. Regardless, one major study did find that throughout the pandemic, U.S. resettlement agencies did continually to perform “admirably” despite the numerous issues.44

The COVID-19 pandemic presented major challenges to refugees and resettlement policies. These challenges led to fewer opportunities for refugees, and to greater threats of poor physical and mental health. Overall, the global responses to COVID-19 largely neglected the health needs of refugees, especially in camps and detention centers, but the U.S. (mostly against President Trump’s wishes) tried to do whatever was possible to not leave refugees out in the cold, and they had more success than many other countries.45

**Refugees and Social Determinants of Health**

From a public health perspective, social determinants of health theories provide for a deeper understanding of the challenges and barriers that refugees face. Social determinants of health are nonmedical factors that impact and influence the health and wellness of a population. They are the contexts that produce ill health that are “beyond the observable biopathogenic processes.”46 Often, social determinants of health (SDOH) are recognized as falling into the five categories of economics, education, social and community context, health and health care, and neighborhood and built environment.47 SDOH can also include attitudes, beliefs, behaviors, and opinions that influence health. More importantly, and more specifically, determinants can

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46 Castañeda, 2023.

include “upstream” factors that play a causal role in poor health outcomes, such as social
disadvantage and social inequities. In the United States, race is a social determinant of health as
social disadvantages and inequities are often related to race, and issues such as structural racism
impact many aspects of health and health care. Structural racism, or what Dubal describes as an
infrastructural determinant of health, is a result of the larger historical and political frameworks
and underlie experiences of health and illness. In combination with other SDOH, race operates
to create disparities in health outcomes by increasing discrimination, reducing access, enabling
mistrust, and putting different racial groups in difficult situations preventing them from receiving
the necessary care.

Race operates to create disparities in health in the U.S. because racism is a fundamental
cause of disparities in socioeconomic status, and socioeconomic status is a fundamental cause of
health inequalities. Racism influences health directly through physiological stress responses, as
stress can cause negative emotional states, which can in turn have direct effects on the immune
system. Prolonged stress from situations cause by racist thoughts, words, or actions not only
directly impacts emotional states such as anxiety and depression, but it also can lead to high-risk
health behaviors such as substance abuse. Further, since racism is rooted in an ideology of
inferiority, non-dominant racial groups in the United States have, throughout the history of the

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48 Nazleen Bharmal, Kathryn Pitkin Derose, Melissa Felician, and Margaret M. Weden, Understanding the Upstream Social Determinants of Health, (RAND Health: RAND Social Determinants of Health Interest Group, 2015).


51 Ilene Hyman, Racism as a Determinant of Immigrant Health, (Public Health Agency of Canada: Strategic Initiatives and Innovations Directorate, 2009).
U.S., received inferior treatment in major societal institutions, either by law, or by custom. The history of medicine and health care in the United States is marked by racial injustice. The history and legacy of slavery, Jim Crow, the experimentation of James Marion Sims, and the Tuskegee Study highlight some of these racial injustices in health.\textsuperscript{52} Furthermore, the history of women of color in America is “bloodied by instances of forced sterilization by the state.”\textsuperscript{53} Some states, including Tennessee, even considered compulsory sterilization laws for Black mothers on welfare as late as the 1970s. Specifically, in April 1971, a bill was introduced into both houses of the Tennessee legislature to offer “voluntary” sterilization to women on welfare, and if the women did not “volunteer” each subsequent “illegitimate” child born would be considered dependent, destitute, or orphaned, and the state could legally take the child from its mother, as refusing to get sterilized ended the ability to receive welfare.\textsuperscript{54} These traumatic memories haunt racial experiences in the United States, and point to some of the ways that race has operated to create disparities. The simple fact that individuals were “different” in appearance caused them to be seen as less important, less requiring quality medical care, and in essence, test subjects that would not be missed. Since a majority of resettled refugees are classified as racial minorities, they are entering a system in a county that discriminates against them before they even arrive.

Unfortunately, these examples are not all limited to “history,” and some are still being used in the present. In 2017, a judge in White County, Tennessee, signed an order providing thirty days of “credit” toward jail time if inmates undergo a sterilization or contraceptive


\textsuperscript{53} Tithi Bhattacharya, “What is Social Reproduction Theory?” \textit{Socialist Worker} (10 September 2013).

procedure, which was targeted at the incarcerated African American and minority populations. This shows a continuation of ideas of Social Reproduction Theory and Reproductive Racism. Social Reproduction Theory argues that female oppression, especially limitations and restrictions on reproductive health derive from the belief that women are necessary to produce children in order to “renew direct producers” for the economy and nation. However, somewhat contradictorily, Reproductive Racism focuses on who is allowed to reproduce, arguing that minorities having more children could lead to a social and demographic change in the population of the United States, which could threaten the “purity of the nation.” By combining the ideas of Social Reproduction Theory and Reproductive Racism, elites in society can attempt to secure the desired workforce through limiting contraception and family planning services for those who may produce lower-class workers, while also manipulating and controlling their reproductive output to prevent an undesirable shift in the demography of society.

However, racism also operates more significantly to have indirect impacts on health. In the literature, this is often referred to “upstream” social determinants of health, as they often occur further up in the levels of determining health. For example, race and racism can lead to discrimination in housing, and lack of adequate housing is often considered a SDOH. The role of housing as a social determinant of health is well-established, and a lack of adequate housing, tenants’ experience of property quality, and aspects of neighborhood are all demonstrated to be

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significantly correlated with measures of health and wellbeing.\textsuperscript{58} Racial discrimination is also commonly cited in reasons for poor housing, with minorities often getting less access to loans, and less ability to afford appropriate housing. The same is often true with employment and education. Mickelson found that racial discrimination in education arises from “actions of institutions or individual state actors, their attitudes and ideologies, or processes that systematically treat students from different racial/ethnic groups disparately or inequitably.”\textsuperscript{59} As a result, lower education levels also limit employment opportunities, which then causes lower incomes, and less access to housing. All of these factors are important SDOH, which are all put into motion by race being an upstream, indirect catalyst. Bharmal diligently shows how all of these factors that are impacted by race combine to lead to multiple diseases and risk factors, through the Social Disadvantage Theory. For example, racial residential segregation is an example of institutional racism that produces and perpetuates social disadvantage in resource-challenged neighborhoods, low-quality and under-resourced schools, and inadequate and unsafe housing.\textsuperscript{60}

Beyond these upstream factors, racial discrimination by health care providers also illustrates how race creates disparities in health outcomes in the United States. The U.S. healthcare system already contains perceived and actual disparities. A Kaiser Family Foundation study showed that 29\% of physicians and 47\% of non-physicians believed that the U.S.

\begin{footnotes}
\item[60] Bharmal et al., 2015.
\end{footnotes}
healthcare system treats people unfairly based on their race or ethnicity. In addition, the Institute of Medicine found evidence that suggests “bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care.” The evidence of racism and discrimination in medicine in the United States is so abundant, that Williams and Rucker declared that it is not the behavior of a few, but is “often supported by institutional policies and unconscious bias based on negative stereotypes.” Their review of records and evidence led them to conclude that racism is a “technological hazard in the practice of medicine.”

Gender also acts as a determinant of health in a similar way that race does. Gender is accepted as one of the core social determinants of population health and health inequalities within the social determinants of health (SDOH) framework of the World Health Organization. As a determinant of health, gender should be understood as socially ascribed attributes, roles, responsibilities, and expectations in a given society based on their gender expression and how others perceive it, rather than their sex, which is based on the biological, physiological, genetic and hormonal bodily characteristics of a person. Gender can affect economic status, access to education and employment, and ability to find affordable housing. In addition, gender can be limiting due to the allocation of resources (usually provided directly to men as the “head of the

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61 Kaiser Family Foundation, National Survey of Physicians Part I: Doctors on Disparities in Medical Care, (The Henry J. Kaiser Family Foundation, 2002).


64 Williams and Rucker, 2000: 87.


household”) and limiting in the access and utilization of services. Finally, gender power dynamics, especially in cultures from which the refugees derive, often limit female control and decision-making power when it comes to healthcare decisions.

All of these aspects of race and gender as SDOH often get placed on resettled refugees as well. To begin with, refugees are often viewed as outsiders, and they are often placed in countries that view them as minorities, or “others,” due to their culture and race. This “othering” and discrimination can lead to issues obtaining quality housing, education, and employment, and those barriers are added to the language, cultural, and practical barriers that exist. Even with resettlement assistance provided by the federal government and refugee nonprofits, refugees are typically settled in low-income areas that are usually already racially segregated and are commonly underserved by health care institutions.\textsuperscript{67} In addition, these areas often have lower educational scores, less access to nutritious foods, and less reliable public transportation. Again, all of these are usually the result of larger, institutional policies that do not provide these resources, and all are downstream determinants of health, that are impacted by racism upstream.

**Cultural and Social Barriers to Health**

As the flow of refugees increased in the last decades, countries have also become less willing to host and resettle them. Refugees are routinely demonized by Western countries who illustrate them as threats to both safety and jobs, while also being a burden on governmental finances.\textsuperscript{68} The situation has reached a point to which the United Nations has even identified “a


\textsuperscript{68} Pittaway and Bartolomei, 2001: 22.
climate and a perception that a priori regards a foreigner as an adversary, a rival, a competitor, or an adventurer who is a threat to prosperity, culture, and identity.⁶⁹ Although some of this demonizing is based on racism, the theory of cultural racism is also at work. Cultural racism evolved from Modernization Theory, and its association with the idea that all cultural innovations came from Europe and the West. Cultural racism, as a result, calls for the exclusion of those who do not share the “common interest” of the culture of society. In this way, cultural racism relies on history, rather than biology or race to discriminate against non-Westerners, especially when they are residing in Western countries.⁷⁰ Furthermore, cultural racism desires a closed culture that keeps foreigners out, and believes that any “outsiders” should not share in the national resources of the country, including social safety net programs, and access to financial and health resources.⁷¹ In the United States, the Trump administration used these ideas and fears to support its policies to reduce refugee resettlements and ban specific refugee groups altogether. The administration also attempted to link refugees to terrorism, leading to inflated fears and “calls to restrict refugees” from entering the United States, and to expand the narrative of refugees as threats and burdens.⁷² All of these racial, cultural, and ethnic discriminations not only impact refugee women when they seek family planning resources, but also often prevent them from even attempting to access such resources.


Within the United States, a growing number of refugees come from Sub-Saharan Africa. In 2019, Refugees from the Democratic Republic of Congo far outnumbered those from other countries. This national trend is mirrored in Tennessee, with the Tennessee Office for Refugees reporting that over 58% of refugees in Tennessee since 2017 have been resettled from countries in Sub-Saharan Africa, with refugees from the DRC leading the way. With such a large number of resettled refugees being black, and the holes in the maternal health and unintended pregnancy literature for Tennessee, national data disaggregated by race provides information that can substitute for specific data. According to the 2019 PRAMS report, birth and fertility rates for 2019 are very similar between the U.S. in general, and Tennessee as a state (birth rate 11.4 for U.S. and 11.8 for Tennessee; fertility rate 58.3 for U.S. and 60.3 for Tennessee). The nationwide rates by race, on the other hand, show that black women in the U.S. have significantly higher birth and fertility rates than white women (13.4 compared to 9.8, and 61.4 compared to 55.3 respectively). Further, Tennessee had a larger rate of unintended pregnancies (31.1%) than the average U.S. rate (25.8%). The facts that nearly 60% of resettled refugees in Tennessee are from Sub-Saharan Africa, that women in Tennessee have higher unintended pregnancy rates than the U.S. average, and that African American women in the U.S. have higher birth and fertility rates than white women all suggest that the unintended pregnancy rates of


resettled refugee women in Tennessee, although missing in scholarly literature and research, are likely quite high.

In addition to race and country of origin, many refugee women are younger, have lower income levels, and have less education than women in their countries of resettlement. Much research points to younger women, lower-income women, and women with less educational attainment, having higher incidences of unintended pregnancies. Recent and current trends in the United States show that unintended pregnancies generally decrease as age, income, and educational attainment increase, thus pointing to more opportunity for refugee women to experience unplanned pregnancy, especially early in the period after resettlement.

Refugees who are resettled in the United States already have numerous barriers to accessing quality health due to their language, cultural, logistical, financial, and knowledge barriers. Unfortunately, when they are resettled, they often get additional barriers due to upstream determinants, with race being one of the most significant. In 2020, 35% of the refugees resettled in the U.S. were from Africa, meaning that over one-third of the resettled refugees are at risk of being swept away by the upstream determinant of race, just by being resettled. In this way, it is also important to consider that although migration is a consequence of social

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determinants, often from home countries, immigration (in general) and refugee resettlement (as an aspect of immigration) must be understood as social determinants of health themselves.\textsuperscript{80}

Given the principals of SDOH, many thoughtful considerations must be made to improve the health and well-being of refugees in the United States. At the outset, resettlement must be brought more into focus as a SDOH itself, and it is crucial to acknowledge the multiple identities, especially of refugee women, that overlap, including their race, ethnicity, age, and sexual orientation.\textsuperscript{81} The barriers that refugees face must be seen not as challenges to overcome, but opportunities for organizations and government to improve the health and well-being of refugees, and opportunities that will transfer to other populations as well. Many of the categories of SDOH are not unique to refugees, but the barriers that refugees face in all aspects of resettlement almost all fall into the categories of SDOH. Using the five categories of SDOH defined by Health People 2020 (economic stability, education, social and community context, health and health care, and neighborhood and built environment) there are numerous ways that the resettlement policies and processes can be adapted to improve the health and well-being of refugees.\textsuperscript{82}

Most aspects of resettlement in the United States are currently focused on the first two categories of economic stability and education. As previously noted, once refugees are resettled most of the focus on assistance is directed at emphasizing self-sufficiency as soon as possible.

\textsuperscript{80} Heide Castañeda, Seth M. Holmes, Daniel S. Madrigal, Maria-Elena DeTrinidad Young, Naomi Beyeler, and James Quesada, “Immigration as a Social Determinant of Health,” \textit{Annual Review of Public Health} 36 (2015): 375-392.


\textsuperscript{82} Healthy People, 2020.
through language and job skills training. These policies can help overcome some of the SDOH, however social and community aspects, health and health care, and neighborhood and build environment determinants are usually not targeted or seriously considered. In fact, many refugees are focused more on securing housing, food, and education for their families rather than focusing on their own healthcare or social connections. It also does not help that many of the resources for refugees are only available for eight-to-twelve months after resettlement, at which point they are expected to be self-sufficient. This aspect of the resettlement process clearly overlooks the fact that this idealized American concept of self-sufficiency contradicts the fact that refugees were selected for resettlement due to their vulnerability, rather than their ability to achieve self-sufficiency. One way to help improve the health and well-being of refugees through a SDOH approach would be to provide more access to aid for a longer period of time after resettlement. Refugee Medical Assistance, which is currently only available for eight months (and only available if they do not qualify for Medicaid) is also viewed as inadequate both in terms of length and amount. Increasing and lengthening this aid, and other supports, would allow for more time to focus on aspects of the SDOH that are often ignored by refugees, such as finding their place in the community, building social relationships, and taking better care of their own health.

Additionally, the resettlement program in the United States can do better to provide refugees with housing that is higher quality to help reduce the greater health disparities that are

83 Brown and Scribner, 2014: 106.

84 Kerwin, 2012; Castañeda, 2023.

associated with low-quality housing.\textsuperscript{86} Providing this more adequate housing in locations that have better access to transportation would also work to reduce the impacts of the neighborhood and built environment variety. However, it is also important to resettle refugees in locations where they at least have the opportunity to be near others that share their culture and beliefs, to give them a sense of community. Strong social support networks have been shown to increase life satisfaction, mediate stress, and improve access to healthcare services so it is important to allow for these networks to be formed with culturally similar individuals.\textsuperscript{87} This becomes a “double-edged sword” however, as many established communities of resettled refugees still suffer from racial SDOH that keep their neighborhoods and built environments at levels that do not improve their situations. However, better housing in better locations will also help to improve educational and employment opportunities, which in turn can help increase the health and well-being of refugees.

Unfortunately, refugees are often hit harder by the SDOH in general, while racism and discrimination further those challenges. Many refugees are triply marginalized due to their economic, citizenship, and racial status, and refugee women, who are more than 50\% of the refugee population, have the added gender marginalization.\textsuperscript{88} Refugees have both traditional and upstream SDOH stacked against them when they resettle, and race clearly operates to create


further disparities in refugee health outcomes in the United States. Combining with these SDOH, the general barriers faced by all refugees, such as language, cultural, logistical, and geographical barriers, refugees struggle to get access to the health and well-being they deserve as humans. However, taking an optimistic view, by working directly to change and influence race as a SDOH, both the direct and indirect impacts can be lessened. Although it will not solve all of the problems, reducing the role of race as a SDOH can have a domino effect that helps to improve economic, educational, housing, employment, social, and environmental factors, which are all SDOH themselves. Though not a panacea, it can make the most impact for the most refugees (and others) at the most levels of the Social Ecological Model of health, and therefore create the most positive change.\(^89\) Although these considerations may not be necessarily unique to refugees, improving the health and well-being of refugees by limiting the negative impacts of SDOH will arguably help refugees in more ways, due to the additional barriers and challenges they face.

There are many social, behavioral, and environmental risk factors that contribute to unintended pregnancies in resettled refugee women as well. To begin with, refugee populations have high pregnancy rates, especially in their first three months of resettlement, possibly due to feelings of comfort, security, or relief.\(^90\) In addition, they often have little knowledge of available contraception options, or where to obtain them. A study by Aptekman and colleagues showed that unmet family planning needs “are higher in refugee populations owing to lack of access to contraception, lack of knowledge about various methods, and having other priorities.”\(^91\) In


\(^91\) Marina Aptekaman, Meb Rashid, Vanessa Wright, and Shelia Dunn, “Unmet Contraceptive Needs among Refugees: Crossroads Clinic Experience,” *Canadian Family Physician* 60 (December 2014): e618.
addition to this heightened fertility, refugees who resettle in new countries face numerous challenges in everyday life, and many of these challenges are intensified when it comes to healthcare and access to family planning.

**Role of Male Partners**

Furthering cultural barriers are the roles of men in the cultures of the refugees. Although in most countries sexual and reproductive health services, especially family planning services, are predominantly female centered, and the presence of men is “negligible,” the role of men in family and health care decision-making overall is usually supreme. Gender norms across many societies that refugees resettle from often allow men key decision-making power. Some research has also shown that mothers-in-law have more control over family planning decisions than mothers do, as the mothers of male partners can influence and control their sons, leading to limited family planning access, and sometimes this even progresses to the point of reproductive coercion. As a result, family planning programs are directed at women, and women bear the burden of uptake for family planning while men continue to be the primary decision makers on whether to use contraception family planning services, and what type to use. The support and opinions of men directly affect the “choice, adoption, continuation and correct use of family planning methods” in many of the refugees’ home countries and continue after resettlement.

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Further, male partner influence is complex, and does not just directly influence choice, but also has indirect effects, and occurs in both biological and social ways.  

Refugees that resettle in the U.S. have many cultural and traditional attributes that they bring with them. However, due to the U.S. Resettlement Program and the desire of the refugees to be accepted, integration into American culture also becomes a factor in establishing their new lives. With regards to knowledge about the family planning practices of refugees in the U.S., there are many gaps and unknowns. While there has been an increase in studies of resettled refugee knowledge and attitudes about contraception in their new countries, much of it is broad, looking at “refugees” in general, or “African” refugees. In addition, even these studies suffer from issues of “grouping” refugees and immigrants discussed earlier. In fact, as of 2020 there was only “a single qualitative study evaluating family planning among refugees after resettlement to the U.S.,” and it focused on female Bhutanese refugees. The number of quantitative studies was better, but still lacking. Since 2020 there have been further studies, and some of the gaps are slowly being filled in, but there is still more unknown than understood. These broader studies offer some generalizations about the role of men in family planning decision-making but are far from complete. Chalmiers et al. showed that many of the studies highlight that most refugee women come from cultures that value large families, but also that


resettlement often transforms familial power dynamics, and offer women new avenues for negotiating contraception use with husbands. Royer and colleagues also noted that the transformed gender norms made Congolese husbands more supportive of joint decision-making and contraception use. In an earlier study, Royer also found that opinions of partners of African (in general) refugee women were influential in contraception preference. These shifts do illustrate differences between refugees and their compatriots remaining in their home countries, but they still show differences in male involvement between American born citizens and refugees.

Refugee men still view their opinions on contraception as important and significant after resettlement, which contrasts with American Black men, who have been shown in studies to be more likely to view contraception as almost solely a woman’s responsibility and choice. Most of the evidence in the literature shows that refugee women tend to undergo fewer decision-making changes after resettlement than their male counter parts, and most of these changes are based simply on their perception of their partner’s beliefs. After resettlement, refugee women still tend to desire large families with many children, still view modern family planning as “acceptable,” but rarely use it, and still prefer traditional methods for birth spacing. There is some evidence that refugee women are more open to possibly using modern contraception to

99 Chalmiers et al., 2022.

100 Royer et al., 2020.


103 Royer et al., 2020; Agbemenu et al., 2022.
limit births due to the new cultural norms they are acclimating to in the U.S., but even this belief was not widely held, especially due to the evidence of secondary migration to areas with larger co-national communities, which limits the cultural acclimation. Instead, similar to their beliefs before resettlement, refugee women tend to put the most weight behind their perceived views of their partner’s opinions. This view tends to allow resettled women to “justify” their own decisions to not use modern contraception or family planning services based on their often-inaccurate perceptions of their partner’s views. This also allows them to “outsource” their agency by assigning disapproval of family planning to their husbands or partners, even if it is they themselves who do not want to use the modern approaches.

Interestingly, even with the barriers and beliefs of resettled refugee women, they (refugee women in general) tend to experience more favorable reproductive health outcomes compared to U.S.-born groups. This finding suggests that the “healthy immigrant effect” extends to reproductive health of African refugee women. This “success” coupled with traditional cultural beliefs and the well-reported fact that refugee women are often hesitant to use “new” (modern) contraception methods due to negative side effects and infertility, reinforces the belief in these women that they do not need to change their family planning ways, regardless of the level or nature of male engagement.

A final factor that contributes to the rates of unintended pregnancies in refugee women in Tennessee is the religious affiliations of the resettlement agencies and other nonprofit

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104 Mossaad et al, 2020; Royer et al., 2020.


organizations and health centers that are in place to help refugees. All four of the federally recognized and supported resettlement agencies in Tennessee have religious affiliations.  

Although the religious affiliations vary (Episcopal, Evangelical, and Catholic), they are all Christian and all have religiously influenced views on contraception. All three Christian affiliations share the belief that “all human life is sacred,” but their direct approaches to contraception do differ. The Episcopal Church does support the use of contraceptives and affirms “responsible family planning.” However, this “responsible” view does not allow for freedom of family planning choice, rather just when it is necessary for financial or other reasons. The Evangelical Church is somewhat split on family planning and contraception, but most members support similar “responsible” family planning practices. Finally, the Catholic Church, and Catholic hospitals, health centers, and charities are required to comply with the Ethical and Religious Directives for Catholic Health Care Services (ERDs), which are promulgated by the U.S. Conference of Catholic Bishops. The ERDs prohibit all birth control methods, sterilization, abortion, some miscarriage management techniques, and oral emergency contraception pills, even for pregnancy as a result of sexual assault.

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107 As a reminder, the U.S. government only recognizes ten resettlement agencies who receive funding to support refugee resettlement activities. Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement. Nine of the ten agencies are religious/faith-based organizations (eight Christian, one Jewish), thus the majority of refugees being resettled in the U.S., and all of the refugees being resettled in Tennessee, must go through these faith-based, religiously affiliated organizations.


Since all of the resettlement agencies in Tennessee are connected to, and funded by religious organizations, they often ignore or refuse to even discuss contraception or sexual and reproductive health, which leads to many of them not routinely providing information or referrals for sexual and reproductive health needs, and “only a minority of resettlement offices (nationwide) are directly helping refugee women and couples plan for their futures by planning their pregnancies and families, or linking-them to SRH services.”\(^{111}\) In addition to the official resettlement agencies in Tennessee, there are six additional nonprofit organizations and four health clinics that are dedicated fully, or in large part, to assisting refugees. Of these ten organizations, half of them (three nonprofits, two health clinics) are also faith-based and have direct connections to Christian religious denominations. Further, in order to have “access” to the resettled refugees, all of the organizations must be aligned with the four resettlement agencies, so even if they are not explicitly a faith-based organization, they must at least be aware of the opinions and directives of the church-based resettlement agencies. Technically, all of the nonprofit organizations must be non-proselytizing to secure their government funding and relationships, and they are prohibited from spending federal dollars on religious activities. However, they still operate as religious organizations, and in the literature they produce, and the language their staffs use, they explicitly express their religiosity.\(^{112}\) When it comes to contraception and family planning services, they often let their religious views “speak” by not saying anything so as to avoid any moral or ethical conflicts, and so that their religious beliefs do not appear to be influential. Rather, they just direct any health care concerns from their clients to


the health clinics, who are arguably less-directly influenced by their religious positions. However, the fact remains that many of the organizations that are specifically designed to help refugees start their new lives and access the services and care they need often become barriers themselves when contraception and family planning are involved.

**Conclusion**

On the whole, the history of refugee resettlement and sexual and reproductive health in Tennessee provides numerous lenses with which the dire situation of refugee women can be examined. From social, cultural, and racial discrimination generically as refugees, to the reproductive challenges faced by all women in Tennessee, resettled refugee women find themselves in a position that is often untenable. There is not a single solution for improving the access to health care for refugee women in Tennessee, and improvements need to be made across all sectors of society. These barriers and challenges are extremely significant in the high rate of unintended pregnancies among refugee women in Tennessee, and in order to provide a healthier, safer situation for resettled refugee women, where they can have full control and autonomy of their reproductive lives, the past must be remedied to provide a brighter, more successful future.
5. Policy Analysis

Introduction

Public policy has become an integral aspect of understanding politics and decision making in the United States. More recently, aspects such as agenda-setting and policy implementation have become key to understanding public policy. Policy narratives are used to construct stories about views, and to create meaning for decision making, which becomes the “lifeblood of politics.”¹ These narratives can convey meaning and policy preferences by framing issues in certain ways, but can also contain political strategies that can determine winners and losers, and to establish inequalities in policy and procedures.²

Both refugee resettlement policies and health policies are interdisciplinary by nature due to the complex situations of the refugees, and the complicated concepts of health. The United Nations High Commissioner on Refugees (UNHCR) defines a refugee as someone who has been forced to flee his or her country because of persecution, war or violence, and who has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group.³ Refugees come from numerous countries to the United States each year, driven by politics, conflict, violence, environmental challenges and social discrimination. The World Health Organization (WHO) describes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”⁴

⁴ World Health Organization Constitution Preamble, 1948, p. 100.
Although this definition “tends to be more aspirational, with a focus on what it takes to achieve human potential rather than a description of reality,” societies still have the ability to influence their health through public policy. By examining numerous different types and approaches to policy and policy narratives, the “othering” of refugees becomes more clear, and the policies impacting them end up having less to do with them or their situations, and more to do with politicians, the public, and the media.

Public policy concerning both refugees and health are complex and interdisciplinary, but they are also intricately intertwined. In order to provide refugees with the opportunity for a successful life after resettlement in the United States, public policy must provide them with the tools and necessities required for resettlement, including health. These complicated policies need to be based on data, their experiences, and how they are viewed by society. Understanding the extent and nature of the challenges they face is crucial for developing effective policy responses to address their needs and support their successful integration into their host communities.

However, existing data gaps and poor health program research make it challenging to design and implement such responses. Refugees are difficult to track and record, especially after they have resettled, and one analysis found that publicly available datasets for refugees are “largely lacking.” Furthermore, according to the Institute of Medicine (IOM) guidelines and research, only about 4% of health services have strong scientific evidence backing them, and more than half have weak or no evidence to support them. As a result, policies concerning refugees and

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their health are often determined and shaped not as much by data and their experiences, as it is by how they are viewed by policymakers and society.

**Social Construction Theory**

An important, yet often overlooked political phenomenon that impacts public policy is the social construction of target populations, also known as the Social Construction Theory, developed by Anne Schneider and Helen Ingram. The social construction of target populations refers to characteristics or popular images of groups who are affected by public policy. Schneider and Ingram contend that this phenomenon has a powerful influence on policy agenda, and helps to explain why some groups are advantaged more than others. Social construction of target populations provides a valuable lens into examining refugee policies in general, and health care policy for refugees in the United States, as refugees are a distinct target population that both benefits and suffers from social constructions that have been created by American society, politics, history, and media.

According to Schneider and Ingram, target populations can be organized into four typologies, based on constructions (positive or negative) and power (strong or weak). As a result, most target populations will fall into one of the four categories of Advantaged (positive and strong), Contenders (negative and strong), Dependents (positive and weak), or Deviants (negative and weak). Although there has been no research on the social constructions of target populations from the perspective of elected officials, cultural structure and public policy provide

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9 Schneider and Ingram, 1993.

10 Schneider and Ingram, 1993: 335-336.
ways to place populations into the most appropriate groups.\textsuperscript{11} In addition, politicians are often focused more on reelection than “good” policy making, and thus they will often avoid policy that will harm their reelection chances.\textsuperscript{12} Further, some research has shown that politicians use motivated reasoning to fit new evidence with prior beliefs, making them more reliant on political attitudes, and more likely to make decisions based on reelection rather than unbiased policy information.\textsuperscript{13} All of those factors provide valuable insight into refugee resettlement and health care policy.

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\textit{Figure 5: Social Construction of Target Populations Typologies}\textsuperscript{14}

**Refugees as a Socially Constructed Population**

Traditionally, refugees in the United States would fall into Schneider and Ingram’s dependent type of target populations. They are often seen as having weak political power, due to

\textsuperscript{11} Schneider and Ingram, 1993: 336


\textsuperscript{13} Julian Christensen and Donald P. Moynihan, “Motivated Reasoning and Policy Information: Politicians are More Resistant to Debiassing Interventions than the General Public,” \textit{Behavioural Public Policy} 8, no. 1 (2024): 47-68. \url{https://doi.org/10.1017/bpp.2020.50}.

\textsuperscript{14} Chart adapted by author from Schneider and Ingram, 1993.
their inability to vote and relatively small numbers, but are often viewed positively, as helping
them is good for society, for democracy, and for humanity. As a result, refugees often are the
beneficiaries of positive policies, but those policies are often limited. In the years following the
U.S. Refugee Act of 1980, refugees benefitted from more assistance and policies as officials
wanted to gain the political capital aligned with helping these devastated populations.

Resettlement and acculturation policies were the dominant benefits bestowed upon
refugees shortly after their arrival. To begin with, once a refugee is resettled, they are essentially
“fast-tracked” to naturalization. Upon arrival they are given a social security number, they can
start working immediately, and they can apply for legal permanent residency one year after
arrival, much quicker than other legal immigrants. As a result, after resettlement refugees have
no requirements to classify themselves as refugees unless they are seeking assistance specifically
designed for refugees. Consequently, it is often difficult to determine if someone is a resettled
refugee from employment or medical records, or from school or census records. Once refugees
are resettled, most of the focus on assistance is directed at emphasizing self-sufficiency as soon
as possible.\(^{15}\) This push for self-sufficiency, including at least partial integration, if not complete
acculturation, leaves refugees in a position where they often do not wish to self-identify as
refugees, and prefer to remain “statistically invisible” for fear of stigma, discrimination, or even
loss of benefits.\(^{16}\) In addition, each refugee is officially “placed” by a resettlement agency. The
resettlement agency acts as the first point of contact. They provide initial housing for the

\(^{15}\) Anastasia Brown and Todd Scribner, “Unfulfilled Promises, Future Possibilities: The Refugee Resettlement

\(^{16}\) Roasnna Le Voir “Leaving no One Behind: Displaced Persons and Sustainable Development Goal Indicators on
\(\text{https://doi.org/10.10007/s11113-023-09820-z}\); Gain Kibreab, “Revisiting the Debate on People, Place, Identity and
refugees in their new city, get them settled, and are responsible for helping them find jobs, receive English language training, and welcoming them to their new surroundings. Technically, the resettlement agencies are responsible for helping new arrivals for the first year of their resettlement, and are not required to assist after that year, as the refugees are expected to be active members of society, with secure employment by that point. Many resettlement agencies do try to keep in contact with refugees after the first year, and provide the help they can, but with so many of them under-staffed and over-burdened, and only officially receiving federal funds for assisting during the first year, they often cannot provide additional support after that first year.\footnote{Summer Awad (Preferred Communities Case Manager, Knoxville Office, Bridge Refugee Services, Inc.) in interview and discussion with author, June 2021.}

Although resettlement and acculturation policies were prioritized, health policies were also present. Early health policies were more extensive, and included pre-arrival health screenings, post-arrival health screenings, and access to Refugee Medical Assistance (RMA) programs to provide healthcare coverage. The screenings were easy policies for politicians to support because beyond helping refugees, they provided a public service by ensuring that arriving refugees were not endangering the public health of the host populations. RMA was an insurance-like program that covered refugees who could not get insurance and did not qualify for Medicaid. This program initially reduced healthcare costs for up to thirty-six months after resettlement. However, because of the weak political position of refugees, over time politicians were less willing to invest money and resources into these populations through the RMA program. Thus, from 1980 to 1992 the RMA program was reduced from thirty-six months of coverage down to eighteen months, then to twelve months, and finally to eight months.\footnote{Office of Refugee Resettlement (ORR). Resettlement Services. \textit{U.S. Department of Health and Human Services}, 2021. \url{https://www.acf.hhs.gov/orr/programs/refugees}.}
Consequently, refugee health care became viewed more as the responsibility of churches, nonprofits, and the private sector, rather than the responsibility of politicians and governments. This shift in policy falls directly in line with Schneider and Ingram’s social construction theory concerning dependent populations. Refugee resettlement and health care policy, as a result, became more symbolic, allowing politicians and officials to show concern and earn political capital for their humanitarian endeavors, while limiting their financial and political expenditures.

Refugees have traditionally been welcomed in the United States and have often received strong bipartisan support for assistance. For over two centuries, public support has also remained high for refugees and the tradition of welcome among many Americans remains strong. However, this support and tradition of welcome can be best defined by the social construction theory, and refugees’ status as dependents who need to be looked after and cared for. This status as dependents has led to policies that are much more symbolic than direct, and this is especially the case concerning health and health care policy. Resettlement, acculturation, and self-sufficiency have been the areas for direct intervention and resources. The main source of support for newly resettled refugees are the nonprofit resettlement agencies. These agencies are designed to provide initial housing, English language training, and job acquisition skills, while just helping the refugees get settled in general. They are also the front line for refugees to seek out healthcare, but most resettlement agencies provide little more than referrals to hospitals.

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19 Schneider and Ingram, 1993: 338.


clinics, and other providers, citing their lack of funding, knowledge, and scope of their mission to provide further healthcare assistance. As a result, health-related information and outreach programs are less common and often require refugees to seek out care and benefits based solely on referrals. In these ways, refugees provide a textbook example of the dependent typology of the social construction of target population theory.

**Refugee Resettlement Policies**

Refugee resettlement is shaped by international, national, state, and local politics and environments. Through all of those policies, however, United States has traditionally been the leading country in refugee resettlement, and resettlement numbers are determined each year by presidential proclamation. From 1980 to 2016, the United States averaged nearly 96,000 refugee resettlements a year. However, the U.S. resettlement policy is also one of the strictest and longest processes of any country, averaging over two years from identification to resettlement. These policies and environments are constantly changing and evolving to fit the humanitarian needs and (especially recently), the political agendas of the times. Refugee resettlement is often used by presidents and other politicians to support or demonize groups of people, and to stir controversy or support. Refugees often get caught in the middle of this political theatre, and their ability to resettle is often controlled or limited by the whims of political leaders.

Refugee women tend to suffer the most from the policies, starting with the more general idea that resettlement policies actively discriminate against women on the grounds of both race

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and gender. The 1951 Refugee Convention, the basis for current laws and policies, has been labeled as “gender blind,” and later research, such as the 2000 paper “Racism, Refugees, and Multi-Ethnic States,” while detailing the link between refugee issues and racism, does not once mention gender. This is especially unfortunate, as more than half of the refugees in the world are women, and some estimates claim that 70-80% of the world’s refugees are women and children. On the whole, efforts to address the particular situation of refugee women have “fallen short of the adoption of any legally binding international instruments singling them out as a specific group.” These international issues are further exacerbated by national, state, and local policies in the United States.

**Refugee Healthcare Policies**

Refugees face many social, behavioral, and environmental risk factors that contribute to healthcare barriers. Although nations that accept refugees are usually wealthy and capable of providing assistance, it still proves challenging for them. In addition to these structural barriers, refugees also face language and cultural barriers, social isolation, personal financial and insurance issues, transportation challenges, discrimination, and an overall difficulty in understanding the healthcare system in the United States. Language and cultural differences are some of the most obvious, but also important, barriers to health care access. Not speaking the

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language of their new country can lead to problems finding, accessing, and understanding medical care for refugees. Practitioner-patient communication can be difficult in all medical encounters, but the added language and cultural barriers makes practitioner communication with refugee patients more difficult and important. Further, many of the cultures and religions of the refugees require that females only be seen and treated by female practitioners. This also provides more comfort for the patients, as they are more willing to discuss their health with other women. However, due to the language and cultural barriers, many times women are accompanied to their appointments by their husbands, who often speak better or more English, and often serve as translators and interpreters. Although the husbands often speak better English, their presence often prevents the female patients from being as open and honest, and male partners often dominate the conversation, “leaving women unable to disclose their SRH (sexual and reproductive health) needs in the presence of their partners.”

Refugee women are a group that are especially vulnerable to healthcare barriers, especially in regard to maternal health. Maternal health services, including general sexual and reproductive health and family planning, are essential in reducing morbidity and mortality in populations, especially for mothers, but also for the children that they are responsible for raising. Specifically, the current political climate around sexual and reproductive health in the United States also leads to a situation where refugee women are the most impacted and suffer from multiple discriminations due to the intersectionality of race, gender, and citizenship status. In addition to language, cultural, logistical, and financial barriers, there are many cultural rituals imbeded in birth and maternal health, which leads to the potential for misunderstanding and

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conflict that can further increase the challenges and barriers to care. It is difficult to overemphasize the importance of maternal health, not just for women, but for families and society in general. Maternal mortality is responsible for roughly seventeen deaths per 100,000 pregnancies in the United States.\textsuperscript{29} However, studies have shown that migrant and refugee women have a higher risk of maternal mortality than mothers from the host countries.\textsuperscript{30} In fact, as many as nine additional maternal deaths per 100,000 (a 53% increase) were found just within these populations.\textsuperscript{31} Unfortunately, many of these deaths could have been prevented or avoided with proper maternal care.

Many refugee women are not familiar with the cultural norms and policies of the United States, and many more American practitioners are not aware of the cultural practices of their refugee patients. Continuity of care is another major issue and barrier that relates to language and cultural challenges. In fact, in a study by migrant and refugee public health specialist Julia Brandenberger, continuity of care was the second most important issue discussed concerning refugee health care, behind only communication issues.\textsuperscript{32} Resettled refugees find additional barriers to healthcare due to discrimination. Refugees in general are often viewed as outsiders,


and they are often placed in countries that view them as minorities, or “others,” due to their culture and race. Studies have even shown that healthcare providers are “tempted to discriminate” against refugees, while doctors “view refugees as unwanted and a burden,” and have even turned them away despite these actions possibly being violations of the Human Rights Act.³³

Although nations that accept refugees as resettlement countries are capable of providing assistance to aspects such as healthcare, and under the Refugee Act of 1980 the U.S. government provides medical assistance (including financial and insurance assistance) to refugees, it still proves challenging to ensure the health and well-being of resettled refugees.³⁴ Refugees are offered pre-arrival (required) and post-arrival (optional, but highly recommended) health screenings by the CDC (or authorized providers), but even these resources are difficult to fully implement due to barriers of logistics and costs, and many refugees never receive their post-resettlement screenings.³⁵ In addition, both pre- and post-arrival screenings only focus on infectious diseases and general health, usually do not provide any information for follow-up appointments, and no questions are asked about potential pregnancies, contraception, or preconception desires or needs.³⁶ In addition to these structural barriers, refugees also face


³⁵ Pace et al. (2015), 65. Also see William M Stauffer, Paul T. Cantey, Susan Montgomery, Leanne Fox, Monica E. Parise, Olga Gorbacheva, Michelle Weinberg, Annelise Doney, Lisa D. Rotz, and Martin S. Cetron, “Presumptive Treatment and Medical Screening for Parasites in Refugees Resettling to the United States,” Current Infectious Disease Reports 15, no. 3 (2013).

language and cultural barriers, social isolation, personal financial and insurance issues, transportation challenges, discrimination, and an overall difficulty in understanding the healthcare system in the United States. All of these barriers are magnified by the fact that attempted solutions are “frequently mired in political disarray, misguided national security concerns or divergent views regarding the best path forward.”  

**U.S. Refugees Transition to “Deviants”**

Health and health care policies for refugees continue to remain, but they are often limited and lacking. Refugees did enjoy the benefits of being dependents according to the social construction theory typologies but were never able to advance to the “advantaged” typology due to their lack of political power. Although Schneider and Ingram show the prevailing rationales for social construction of target populations can change in response to stimuli, unless refugees were provided the opportunity to vote immediately upon arrival, showed their willingness to become a more mobilized political force, and increased their overall numbers, their political power is always going to be lacking. Instead, change of social construction for refugees came in the opposite direction, from dependents to deviants, due to dramatic events, which “often serve as catalysts for changes in social constructions.”

The first recent dramatic event that started the change in social construction for refugees was the terrorist attacks on the United States on 11 September 2001. After the 11 September attacks, refugees often became stigmatized and associated with Muslims and terrorists. This shift in views was capitalized on by many politicians, and refugees often became demonized for

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38 Schneider and Ingram, 1993: 343.
artificial reasons. In addition to their supposed connections to terrorism, refugees were also
demonized by Western counties and medias as illegal immigrants or economic migrants, who
were stealing jobs and wasting tax-payer money by using social services they should not be
entitled to access.39

A second dramatic event that continued the shift from dependents to deviants occurred in late 2015. On 13 November 2015, a string of coordinated terrorist attacks devastated Paris,
France, killing 130 people and injuring over 400 more.40 Although none of the attackers were
refugees, at least three of the seven were “thought to have crossed clandestinely from Syria to
Europe” using the flow of migrants and refugees as a cover to enter the European Union.41 This
led to an inflated fear that refugees getting resettled in the U.S. could also be secret terrorists, and
calls to restrict refugees increased almost immediately.42 While restrictions on refugees did not
directly occur in the United States overall at that time, the popular image and social construction
of refugees did suffer mightily. In fact, in response to the Paris attacks, twenty-nine U.S. state
governors attempted to defy federal policy by announcing they would not accept refugees in their
state due to the potential threat the refugees posed.43 This shift in perception gained momentum
because studies have shown that the media can have extensive power in covering and controlling


how refugees are portrayed, and often times authorities and politicians dominate the press coverage concerning refugees, while the refugees themselves remain “voiceless.”44 In this case, governors attempted to establish a state of exception by focusing on the sense of pending threat, and the media (especially in those states) reported on the threat, without much questioning. As a result, journalists who report of refugees did not provide the entire story and regularly “fell into propaganda traps laid by politicians.”45 This was also true, but in the opposite sense, for example, with the start of the Russian invasion into Ukraine, and the uptick of Ukrainian refugees resettling in Western Europe and the United States. Many of these Ukrainian refugees were referred to as “people like us,” “educated people,” and “of great quality,” often contrasting them to refugees from sub-Saharan Africa, the Middle East, or East Asia.46 Statements like this in the media support the ideas promulgated by (mostly right-wing) politicians, who see refugees from places like Syria, Gaza, Somalia, Yemen, and other places, those who are “not like us,” as threats to security and safety.

The final dramatic event that completed the transition of refugees to deviant populations was the election of Donald Trump as President of the United States. On 27 January 2017, shortly after he was sworn in, President DonaldTrump signed an executive order titled “Protecting the Nation from Foreign Terrorist Entry into the United States” – also known as the “Muslim Ban.” This order lowered the number of refugees to be admitted into the United States, suspended the


U.S. Refugee Admissions Program for 120 days, and suspended the entry of Syrian refugees indefinitely, in addition to banning travel from seven Muslim-majority countries.\textsuperscript{47} The Trump Administration used the fears of the previous terrorist attacks in the United States and in Europe to support its policies to reduce refugee resettlements and ban specific refugee groups altogether. The administration also attempted to link refugees to terrorism, leading to inflated fears and calls to restrict refugees from entering the United States.\textsuperscript{48} With these policy adjustments, Trump solidified the transition of refugees from dependents to deviants in the view of many politicians and in much of the general public. While many are starting to call out the racism and propaganda embedded in these bans, Donald Trump, now the presumptive Republican Presidential nominee for 2024, continues to double down on these ideas, stating as recently as November 2023 that he would again suspend the refugee resettlement program if reelected, and only reopen it for refugees who look like ‘us’ and promote “American Values.”\textsuperscript{49}

**Refugee Policies and COVID-19**

A new dramatic event that helped to shift refugees back towards dependent status was the COVID-19 pandemic. The COVID-19 pandemic drastically changed how many aspects of modern life functioned. Fears about the spread of the disease led to social distancing, face coverings, and overall restricted mobilization in many countries of the world. These mobility restrictions had a significant impact on refugee resettlement policies, especially in the United States.\textsuperscript{50} Viewed through a Political Economy of Migration Theory, the pandemic served as a

\textsuperscript{47} Executive Order No. 13,769, 2017.

\textsuperscript{48} Coleman, 2018.


catalyst to transform economies through a broad range of factors. Even refugees, who often bring little economic value immediately to their new countries, and whose lives are fraught with such dire economic difficulties, can create an impact through their resettlement (migration). The Political Economy of Migration Theory requires an examination of all aspects and levels of society, including state, commercial, and individual actors. Thus, it is necessary to “pay attention to power structures and relations and actor’s agency” to fully understand the impact of the pandemic. Through this analysis, the United States took different approaches to manage refugee resettlement during the pandemic, and all of the approaches had impacts on not just resettlement, but also on the health and well-being of refugees. Somewhat surprisingly, although many policies continued to limit refugees, COVID-19 did have the effect of pushing their social construction back towards dependent status.

The United States had traditionally been the leading country in refugee resettlement, with an average of nearly 96,000 refugee resettlements a year from 1980 to 2016. However, the U.S. resettlement policy was also one of the strictest and longest processes of any country, averaging


54 MPI, 2022.
over two years from identification to resettlement.\textsuperscript{55} Moreover, years could be spent in refugee camps, with many political, cultural, social, and economic factors considered, before individuals were “identified” for resettlement in the United States. Refugees hoping to be resettled in the U.S. had to be identified and approved through the United Nations High Commissioner on Refugees (UNHCR), then screened and interviewed, pass a background check, and then undergo a medical screening before being accepted for resettlement. Once approved, they were assigned to one of only ten resettlement agencies that is supported and funded by the U.S. federal government for resettlement. Those ten VOLAGs, or sub-contracted partners, were then responsible for finding a location for resettlement in the U.S. and assisting with the technical and logistical aspects of resettlement.\textsuperscript{56}

Before looking at the direct impact of the COVID-19 pandemic, it is also necessary to examine the other changes made to U.S. resettlement policies by President Trump, in addition to his “Muslim Ban,” before the pandemic began. United States resettlement numbers are set each year by presidential proclamation. From the passing of the U.S. Refugee Act of 1980 through the end of the Obama administration, the annual resettlement ceiling was set at an average of 95,500 per year.\textsuperscript{57} After Trump was elected president, he lowered the annual resettlement ceiling drastically to average only 35,750 per year during his four years in office.\textsuperscript{58} This dramatic decline started well before the pandemic and created challenges to refugee resettlement

\textsuperscript{55} Appleby, 2022.

\textsuperscript{56} The U.S. government only recognizes ten resettlement agencies who receive funding to support refugee resettlement activities. Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement.

\textsuperscript{57} MPI, 2022.

\textsuperscript{58} MPI, 2022.
throughout the United States. As a result of Trump’s policy changes and fewer refugees being resettled in the U.S., all nine resettlement agencies had to close offices, and by April 2019 “around 100 offices have either closed entirely or suspended their refugee resettlement program, a third of offices nationwide.”59 These closures were required because funding for resettlement offices is directly tied to the number of refugees resettled in a given year, thus the lower resettlement numbers led to less funding, which in turn, led to fewer resettlements. Trump’s limitations on refugee resettlement was basically a legalized extension of his aforementioned “Muslim Travel Ban” that sought to prevent individuals from Muslim majority countries from entering the United States. Due to the Trump administration’s gutting of the U.S. resettlement policy, the U.S. was no longer the leading resettlement country.60 As a result, when the COVID-19 pandemic hit, the refugee resettlement policies of the United States had already undergone a seismic shift.

When the World Health Organization officially announced COVID-19 as a global pandemic on 11 March 2020, governments faced many challenges to protect their countries and citizens. One attempt made by many countries to prevent further spread of the pandemic was to limit travel and close borders. These often “blanket” border closures prevented most refugee resettlements from occurring, even those who had already been identified, screened, and approved. This also led to some arguments that the pandemic closures were violations of international humanitarian laws, and organizations such as the UN and WHO called for using quarantines and health measures so that refugees could still be resettled in their destinations.


60 As a result, Canada emerged as the new country resettling the most refugees by 2018 (Jennifer Edmonds and Antoine Flahault, “Refugees in Canada during the First Wave of the COVID-19 Pandemic,” International Journal of Environmental Research and Public Health 18, no. 3 (2021). https://doi.org/10.3390/ijerph18030947).
rather than having them completely shut out and confined to locations that were not safe for their physical, mental, and emotional safety.\textsuperscript{61} Unfortunately, with all of the border restrictions in place, the UNHCR had no other option but to officially decide to temporarily suspend resettlement departures on 17 March 2020.\textsuperscript{62} With this temporary suspension, the UNHCR policies basically aided President Trump’s desired policies in the United States of limited refugee resettlements. All the while, President Trump continued to used fear during the pandemic to create policies that further restricted resettlement, including targeting refugees as potential health risks, security threats, and economic burdens. President Trump even willingly rejected and ignored a study by his own Department of Health and Human Services that showed the positive impact of refugees on the United States, in order to preserve the narrative of refugees as terrorists and threats.\textsuperscript{63}

The changes in resettlement policies in the United States had some major implications for the health and well-being of refugees. To begin with, the policy changes, coupled with the UNHCR’s temporary suspension of resettlements, created a situation where refugees were stuck in limbo, often in camps and unable to continue or finish their resettlement processes. This created major challenges to refugee health as many of the camps were extremely vulnerable to outbreaks of COVID-19 due to their overcrowding and poor medical infrastructures.\textsuperscript{64} Further,

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longer times in camps have been shown to increase overall health risks and increase poor health outcomes. The COVID changes also resulted in delayed family reunifications, possibly contributing to additional mental health issues.\(^{65}\) Although the precarious situation of refugees was present before the pandemic, all health issues, including physical health, depression, post-traumatic stress disorders, and other mental and emotional health concerns became more prominent and relevant in the COVID-19 pandemic both in camps and in resettlement countries.\(^{66}\) Within the United States, pandemic policies such as social distancing and stay-at-home orders also had a major impact on refugee health and well-being. Most refugees could not access health care providers due to closures, and although telehealth options were expanded, many resettled refugees did not have the ability to access virtual medicine. Even with those attempts to see patients virtually, more significant socio-cultural and structural barriers existed for refugees compared to non-refugees, such as language barriers, lack of access to interpreters, and lack of technological knowledge. All of the traditional barriers to health care that refugees already faced, such as language barriers, cultural issues, lack of insurance, and logistical barriers were further exacerbated by the pandemic.

Conversely, however, there were some policies during the pandemic that ended up benefiting refugees, at least to a degree. As a result of the pandemic, the Office of Refugee Resettlement (ORR) expanded the RMA program from eight months back up to twelve months, hoping to help give refugees more time to afford and access healthcare and become self-sufficient.\(^{67}\) Further, the United States congress passed the Coronavirus Aid, Relief, and

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\(^{65}\) Abu Alrob and Shields, 2022.


\(^{67}\) ORR, 2021.
Economic Security Act (CARES Act). This act allocated $350 million to provide services, including health care, for refugees both domestically and internationally. In addition, the need for medical workers due to healthcare employee burnout as a result of the pandemic, led to a collaboration where the International Rescue Committee identified foreign-trained refugee medical practitioners to see if they could meet requirements for temporary medical licenses, and help relived the overburdened healthcare force. Finally, the pandemic led to a rise in virtual medical appointments and telehealth. Although virtual appointments and telehealth were not widely used by refugees, when and where telehealth was available and accessible for refugees, studies showed that it did lead to fewer missed appointments, and fewer transportation and childcare issues. The pandemic also impacted resettlement agencies with the loss of funds and limited opportunities to make a difference virtually, since many of their responsibilities require hands-on assistance. Regardless, one major study did find that throughout the pandemic, U.S. resettlement agencies did continue to perform “admirably” despite the numerous issues.

The COVID-19 pandemic presented major challenges to refugees and resettlement policies. These challenges often resulted in fewer opportunities for refugees, and greater threats of poor physical and mental health. Overall, the global responses to COVID-19 largely neglected the health needs of refugees, especially in camps and detention centers. However, despite the agenda of the Trump administration (and helped by Trump’s defeat in the 2020 U.S. Presidential election), the U.S. tried to do whatever was possible to not leave refugees out in the cold, and

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68 Grant, 2020.

69 Grant, 2020.

70 Weith et al., 2022.

71 Moise et al., 2022.
they did have more success than many other countries. However, the global nature of the pandemic meant that many of the policy changes in the United States were similar to those in other countries. While the pandemic increased and exacerbated many of the issues resettled refugees in the U.S. faced, the pre-pandemic situation could be cited as the greater cause for additional barriers for refugees. In the end, the pandemic challenges did more to highlight the already present issues refugees faced in the country, while exacerbating the barriers to health care that were already in place and adding a few more.

**Refugee Policies under Biden**

After Joe Biden defeated President Trump in the 2020 presidential election, the view of refugees in the United States started to improve slowly and slightly, and currently the view of refugees in the United States is still fairly evenly split between dependents and deviants. The damage of the dramatic events also had some lasting effects on refugee health and health care policies, which have yet to fully be erased. In addition, these stigmatizing experiences caused refugees to illustrate another aspect of Schneider and Ingram’s theory, which claims that groups negatively constructed will see the government as a source of problems, rather than a source of solutions and assistance. Further, refugees see little motivation to mobilize because of the stigma, and they fear that if they did try to speak up or mobilize, they could lose what little benefits they still had, or worse, end up getting deported. Although the Biden Administration

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73 Schneider and Ingram, 1993: 345

has made strides in improving policies for refugees, he did keep some of the restrictive policies in place from the previous Administration. Biden often claimed his goal was to fix the broken resettlement system in the United States, but so far, not enough has been done to remedy the situation or to move refugees fully back to dependent classification. Unfortunately, the depth of the social re-construction under the Trump administration makes it likely that it never will fully return, as social constructions become increasingly important over time, and more difficult to refute. As a result, refugee resettlement and health care policies have not recovered to a level when most refugees can actually benefit from them.

**Sexual and Reproductive Health Policies**

Prior to 2022, most of the barriers to refugees’ sexual and reproductive health were similar to the general barriers to health care discussed above. One of the biggest issues refugee women face specifically concerning sexual and reproductive health is not being able to fully utilize traditional means that may have been common in their home cultures. Part of the reason for this is that these traditional means are often seen as strange, primitive, or inappropriate by American medicine and culture. An example of this is the tendency of refugees to desire large families and numerous children. After resettlement many refugee women are caught between their traditional beliefs of having large families, and the more American cultural ideal of smaller families and fewer children. This often leaves many refugees feeling forced to use contraception or other family planning practices that they may not wish to use. This is often the case because of the stigma that is attached to women in the United States who have numerous children. They are often viewed as lazy, promiscuous, poor, and relying on governmental assistance.


refugees are encouraged and expected to integrate into society as quickly as possible after resettlement, this pressure often leads refugee women to unwillingly reduce the number of children they desire or have. A second example of pre-2022 issues for refugee women is the desire for vaginal (natural) births. Many refugee women complain about having to deliver through cesarean section rather than naturally. Although the rates of cesarean section in refugee populations are unknown, they are estimated to be much higher than the national averages. These higher rates of cesarean section in refugee populations are often attributed to the lack of cultural competency by American practitioners, and to erroneous preconceived beliefs about black and refugee pregnancy outcomes, such as their lack of intelligence or knowledge about childbirth, the belief they will have larger babies, or that their babies will not be healthy. In addition, some refugee women lack trust in American medical providers and believe doctors in the United States try to find medical “problems” in order to “require” cesarean sections and thus charge more money. This reasoning also informed refugee women’s beliefs in the high rates of cesarean sections that were requested or required by doctors in the U.S. after resettlement. Abortion, while legal in the United States (pre-2022), was also a challenge for refugee women


due to access barriers such as cost, location, transportation, and understanding of the American medical infrastructure, as well as the negative stigma that was associated with abortion by many in the United States. While refugee women resettled in the United States, and in Tennessee specifically, are not monolithic, and come from many different countries and cultures, abortion is a more common and accepted form of family planning in many of their home countries.

Legal and policy aspects created more chaos in 2022, after the Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization*. The decision, which overturned *Roe* and *Casey*, and claimed that the U.S. Constitution does not confer a right to abortion and changed discourse on sexual and reproductive health dramatically. To begin with, states now controlled the legality of abortion, and many states quickly criminalized the procedure. Furthermore, access to contraception in general was threatened in Justice Thomas’ concurrence, where he argued: “In future cases, we should reconsider all of this Court’s substantive due process precedents, including *Griswold*…” referring to decisions on contraception.81 These political challenges will make it more difficult for any women in the United States to get family planning services. A recent research study in four U.S. States has already discovered evidence of this, finding statistically significant evidence that barriers to accessing contraception increased and high-quality contraceptive care decreased since the *Dobbs* decision.82

This potential attack on contraception is evidence that supports the fear of the Replacement Theory in the United States. The Great Replacement Theory contends that certain groups in the U.S. are attempting to replace white citizens with nonwhite “immigrants,” and the

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increased presence of immigrants (including refugees) in the United States will enable new nonwhite majorities to take control of national political and economic institutions, to dilute or destroy the United States’ distinctive cultures and societies, and eventually to eliminate the “native” white populations.\textsuperscript{83} Due to this belief, many policy makers and politicians are trying to limit reproductive choice in order to make sure the native population of the United States is not suffering from a decline. This is further supported by the fact that the United States is more than willing to help support family planning and contraception access abroad, through international aid, while further limiting access domestically.\textsuperscript{84} In fact, the United States is the most significant donor to international aid for family planning and contraception, being involved in more than 30 countries, especially countries that are politically unstable, which often account for situations creating the refugees that resettle in the United States.\textsuperscript{85} Thus, increasing and improving access to family planning and contraception in the developing world, while believing that increasing the domestic population by increasing birth rates, limiting access to contraception and family planning, and severely punishing and restricting abortions will help guarantee the survival of “traditional” populations that are “American.”\textsuperscript{86}

Women, who make up a majority of resettled refugees and are one of the most vulnerable groups, face these plus additional barriers, and now may be more fearful that accessing such

\begin{thebibliography}{9}
\bibitem{Pelikanova} Kristyna Pelikanova, Family Planning in the Development Policy of the United States: Empowering Women or Instrumentalization of Women’s Bodies? Master’s Thesis; Praha, 2024.
\end{thebibliography}
Services could affect their refugee status in the United States. Unfortunately, resettlement services and organizations “seldom acknowledge the experiences of refugee women and their need for services to be provided,” and they often leave any health-related discussions or questions to healthcare providers. Although these issues are widespread, there is no justification for limiting the rights of refugees or denying the fact that all people deserve equitable access to contraception and family planning services.

The most direct result of the Dobbs decision deals with access to, and legality of, abortion. After the decision was made, many states had “trigger laws” that went into effect banning abortion (usually very early in pregnancy, and often essentially resulting in an outright ban), and others quickly passed laws to do the same. This further reduced access to sexual and reproductive health for refugee women, many of whom had enjoyed access to abortion in their home countries as a natural and reproductive health right. According to the Center for Reproductive Rights, nearly 60% of reproductive-age women worldwide live in countries where abortion is broadly legal (including Ukraine, Colombia, and Rwanda – three countries where a large number of refugees to Tennessee arrive from), and since 1994 over 60 counties have liberalized abortion laws (including the Democratic Republic of the Congo, Bhutan, and Ethiopia – three more countries where the majority of refugees resettled in Tennessee arrive from), while only four (El Salvador, Nicaragua, Poland, and the United States) have reduced access and rolled

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87 Studies have shown that women make up a majority of resettled refugees, with some showing that more than 80% of the world’s refugees are women and their dependent children (Pittaway and Bartolomei, 2001: 21).


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back legality. In general, the *Dobbs* decision overturned the established and preecedent rights of abortion that were enshrined under the *Roe v. Wade* decision. This overturning of *Roe* completely eliminates the option of abortion as a means of family planning and public health in many states, including Tennessee.

This was codified in Tennessee on August 25, 2022, when the Tennessee “trigger law,” officially the *Human Life Protection Act*, went into effect. Although the law does not criminalize women or pregnant people who seek and abortion, it criminalizes performing or attempting to perform an abortion, resulting in a near-total abortion ban. This is significant because not only are their higher maternal and child fatality rates in states where abortion is banned, these “trigger laws” also often create unclear policies and leave pregnant women in situations where neither they, nor their healthcare providers, know what they are allowed to do. A 2023 study on the post-*Dobbs* trends in states like Tennessee found that unclear legal risk “chills the availability of abortion care and healthcare more broadly.” In addition, although refugees have permanent residence status and rights after resettlement, these laws heighten the fears of further ostracism, or worse, deportation for not fitting in or conforming to U.S. customs and laws. In fact, a 2024

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90 In Tennessee there is a six-week gestational ban, and only a licensed physician can perform an abortion. The only exceptions to the ban are limited medical emergencies, such as molar or ectopic pregnancies, to remove a miscarriage, to save the life of the mother and “prevent serious risk of substantial and irreversible impairment of a major bodily function of the pregnant woman.” Tennessee’s abortion ban provides no exceptions for fetal abnormality, incest, or rape. See: Anita Wadhwani, “Gov. Bill Lee Signs Law Carving out Narrow Exceptions to Tennessee Abortion Ban.” *Tennessee Lookout* (2023, 28 April). [https://tennesseelookout.com/2023/04/28/gov-bill-lee-signs-law-carving-out-narrow-exceptions-to-tennessee-abortion-ban/](https://tennesseelookout.com/2023/04/28/gov-bill-lee-signs-law-carving-out-narrow-exceptions-to-tennessee-abortion-ban/).


study found that women who were born outside of the United States have reported lower levels of recent contraceptive care and lower levels of using preferred contraception in the post-Dobbs period.93 Even if it is not a felony for the mother to seek or get an abortion under the new law, it could lead to other issues or charges, such as being an accessory to a crime. Sadly, in Tennessee there is already a tradition of legal attacks on pregnant women. Tennessee (along with Alabama and South Carolina) led the nation in arresting and criminally punishing women for allegedly posing a danger to their fetuses well before Roe was ever overturned.94 This fear of possible deportation for refugees due to “criminal” activity has increased in recent years, especially after the Trump Administration deported hundreds of Iraqi refugees because they never completed their naturalization process, and committed a crime.95 More recently, in late 2021 a U.S. judge ruled that an Iraqi refugee was eligible to be deported for simply lying on his immigration papers.96 Overall, while the ultimate impacts and consequences of Dobbs v. Jackson will take years to fully play out, the implications and fears caused by it have already created a chilling effect on all reproductive and family planning rights, but especially for vulnerable resettled refugees.

In addition to the trigger law and history of legal attacks on pregnant women, Tennessee has a poor track record of availability of care, and it has also started to limit or restrict access to


95 Campana, 2019.

contraception and family planning outside of the abortion context. As of the end of 2022, over 45% of Tennessee counties (43 out of 95 counties) were classified as “Maternity Care Deserts,” defined as having no hospitals providing obstetric care, no birth centers, no OB/GYNs, and no certified nurse midwives.\textsuperscript{97} Tragically, the state also lost around $7 million when the federal government withheld Title X family planning funds from the state for not being in compliance with federal regulations surrounding the funds. This made Tennessee, at the time, the only state in the U.S. not receiving Title X funding.\textsuperscript{98} The situation in Tennessee became even more volatile in February of 2024 when the Tennessee House of Representatives Population Health Subcommittee took up proposed HB 1985. This bill sought to expand abortion restrictions, making it a crime to “recruit, harbor, or transport a young person to help them obtain abortion care or abortion pills.”\textsuperscript{99} This bill, known as the “Abortion Trafficking” bill, has currently passed subcommittees in both the Tennessee House and Senate, and is quickly working its way to being passed in both chambers. If the bill passes and is signed into law, it would add to the potential criminal offenses that could be issued for simply driving a minor to an appointment. The vagueness of the bill, however, would also cause many to refrain from assisting in any or all sexual and reproductive health actions or appointments for fear of possible prosecution. As for refugees, this could mean the loss of benefits or even deportation.


Further adding to the confusion and fear surrounding Tennessee policies on sexual and reproductive health, in March of 2024, the Tennessee House of Representatives subcommittee also failed to advance a bill meant to protect access to contraceptives and family planning. The bill (HB 1943) was referred to as the “Tennessee Contraceptive Freedom Act,” and was drawn up and introduced as a way to make sure families could access family planning care and contraception in Tennessee, which had been feared to be under attack since the *Dobbs* decision. This fear was confirmed when ProPublica reported that a Tennessee lawmaker spoke about the possibility of regulating contraception and invitro fertilization after a few years, during a webinar by the Tennessee affiliate of the National Right to Life organization. In addition to creating language in the state code that would require licensed healthcare providers to provide contraceptives and information on contraception, or referrals to providers who can, it also would have required health insurance carriers and public health agencies to ensure affordable access to contraceptive methods for all consenting people. This bill would have helped to eliminate some of the confusion and fear created by Tennessee’s trigger law, and the aforementioned HB 1895/SB 1971. However, the inability of this bill to make it out of subcommittee (it failed along party lines in the supermajority Republican Tennessee State House of Representatives Population Health Subcommittee – a committee that includes two physicians who voted against


only added to the fears in Tennessee that restrictions on contraception and family planning services could become a reality in the near future.

**Sexual and Reproductive Health and the U.S. South**

The intersections of race and gender, and policy and discourse have further implications for refugee women in the U.S. South. The history of medicine and health care in the United States is marked by racial injustice, and this injustice is more prominent in the South. The history and legacy of slavery, Jim Crow, and the Tuskegee Study all highlight these racial injustices. Further, the work of James Marion Sims, often considered the founder of U.S. gynecology, came to many of his discoveries by experimenting on enslaved black women without their consent. These traumatic memories haunt both gender and racial experiences in the South, and are still an issue today. African Americans in the South are still concerned about the healthcare they receive, and believe that providers are more likely to withhold information about their health care. Further, physicians and non-physician healthcare workers, especially in the South, were shown to have more implicit and explicit prejudice against Blacks and Arab-Muslims than the general population in a recent study. Race is also still used in tools, formulas, and algorithms that

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102 The two committee members who are physicians who voted against the bill were Dr. Bryan Terry, R – Murfreesboro, and Dr. Sabi “Doc” Kuman, R – Springfield. Two other bills also failed in the same committee on the same day. The first (HB1626/SB1590) attempted to repeal the existing state abortion ban. The second (HB2227/SB1918) sought to clarify that the term “abortion” does not include contraceptives or other devices and procedures used to prevent pregnancy.


adjust or “correct” their outputs based on patient’s ethnicity or race. This has led to practitioners denying black patients access to certain treatments and diverting resources away from black patients.\textsuperscript{106} Finally, the South is also seeing challenges to other sexual and reproductive health services, such as in vitro fertilization. On February 16, 2024, the Alabama state Supreme Court issued a decision which held that stored embryos are afforded the same legal protection as children under the state’s Wrongful Death of a Minor Act of 1872.\textsuperscript{108} Decisions such as these continue to put the sexual and reproductive health of all women, especially those most vulnerable, under threat. These challenges and burdens have also led to racial and ethnic minorities experiences greater gaps in care and coverage, and specifically greater burdens of unintended pregnancy in the U.S., further supporting the need for improved refugee access to family planning.\textsuperscript{109}

The South is also the location of the majority of states that did not expand Medicaid under the Affordable Care Act, as eight of the twelve states that did not expand Medicaid are located in the U.S. South.\textsuperscript{110} Since refugees often rely on Medicaid for health care – especially after the expiration of their Refugee Medical Assistance – many refugees in the South have a


\textsuperscript{110} Matthew Buettgens and Urmi Ramchandani, 3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility, (Urban Institute. United States of America, 2022).
higher likelihood of interrupted healthcare coverage and are more likely to be uninsured completely.\textsuperscript{111} Overall, states that did not expand Medicaid end up with more refugees not obtaining health insurance and in Tennessee specifically, a Case Manager from the Tennessee resettlement agency Bridge Refugee Services echoed this, saying that the lack of Medicaid expansion in Tennessee is a “major barrier” for refugee clients, and one of the biggest obstacles the organization is fighting to overcome.\textsuperscript{112} More specifically, studies have shown that there is a significant increase in contraception use among women living in states that expanded Medicaid, including increases in long-acting reversible contraception (LARC), which have traditionally been shown to be more successful.\textsuperscript{113} Thus the lack of Medicaid expansion not only serves to limit refugee access to healthcare in general, but it also leads to refugee women, and all women in Tennessee, having lower utilization of contraception and other family planning services.

\textbf{Conclusion}

In the end, refugee women in Tennessee face multiple discriminations around reproductive healthcare access. The unique aspect of their situation is not simply that they face discrimination and rights abuses – many women in general do as well – but rather that they are more vulnerable as a result of numerous factors related to their position as refugees.\textsuperscript{114} They have


been hampered by the politics and policy narratives that have created fear, inequality, and “othering.” Although there has been a shift back towards the “dependent” status for refugees, the negatives views and narratives established by politicians have impacted Americans’ perception of refugees. As political scientist Murray Edelman argued, once the policy inequalities are established, even if through “untrue” policy narratives, they are likely to continue, and to be reinforced by symbols, actions, and concepts.\footnote{Murray Edelman, \textit{The Politics of Misinformation}, (Cambridge: Cambridge University Press, 2001).} Indeed, when the negative framing of a group becomes strong, individuals are unlikely to support policies that benefit that group, or even to allow them to regain their previous position in society fully.\footnote{Benjamin R. Knoll, David P. Relawsk, and Howard Sanborn, “Framing Labels and Immigration Policy Attitudes in the Iowa Caucuses: Trying to Out-Tancredo Tancredo,” \textit{Political Behavior} 33, no. 3 (2011): 433-454.}

Unfortunately, then, refugee women are often “triply marginalized” due to economic, racial or ethnic, and gender issues.\footnote{Jessica R. Goodkind and Zermarie Deacon, “Methodological Issues in Conducting Research with Refugee Women: Principles for Recognizing and Re-Centering the Multiply Marginalized,” \textit{Journal of Community Psychology} 32, no. 6 (2004).} Access to sexual health services and information is critical to achieving the highest possible standard of sexual health, and enabling legal evnironments are key for progress in these areas.\footnote{Laura Ferguson, Sarah Emoto, and Sofia Gruskin, “Laws Governing Access to Sexual Health Services and Information: Contents, Protections, and Restrictions,” \textit{Sexual and Reproductive Health Matters} 32, no. 1 (2024). \url{https://www.tandfonline.com/doi/epdf/10.1080/26410397.2024.2336770?needAccess=true}.} Unfortunately, Tennessee does not provide the enabling legal environment that refugees – or women in general, for that matter – need for sexual and reproductive health. Rather, policies and narratives on refugee resettlement, status, and healthcare all combine to limit sexual and reproductive health resources for refugee women. When combined with the restrictive sexual and reproductive healthcare policies and the general barriers faced by all refugees, such as language, cultural, logistical, and geographical barriers,
refugee women in Tennessee are fighting an uphill battle just to get access to the sexual and reproductive health care they need and deserve as a human right. Refugee resettlement and healthcare policies in the United States, and in Tennessee in particular, create a dire situation that prevents refugee women in Tennessee from having access to the contraception, abortion, and family planning services that are essential to prevent unplanned pregnancies. Preventing unplanned pregnancies is a reproductive and health justice issue, and an effective way to increase the health and quality life of resettled refugee women. Unfortunately, the current policies and political discourse in Tennessee (and in the United States in general) makes it likely that the situation will only continue to get worse, before it can improve.
6. Case Study 1: **Family Planning Knowledge and Practices of Tennessee Refugees.**

**Introduction**

This study was designed to look at refugees in Tennessee to see how their knowledge, access, and experiences with family planning compares to refugees in other studies. The main goal was to determine the major barriers that refugee women face in accessing contraception, family planning, and other sexual and reproductive health services after resettling in the U.S. state of Tennessee. It is important to understand the barriers and challenges of refugees in Tennessee so that culturally relevant and community informed plans, practices, and procedures can be put into place to improve refugee knowledge of contraception and family planning, increase their access to family planning methods, and expand the use of those methods to help reduce unintended pregnancies in this vulnerable population.

**Background**

Resettled refugee women are a group that are particularly vulnerable to healthcare barriers, especially regarding maternal health, including access to, and use of, family planning methods, which are constantly shown to reduce unintended pregnancies. ¹ In the United States in general, and in Tennessee in particular, there is a major hole in the public health literature concerning refugee women, unintended pregnancy, and family planning. As a result, data and information from the larger United States must be used to better understand the issues.

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Maternal mortality is responsible for roughly seventeen deaths per 100,000 pregnancies in the United States.\(^2\) Although there is limited data on resettled refugee women in the United States, some additional studies have shown that migrant and refugee women (in countries throughout the world) have a higher risk of maternal mortality than mothers from the host countries.\(^3\) In fact, Public Health researcher Grete Pedersen and her team determined that as many as nine additional maternal deaths per 100,000 (a 53% increase) were found within these populations.\(^4\) Research in other Western countries has also shown that refugees from lower income countries have higher unmet contraceptive needs, which also leads to more unplanned or unwanted pregnancies.\(^5\)

Within the United States, a growing number of refugees come from Sub-Saharan Africa. In 2019, Refugees from the Democratic Republic of Congo far outnumbered those from other countries.\(^6\) This trend is also mirrored in Tennessee, with the Tennessee Office for Refugees


reporting that over 58% of refugees in Tennessee since 2017 have been resettled from countries in Sub-Saharan Africa, with a majority of them coming from the DRC. With such a large number of resettled refugees being black, and specifically from Sub-Saharan Africa and Caribbean countries that tend to reflect the traditional percentages of black Americans, and the holes in the maternal health and unintended pregnancy literature for Tennessee, national data disaggregated by race provides information that can substitute for specific data. According to the 2019 PRAMS report, birth and fertility rates for 2019 are very similar between the U.S. in general, and Tennessee as a state (birth rate 11.4 for U.S. and 11.8 for Tennessee; fertility rate 58.3 for U.S. and 60.3 for Tennessee). The nationwide rates by race, on the other hand, show that black women in the U.S. have significantly higher birth and fertility rates than white women (13.4 compared to 9.8, and 61.4 compared to 55.3 respectively). Further, Tennessee had a noticeably larger rate of unintended pregnancies (31.1%) than the average U.S. rate (25.8%). The fact that nearly 65% of resettled refugees in Tennessee are of Sub-Saharan African or Afro-Caribbean descent, that women in Tennessee have higher unintended pregnancy rates than the U.S. average, and that black women in the U.S. have higher birth and fertility rates than white women all point to the conclusion that the unintended pregnancy rates of resettled refugee women in Tennessee, although missing in scholarly literature and research, are likely quite high.

In addition to race and country of origin, many refugee women are younger, have lower income levels, and have less education than women in their countries of resettlement. Much research points to younger women, lower-income women, and women with less educational

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attainment, having higher incidences of unintended pregnancies.\(^9\) Recent and current trends in the United States show that unintended pregnancies generally decrease as age, income, and educational attainment increase, thus pointing to more opportunity for refugee women to experience unplanned pregnancy.\(^10\)

Finally, research has shown that refugee populations have high pregnancy rates, especially in their first three months of resettlement, possibly due to feelings of comfort, security, or relief.\(^11\) In addition, they often have little knowledge of available contraception options, or where to obtain them. Unintended pregnancy rates are high across the world, and unmet contraception needs are one of the major barriers to reducing unintended pregnancies, especially in refugee populations. A further study by Canadian physician Marina Aptekman and colleagues showed that unmet family planning needs “are higher in refugee populations owing to lack of access to contraception, lack of knowledge about various methods, and having other priorities.”\(^12\) As a result, it proves challenging to ensure that resettled refugees have access to, and proper knowledge and understanding of, family planning practices, due to the structural barriers, language and cultural barriers, social isolation, personal financial and insurance issues,


\(^12\) Aptekman et al. (2014), e618.
transportation challenges, discrimination, and an overall difficulty in understanding the healthcare system in the United States.¹³

**PERCENT OF UNMET CONTRACEPTION NEED (2019)**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent Unmet Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>17</td>
</tr>
<tr>
<td>United States</td>
<td>15</td>
</tr>
<tr>
<td>Latin America</td>
<td>15</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>26</td>
</tr>
<tr>
<td>South Asia</td>
<td>32</td>
</tr>
<tr>
<td>West Asia</td>
<td>40</td>
</tr>
<tr>
<td>Refugees</td>
<td>40</td>
</tr>
</tbody>
</table>

*Figure 6: Percent of Unmet Contraception Need (2019)*¹⁴

**Research Questions**

In order to address the particular difficulties and vulnerabilities that this underprivileged group faces, their participation is crucial.¹⁵ The best way to approach such a situation, and to get their participation is to ask them directly in a needs analysis survey. As a result, this needs analysis survey was developed to determine what refugees themselves see as the most significant barriers to their ability to access family planning and contraception services in Tennessee. The specific research questions developed asked what barriers and challenges refugees face when

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attempting to access and use different family planning methods, which barriers are the most challenging to overcome, and what role male partners play in the family planning decision making processes of refugees resettled in Tennessee. By understanding the perspectives of refugees themselves, it will be possible to better understand how they experience the barriers that they face when trying to access family planning services, and what steps can be attempted to overcome those barriers.

**Methods**

This study used an online survey designed through Qualtrics to collect the anonymous and confidential responses of participants regarding the knowledge, opinions, feelings, and access to family planning methods of resettled refugees living in Tennessee. The survey was open to participants who identified as both women, as the primary users of family planning methods, and also from men, as partners and spouses. The study was open to any individuals who were resettled in the United States as refugees, were at least 18 years old, and who lived in Tennessee at the time of the survey. The survey was only available in English.

The survey started with some questions that were specific to the participants, including basic demographic questions (age, location, gender, etc.), questions about family characteristics (number of children, size of family, relationship status, etc.), basic education, employment and income questions (education level, current employment, family income level, etc.), home country before resettlement, who they resettled with (spouse, children, etc.), current pregnancy status, and religious identification. The survey then asked a series of questions about participants’ experiences in the US, including ideas on inclusion, acculturation, work, and connections. The third section asked questions about English language abilities and knowledge and understanding of U.S. politics. Questions in section two and three were adopted from the Immigration Policy
Lab’s “IPL-12,” which is designed to measure levels of integration across immigrant and refugee communities. The fourth and fifth sections of the survey asked questions about family planning (birth-spacing) experiences of the respondents directly. These included questions on their knowledge and opinion of different family planning and contraception methods, their understanding of how to access different methods, and their perceived partners’ views on different options and methods.

The survey was designed to have minimal risks to the participants. The risks or discomforts of participating in this research included being asked questions of a private and sensitive nature, which could be distressing to some participants. There are no direct physical risks for participating in the survey. Some examples of possibly distressing topics were: (1) Discussing information about reproductive practices and prevention, (2) discussing opinions on family and partner participation in family planning, (3) discussing information about culture and religion in relation to reproductive health and practices. There was also some possibility of shame or embarrassment from answering questions about reproductive practices and health, and possible feelings of regret or remorse for previous family planning and reproductive decisions. All risks had only a slight probability and were very unlikely to be severe. The duration of the risks did not last much longer than while taking the survey. Participants were encouraged to take the survey in a private location, and on a secure or personal device to reduce risks. In addition, participants could skip any question they are uncomfortable answering and may quit the survey at any time without any repercussions. Finally, participants will be provided the contact

information for the University of Memphis IRB, and for the PI and his faculty advisor, should they have any need to discuss any potential risks.

**Recruitment**

Recruitment was done through local refugee resettlement agencies in Chattanooga, Knoxville, Memphis, and Nashville. Directors and case workers sent emails to prospective participants and passed on information through word-of-mouth recruitment. In addition, all of the local resettlement agencies were provided flyers with a brief overview of the survey, a link to the survey, a QR code for survey access, and the contact information for the PI and his faculty advisor for questions. Social media was also used for recruitment purposes. Posts were made on the Facebook pages of the local resettlement agencies with information about the survey, and a link to access the survey. In addition, a tweet was posted by the PI and the local resettlement agencies' “X” (formerly Twitter) accounts, with information about the survey and a link to access the survey. Finally, all participants were asked to pass on the link to any other qualified individuals to generate some snowball recruitment from the participants. The recruitment and response period ran from 1 April 2022 until 1 December 2023.

**Results**

The research survey opened on 1 April 2022, which was notably before the U.S. Supreme Court Decision in the *Dobbs v. Jackson Women’s Health Organization* decision that overturned *Roe v. Wade*. There was the potential that the decision in *Dobbs* may affect the survey results, however no responses were recorded before the *Dobbs* decision on 24 June 2022.\(^\text{17}\) After the *Dobbs* decision, the survey remained open until 1 December 2023, and only received one

\(^{17}\) There was also the potential that the “leak” of the *Dobbs* decision, which occurred on 2 May 2022, may have affected results, but again, no responses were recorded before the leak.
response. The sole response was from a married female refugee from Ukraine, who was resettled in Knoxville, Tennessee in May of 2022. Although a single response does not provide much data, it still provides some information on refugee access to family planning services.

The sole respondent was a married female, aged 30-39, who identified as atheist. She was resettled with a child, while her husband stayed behind in Ukraine to fight in the war with Russia. Although she clearly stated that her husband was still in Russia so “questions about planning pregnancy is really not for me,” she completed all parts of the survey. The respondent indicated that while she was “extremely familiar” with condoms as a method of family planning, and “slightly familiar” with oral contraception pills, she was not familiar with any other methods of family planning. She also indicated that she had never used any family planning method except for condoms and emergency contraception. Her overall lack of familiarity with other methods, such as implants, injectables, IUDs, and patches, aligns with some of the literature on refugees being unaware of long-acting reversible contraception methods.\textsuperscript{18} In addition, the respondent has healthcare coverage through Medicaid, and obtained information about contraception and family planning from her primary care physician, but also noted that as a refugee, it was “extremely difficult” for her to see a doctor in the United States.

The respondent indicated that the single greatest barrier to accessing and using family planning and contraception methods was her own personal beliefs. Out of eleven different types of family planning or contraception methods, the respondent only found oral contraception pills to be “moderately acceptable” and condoms to be “very acceptable.” The other options,

\textsuperscript{18} Zelalem B. Mengesha, Janette Perz, Tinashe Dune, and Jane Ussher, “Challenges to the Provision of Sexual and Reproductive Health Care to Refugee and Migrant Women: A Q Methodological Study of Health Professional Perspectives,” \textit{Journal of Immigrant and Minority Health} (2018); Aptekaman et al. (2014).
including IUDs, implants, injections, natural methods, and permanent methods (among others) were viewed as “not acceptable” personally by the respondent. For this single respondent, personal beliefs outweighed cultural, religious, partner, and family beliefs, as well as transportation, cost, insurance, and language barriers, when it came to accessing and utilizing family planning and contraception methods.

Finally, the respondent indicated that her partner was “somewhat involved” in the family planning decision making process. This aligned with her desire to have her partner “somewhat involved” in the process, and her perception that he would like to be “somewhat involved.” This was reflected in her response that her partner would only find condoms acceptable as a family planning method, while he would find all other methods “not acceptable.” It is important to point out, however, that the respondent stated that her husband was still in Ukraine, and that family planning and pregnancy were not of concern to her at the present.

**Discussion**

The aim of this survey was to better understand the knowledge and utilization of family planning and contraception services by refugees resettled in Tennessee. With only one response to the survey, there is only very limited information that can be gathered. However, the limited responses to the survey actually speak to a larger issue concerning refugee access to and utilization of family planning services in Tennessee: the religious affiliations of resettlement agencies and nonprofits.

All four of the federally recognized and supported resettlement agencies in Tennessee have religious affiliations. Although the religious affiliations vary (Episcopal, Evangelical, and

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19 The U.S. government only recognizes ten resettlement agencies who receive funding to support refugee resettlement activities. Those ten agencies then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement. Nine of the ten agencies are religious/faith-based organizations (eight
Catholic), they are all Christian and all have religiously influenced views on contraception, which usually does not allow for freedom of family planning choice. This is especially true within Catholicism, which prohibits all birth control methods, sterilization, abortion, some miscarriage management techniques, and oral emergency contraception pills, even for pregnancy as a result of sexual assault.20

Since all of the resettlement agencies in Tennessee are connected to, and funded by, religious organizations, they often ignore or refuse to even discuss contraception or sexual and reproductive health. This is significant because the “complex environment of pressures” put on practitioners leads many of them to not routinely providing information or referrals for sexual and reproductive health needs, and they rarely directly help refugee women regarding family planning or contraception.21 In addition to the official resettlement agencies in Tennessee, there are six additional nonprofit organizations and four health clinics (within hospitals) that are dedicated fully, or in large part, to assisting refugees. Of these ten organizations, half of them (three nonprofits, two health clinics) are also faith-based and have direct connections to, and funding from, Christian religious denominations. In fact, a majority of all hospitals in Tennessee are religiously affiliated, thus adding more barriers. Since Catholic hospitals must follow the

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aforementioned ERDs, they often do not provide common reproductive services that are critical to women’s sexual and reproductive health, and are creating an environment that is less safe than other medical settings.\textsuperscript{22}

An additional religious issue arises outside of the hospitals and health care centers. Officially, in Tennessee, in order to have “access” to the resettled refugees, all of the organizations must be aligned with the four resettlement agencies, so even if they are not explicitly a faith-based organization, they must at least be aware of the opinions and directives of the church-based resettlement agencies. Technically, all of the nonprofit organizations must be non-proselytizing to secure their government funding and relationships, but most of the organizations avoid any conflict over contraception and family planning by simply not discussing it, so that their religious beliefs do not appear to be influential. Rather, they just direct any health care concerns from their clients to the health clinics or hospitals, who are arguably less-directly influenced by their religious positions, unless they are a Catholic hospital or clinic, as noted above. This became a major issue in this study as early as the recruitment phase. Many of the refugee resettlement agencies and refugee-serving nonprofit organizations in Tennessee were unwilling to assist in recruitment because of their religious affiliations.

In order to reach refugees to partake in the survey, it is necessary to get assistance from the resettlement agencies and nonprofits. Officially, the resettlement agencies and their affiliates are the only organizations who are aware of who has refugee status. Once a refugee is resettled, their main goals are to learn English, obtain employment, and become self-sufficient, and therefore many do not openly describe themselves as refugees. Thus, the resettlement agencies,

\textsuperscript{22} Lori Freedman, \textit{Bishops and Bodies: Reproductive Care in American Catholic Hospitals}, New Brunswick, New Jersey: Rutgers University Press, 2023.
and to a lesser degree the refugee-serving nonprofits, serve as a gatekeeper to interaction with resettled refugees.

During the recruitment process for this study, most of the resettlement agencies, nonprofits, and hospitals were unwilling to assist or support the distribution of the survey because of their religious affiliations. Each of the fourteen organizations (four resettlement agencies, four hospital-based clinics, and six refugee-serving nonprofits) were contacted about assisting in recruitment and distribution for the study. Of the fourteen organizations, only one was willing to assist. Unfortunately, even the one organization that agreed to help eventually stopped responding. The sole organization that was willing to help was one of the resettlement agencies, whereas the other three resettlement agencies did not respond to multiple requests for meetings or assistance. Two of the four health clinics responded that they were unwilling or unable to help in distributing the survey. One of the two cited religious objections to assisting, while the other noted logistical reasons. Finally, four of the six refugee-serving nonprofits in Tennessee responded that they were unwilling to support the distribution of the survey, while the other two never responded. Of the four who were unwilling, two cited religious beliefs and affiliations preventing them from discussing contraception and family planning with clients, one indicated that it was not “aligned with the mission” of their nonprofit, and the fourth considered assisting, before responding that they would not be willing to help, without providing any additional information. After the struggles to get assistance in the distribution of the survey, local food markets in refugee neighborhoods in Nashville were approached and asked to display a

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23 The health clinic citing logistical reasons noted that it was a teaching and research hospital, and in order to participate by discussing or disseminating the survey with patients, it would have to be approved by their own, internal IRB board, and that the IRB approval from the University of Memphis, obtained by the PI for the study, would not be enough.
flyer for the survey. All six of the markets approached were more than willing to hang the information in their stores, however, this survey advertising did not appear to reach any willing participants.

Due to the refugee resettlement agencies and other refugee-serving organizations not being willing to assist in the recruitment and distribution, it was extremely difficult to reach refugees in Tennessee to even make them aware of the survey. These attempts to reach refugees for this survey on family planning and contraception were further limited in June 2022 after the Dobbs decision was released. After the Supreme Court overturned Roe, a “trigger law” went into

Figure 7: Willingness to Distribute Refugee Family Planning Survey

Data gathered from recruitment emails, phone calls, and discussions.
effect in Tennessee that essentially banned all abortions, but also threatened other aspects of sexual and reproductive health in Tennessee. Thus, support for a research study on family planning and contraception (especially one that discusses abortion) was even more difficult to find. In addition to the trigger law, Tennessee also lost around $7 million when the federal government withheld Title X family planning funds from the state for not being in compliance with federal regulations surrounding the funds (however the Title X funds were eventually directed to Tennessee through a federal grant given to Planned Parenthood of Tennessee and North Mississippi).25 All of these political concerns in Tennessee over abortion, contraception, and family planning, added to the religious objections from the resettlement agencies and nonprofit organizations created a climate of hostility towards any research or discussions about family planning and contraception access and utilization, and all contributed to the poor number of responses to the research survey.

**Strengths and Limitations**

The major strength of this research is that it is the first and only known survey directly asking refugees in Tennessee about their knowledge and use of family planning services. There is a dearth of research and literature on refugees in Tennessee in general, but especially when looking at healthcare and access to services. Although this survey had very limited responses, getting information directly from the perspectives of refugees provides an opportunity to get the most accurate and authentic information. Furthermore, the research uncovered and highlighted a potential additional barrier to refugee family planning services that has not been thoroughly examined.

Unfortunately, this study has many limitations, but they should not take away from the larger overall theme that helps to explain some of the limitations. First, the major limitation is the extremely small response rate for the survey. Any survey with only one response does not provide a data set that can be of much value. A second limitation of the study is the fact that it was only made available in English, which was unavoidable due to funding and time. While one of the main goals for refugees is English language learning, and many possess at least moderate English skills upon arrival, the survey not being available in their native languages, especially since it contains medical and technical terminology, may serve as a further deterrent to participation or understanding. The survey could also suffer from limitations due to the fact that respondents were reflecting on past experiences, so recall bias could possibly exist. Self-reporting questions can also lead to response bias, such as social desirability bias. Although these limitations are possible, with only one response to the survey, the most significant limitation is that of the small sample size, and the religious bias that led to the lack of dissemination and support of the survey.

**Policy Implications**

As a result of this study and the challenges in recruitment and participation, a few opportunities for policy have emerged. To begin with, it is important that refugees have access to nonprofits and health clinics that are secular to provide more culturally and religiously competent assistance. Although recently the largest number of refugees resettled in Tennessee come from the Democratic Republic of Congo, which is a Christian country, over 70% of refugees resettled in Tennessee from 2002-2022 have come from countries that are a majority religion that is not Christian.\(^2^6\) In fact, four of the top five, and seven of the top ten countries

represented in refugee origin are non-Christian countries, including Myanmar (majority Buddhist country, but may refugees come from the Muslim Rohingya populations), Iraq (majority Muslim), Somalia (majority Muslim), and Bhutan (Buddhism). Thus, over two-thirds of the individual refugees resettled in Tennessee are placed by a resettlement agency that does not share their religious affiliation, and they must rely on nonprofits and hospitals who do not share their religious (and as a result, often cultural) views. This is extremely significant for all aspects of resettlement and acclimation, but especially for healthcare, which often has very religious and cultural foundations. The governments of both the United States, and the state of Tennessee, need to be more proactive in supporting and funding organizations that serve refugee populations that are secular in their beliefs and missions, to better help resettled refugee women obtain the family planning and contraception care they need from a location that will not judge or restrict them based on their religious beliefs.

**Conclusions**

Although this research study had many noticeable limitations, those limitations should not obscure the fact that some conclusions can still be developed. The ability to access refugees to better understand their lives and situations is a significant way to try to provide better assistance and interventions to improve their lives. Refugee women, in the social, cultural, and political climate currently present in Tennessee, are experiencing many threats to their sexual and reproductive health, in addition to the general health and security threats that are ever-present with resettling and starting a new life in a new, foreign land. Unfortunately, the most concrete conclusion from this research study implicates the agencies and organizations that should be reducing barriers as those constructing them. The resettlement agencies, health clinics, and nonprofit organizations in Tennessee, which are specifically designed to help refugees,
are among some of the greatest barriers themselves, due to religious affiliations and politics, when it comes to refugee women in Tennessee accessing contraception and family planning services.
7. Case Study 2: Refugee Healthcare and Service Providers: Perspectives on Family Planning

Introduction

This study was designed to look at the barriers refugees in Tennessee face when trying to access family planning and contraception services, as seen through the eyes of the practitioners who assist them. The main goal was to better understand the barriers and challenges practitioners observe refugee’s experiencing, and to better understand how practitioner’s expertise can help alleviate or expand the barriers. It is necessary to understand the perceived barriers that practitioners witness to see if they align with the barriers that the refugees themselves experience. In addition, by understanding the perspectives of practitioners and volunteers who work with refugees, it will be possible to better understand how their expertise can help alleviate the barriers, or how their biases may further the obstacles that refugees in Tennessee face when trying to access contraception and family planning services.

Background

In the United States in general, and in Tennessee in particular, resettled refugee women are a group that are vulnerable to healthcare barriers, especially regarding maternal health, including access to, and use of, family planning methods, which are constantly shown to reduce unintended pregnancies.1 While it is important to understand the barriers that refugees face from their own personal perspectives, adding the perspectives of the practitioners and volunteers who

work with refugees allows for an expanded insight into both their interpretations of the barriers their clients face, and they barriers they themselves face when attempting to assist their refugee clients.  

One of the most important aspects of maternal health that is directly related to maternal mortality and poor maternal health outcomes is unintended pregnancies. Studies have shown that unintended pregnancies can lead to a myriad of physical and mental health issues, including lower scores for health status in general, higher rates of risky health behavior during pregnancy, and unintended pregnancies have been shown to result in abortions. Unintended pregnancies have been consistently linked to lack of contraception knowledge and the lack of contraception uptake. Furthermore, research has shown that refugee populations have high pregnancy rates, especially in their first three months of resettlement, possibly due to feelings of comfort, security, or relief. In addition, they often have little knowledge of available contraception options, or where to obtain them. Unintended pregnancy rates are high across the world, and unmet contraception needs are one of the major barriers to reducing unintended pregnancies, especially in refugee populations.  

Refugee populations – who face numerous barriers to health in general, such as linguistic, cultural, financial, and access barriers – also suffer from a lack of knowledge of modern contraception methods that may not have been available in their home countries. A study

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2 See previous chapter for needs analysis survey of refugee populations.


by Canadian physician Marina Aptekman showed that unmet family planning needs “are higher in refugee populations owing to lack of access to contraception, lack of knowledge about various methods, and having other priorities.” As a result, it proves challenging to ensure that resettled refugees have access to, and proper knowledge and understanding of, family planning practices, due to the structural barriers, language and cultural barriers, social isolation, personal financial and insurance issues, transportation challenges, discrimination, and an overall difficulty in understanding the healthcare system in the United States.

In addition, refugee women also have been shown to have a desire to continue the health care practices they developed prior to resettlement in their home countries and in refugee camps, after being resettled in new countries. Thus, with this lack of knowledge and tendency to want to continue their pre-resettlement practices, having access to providers and practitioners who are both knowledgeable and culturally competent makes a major difference in their ability to receive the care and options they prefer and deserve.

As a result, it is necessary to gain accounts of the practitioners and volunteers who work with refugees to better understand how they can both positively and negatively influence access to, and utilization of, contraception and family planning methods. This is also significant in Tennessee specifically, because Tennessee is home to many political restrictions on abortion and

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5 Marina Aptekaman, Meb Rashid, Vanessa Wright, and Shelia Dunn, “Unmet Contraceptive Needs among Refugees: Crossroads Clinic Experience,” *Canadian Family Physician* 60 (December 2014), e618.


7 Natasha Davidson, Karin Hammarberg, and Jane Fisher, “‘If I'm Not Sick, I'm Not Going to See the Doctor’: Access to Preventive Sexual and Reproductive Health Care for Karen Women from Refugee Backgrounds Living in Melbourne, Australia – A Qualitative Study,” *Health Promotion Journal of Australia* (2024, 27 Jan). [https://doi.org/10.1002/hpja.844](https://doi.org/10.1002/hpja.844).
women’s health rights, while also consisting of a large number of religious (especially Catholic) hospitals, clinics, and nonprofits. The political situation surrounding reproductive rights in Tennessee serves as an additional barrier that resettled refugee women must contend with, especially with the fear of potential loss of services, or even deportation. Religious hospitals, clinics, and nonprofits also prevent many resources on sexual and reproductive health from ever making it to the refugees, as they often have beliefs on contraception that are not compatible with modern family planning methods. 8

This study attempts to add to the knowledge of the role played by practitioners and volunteers who work with refugees when they are making family planning decisions. In addition, this research can help determine where changes and improvements can be made to increase the access and acceptance of family planning methods for refugee populations in Tennessee. Also, it will provide some opportunities to expand the knowledge and practices of practitioners to help them avoid adding more barriers to refugee clients. An additional outcome of this study will be to make recommendations on improving refugee access to family planning in an attempt to reduce unintended pregnancy and increase the overall health of refugee populations in Tennessee, while also benefitting the literature by providing a new survey tool that could be used in other locations.

Research Questions

Collecting the perspectives of practitioners and volunteers who are directly working with the resettled refugee populations in Tennessee is the best way to get a clear picture of the situation. This survey was developed to determine what practitioners experience when seeing

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refugee clients, what barriers are presented to them by their clients, and what barriers the practitioners themselves face when serving refugee clients. The specific research questions asked what barriers and challenges practitioners and volunteers observe when working with refugees who are attempting to access and use different family planning methods, which barriers do practitioners and volunteers face themselves, and what role do practitioners and volunteers play in reducing or increasing the barriers in the family planning decision making processes of refugees resettled in Tennessee. By understanding the perspectives of the practitioners and volunteers who work with refugees, it will be possible to better understand the role they play – both consciously and unconsciously – when their clients are attempting to access contraception and family planning services, and what steps can be attempted to overcome those barriers.

**Methods**

This study used an online survey designed through Qualtrics to collect the anonymous and confidential responses of participants regarding their experiences and perceptions in working or volunteering with resettled refugees in Tennessee who were curious about, or attempting to access, contraception and family planning services. The survey was open to participants who worked or volunteered with refugees withing the state of Tennessee. They could be resettlement agency workers, health care providers, public health professionals, nonprofit staff, or volunteers. The study was open to any individuals who worked or volunteered with refugees, were at least 18 years old, and who lived in Tennessee at the time of the survey. The survey was only available in English.

The survey started with some questions that were specific to the participants, including basic demographic questions (age, location, gender, etc.), basic education and employment questions, and if they work or volunteer with refugees. The survey then asked a series of
questions about the nature of their work with refugees (type of organization, type of work, location, etc.), and about training or education related to working with refugees. The survey then asked questions about their experiences with refugees regarding their access to healthcare and sexual and reproductive health referrals, followed by questions on their, and their organization’s views on family planning, contraception, and (before the overturning of Roe v. Wade) abortion. Finally, the survey asked questions specifically on their direct experiences with refugees regarding family planning, contraception, and (before the overturning of Roe v. Wade) abortion.

The survey was designed to have minimal risks to the participants. The risks or discomforts of participating in this research included being asked questions of a private and sensitive nature, which could be distressing to some participants. There are no direct physical risks for participating in the survey. Some examples of possibly distressing topics were: discussing information about reproductive practices and prevention, discussing opinions on family planning, and discussing information about the participant’s and their organization’s religion in relation to reproductive health and practices. There was also some possibility of shame or embarrassment from answering questions about reproductive practices and health, and possible feelings of regret or remorse for previous family planning and reproductive decisions. All risks had only a slight probability and were very unlikely to be severe. The duration of the risks did not last much longer than while taking the survey. Participants were encouraged to take the survey in a private location, and on a secure or personal device to reduce risks. In addition, participants could skip any question they are uncomfortable answering and may quit the survey at any time without any repercussions. Finally, participants were provided the contact information for the University of Memphis IRB, and for the PI and his faculty advisor, should they have any need to discuss any potential risks.
Recruitment

Recruitment was done through local organizations that work with refugees, such as hospitals, health clinics, nonprofit organizations, and resettlement agencies in Chattanooga, Knoxville, Memphis, and Nashville. The PI directly emailed individuals and reached out to directors and supervisors requesting them to send emails to prospective participants and pass on information through word-of-mouth recruitment. In addition, all of the local resettlement agencies were provided with flyers with a brief overview of the survey, a link to the survey, a QR code for survey access, and contact information for the PI and his faculty advisor for questions. Social media was also used for recruitment purposes. Posts were made on the Facebook pages of the local resettlement agencies with information about the survey, and a link to access the survey. In addition, a tweet was posted by the PI on “X” (formerly Twitter), with information about the survey and a link to access the survey. Finally, all participants were asked to pass on the link to any other qualified individuals to generate some snowball recruitment from the participants. The recruitment and response period ran from 25 June 2023 until 1 March 2024.

Results

The research survey opened on 25 June 2023, after the U.S. Supreme Court Decision in the Dobbs v. Jackson Women’s Health Organization decision that overturned Roe v. Wade. This was significant because due to the decision in Dobbs, the survey had to be worded to avoid any potential fear of consequences. For any question about abortion, the question clarified that the survey was asking about views and approaches to abortion “before the overturning of Roe v. Wade.” The survey remained open until 1 March 2024, and received eleven total responses, but only ten completed the survey with usable data. Although the participation rate was poor, the
responses still provide some provider perspectives on refugee healthcare access, including access
to contraception and family planning services.

The majority of the total respondents were female (n=7) and were between the ages of
25-44 (n=7). The participants were spread across the four major resettlement cities in Tennessee,
with four working in Nashville, four in Chattanooga, one in Memphis and one in Knoxville. Five
of the ten respondents work for a refugee resettlement agency, with one each working for a
nonprofit organization, a specialty sexual and reproductive health clinic, and one for a religious
organization. Most participants (n=6) have worked with refugees for less than four years, and
only half (n=5) received any specialized formal or informal training specifically for working
with refugees. Those who have received specialized training claimed that their training was
helpful for their work with refugees, and of those who have not received training, all believed
that training would help them to perform their duties better. While most participants felt they
were able to successfully perform their duties regardless of specialized training, this was likely
because most respondents (n=9) have obtained a graduate or professional degree in their field.

Of the respondents who answered questions about their organizations (n=6), half of them
claimed that their organization provides referrals for traditional (calendar and withdraw
methods), modern (oral pills, condoms, injectables, IUDs, etc.), emergency (Plan B, etc.), and
permanent (tubal ligation, vasectomy) contraception. The other half were unsure, but none of
them stated that their organization did not support or provide referrals for contraceptive methods.
However, when asked about their organizations’ support for abortion (before the overturning of
Roe), only two of seven participants noted that that organization provided referrals, while two
others stated their organization did not support abortion nor provide referrals. The final three
participants stated they were unsure or “none of the above” when asked about their
organizations’ views on abortion. Somewhat unsurprisingly, the two participants whose organizations did not support or provide referrals for abortion also noted that their organization had a Christian religious affiliation.

When asked about their organizations’ limitations to providing general family planning services to refugee clients, “financial constraints” was given as the most significant limiting factor. Four out of the seven respondents stated that financial constraints were “moderately” limiting or more, and all seven claimed they were at least “a little” limiting. Overall, a median score of 3.00 on a 1.00-5.00 scale was recorded for financial constraints. On the other end of the spectrum, five out of seven claimed that both their organization’s mission and their organization’s religious beliefs were “not at all” limiting, having the lowest median score of 1.71. Staff and volunteer limitations, including understaffing, were the second most limiting factors (median score 2.57), while policy and legal constraints were third (2.43). When asked more specifically about their organizations’ limitations to providing contraception services, policy and legal constraints were cited as the most limiting (median score 2.00), followed by financial constraints (1.86). Again, all but one (six out of seven) respondent claimed that the organization’s mission and their religious beliefs were “not at all” a factor. This left religious beliefs as the fifth (second to last) most limiting (median score 1.43), and mission as the least limiting factor (1.14).

Finally, when asked the same questions about factors limiting support for abortion (before the overturning of Roe), “other constraints” was given as the most limiting factor (median score 2.71), followed by the organization’s mission (2.14). Financial constraints, staff

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9 In the survey, participants were asked to state how much each of seven factors (mission, financial constraints, religious beliefs, staff/volunteer limitations, policy/legal constraints, other) limited their organization’s ability to provide family planning services. The options were 1 – “not at all,” 2 – “a little,” 3 – “a moderate amount,” 4 – “a lot,” or 5 – “a great deal.” Median scores are based on all participants who answered the specific questions.
and volunteer limitations, and policy and legal constraints were all seen as somewhat limiting (median score 1.71 for each). Once again, six out of seven participants claimed that religious beliefs were “not at all” a limiting factor for their organization when it comes to abortion support and services (median score 1.43). All three of the participants who worked for an organization with a Christian religious affiliation claimed that their organization’s religious beliefs had no limiting effect at all on their willingness or ability to provide knowledge about, or referrals for, abortion. When analyzed in total, looking at general family planning, contraception, and abortion combined, “other” constraints were seen as the most limiting (2.33 combined median score), followed by financial constraints (2.19) and the organizations’ missions (2.09). Organizational religious beliefs were overall found to be the least limiting constraints (1.47).

![Diagram showing organization limitations](image)

Figure 8: Organization Limitations to Sexual and Reproductive Health Services.¹⁰

¹⁰ Data from author’s research study: “Refugee Healthcare and Service Providers: Perspectives on Family Planning.” 2023 (University of Memphis IRB ID: #PRO-FY2023-481, Approved 8/17/23).
When asked about their refugee clients, as opposed to their organizations, respondents ranked seven barriers they observed being faced by clients from greatest to least significant. When asked about general family planning services, financial barriers faced by refugee clients was again the most significant barrier (median score 2.6 out of 7). Three out of five respondents observed that financial barriers were the most significant, followed by language barriers (3.2), cultural or knowledge barriers (3.8), and emotional or social barriers, such as shame or stigma (4.0). Also similar to the results from their organizational views, the refugee’s own religious barriers were seen as the least significant factor faced when seeking family planning services (median score 5.4). When asked more specifically about contraception, the results were nearly identical. Financial barriers were still seen as the most significant (median score 1.8) and religious barriers were still seen as the least significant factor (5.4). The only difference was that emotional or social barriers (3.8) moved up to the third most significant, less significant than language barriers (3.2), but more significant than cultural ones (4.0).

The barriers faced by refugee clients, as observed by the participants of the survey, regarding abortion (before the overturning of Roe) did vary a little bit. Financial barriers remained the most significant factor in limiting information and access to abortion, with a median score of 2.33. However, emotional or social barriers (3.33) and religious barriers (3.67) were the second and third most significant barriers respectively. Language barriers fell to the

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11 For these questions, participants were asked to rank the barriers faced by refugees when requesting family planning, contraception, or abortion information, referrals, and services. The barriers were ranked from 1 – greatest barrier, to 7 – least. The variables used for barriers included the following seven barriers: language, financial, emotional/social, religious, transportation, cultural/knowledge, and legal. Median scores provided are based on a 1-7 scale for each, with the lower the median score, the greater the barrier.

12 Only five out of the ten participants answered the questions about refugee barriers to family planning and contraception. Only three of the ten answered the question about refugee barriers to abortion. The reason for this is believed to be the individual participant’s, or their organization’s, view on abortion, as the majority of participants from Christian organizations did not respond to this question.
fourth most significant barrier (4.62), followed by transportation barriers (5.00) and cultural or knowledge barriers (5.33). Legal barriers were the least significant obstacle observed by the respondents, with a median score of 6.00. This is most likely due to the fact that the questions explicitly asked for their observations “before the Supreme Court overturned *Roe v. Wade,*” which may have subconsciously led respondents to think that legal barriers were not significant, relative to how significant they became after the overturning of *Roe.* However, on a positive note for refugees seeking sexual and reproductive healthcare and family planning assistance, every participant who responded (n=7) claimed they knew who to refer refugee clients to for assistance for these services.

With that legal aspect a possible factor in shifting opinions of access to sexual and reproductive health services, participants were also asked three specific questions about the role of *Dobbs,* in their opinion, on access to family planning services, contraception, and abortion. When asked about the role of *Dobbs* in increasing challenges to family planning services in general, three respondents stated that the *Dobbs* decision was “not at all” significant, while one respondent each stated, “slightly significant,” “moderately significant,” and “very significant.” The overall average belief for the questions was that *Dobbs* was “slightly significant” (2.00) in increasing challenges to general family planning services. Respondents held roughly the same view on the significance of *Dobbs* in increasing challenges to contraception for refugees. Again, three stated that the decision was “not at all” significant, but two claimed it to be “moderately significant,” and the remaining selected “very significant.” The average for this question was 2.17, showing that it was still viewed as slightly significant overall. Finally, when asked the same questions about abortion, there was a gradual shift. Although one participant still claimed that the *Dobbs* decision was “not at all” significant in increasing challenges to abortion access,
the average score was 3.33, showing that overall, the respondents found *Dobbs* to be “moderately significant” when considering access to abortion. This average was raised by two participants who believed that the decision was “extremely significant,” while one participant each saw it as “slightly,” “moderately,” or “very” significant.

The respondents were also asked to consider, based on their experiences working with refugees, what they believed was the single greatest barrier that refugees face when trying to access any type of family planning, contraception, or (before the overturning of *Roe*) abortion services. Of the six respondents who answered the question, three claimed that financial barriers were the most significant overall, while two stated language barriers, and one, religious barriers as the most significant. These results are compatible with the previous results asking more specific questions about the different aspects individually, although it was somewhat surprising and noteworthy that one participant claimed religious barriers as the most significant overall, after seeing how low religious barriers scored throughout.

![Figure 9: Greatest Barrier Faced by Refugees When Seeking Family Planning Services](image)

13 Data from author’s research study: “Refugee Healthcare and Service Providers: Perspectives on Family Planning.” 2023 (University of Memphis IRB ID: #PRO-FY2023-481, Approved 8/17/23).
Finally, the respondents were asked who attended appointments or visits to get information on family planning, contraception, or abortion services. All the participants who provided these informational services to refugees noted that it was always only females who attended alone. There was not any indication or recollection of any males attending any of the appointments or visits, nor were any male or female family members or friends in attendance. These results, while limiting the expansion of knowledge on the role of male partners, does fit a trend in the literature of a lack of male involvement in the information gathering process, even if they may be more involved in the family planning decision-making processes.14

**Discussion**

The aim of this survey was to understand the perspectives of healthcare practitioners, nonprofit employees and volunteers, and others who work with refugees when helping them access information and services related to family planning, contraception, and abortion. The combination of low participation and incomplete surveys does limit the information discovered, but there are enough trends included that can provide some knowledge and understanding of the barriers and limitations faced by refugees attempting to access family planning services, and the organizations that are assisting them.

One of the most interesting results of the survey concerns the participant’s knowledge of their organizations. Five of the survey respondents stated that they worked for a resettlement agency organization in Tennessee, and four of the five who stated this claimed that their organization did not have any religious affiliation. However, there are only four federally

recognized and supported resettlement agencies in Tennessee, and all four of them have religious affiliations. The four resettlement agencies (or partners) in Tennessee are Bridge Refugee Services (BRS) (separate offices in Knoxville and Chattanooga), Catholic Charities (Nashville), and World Relief (Memphis). The two BRS offices are partners of Lutheran Immigration and Refugee Services (LIRS), now known as Global Refuge. As apparent in their name, LIRS is a Lutheran affiliated organization, and even with their name change to Global Refuge, they are still maintaining their Lutheran/Christian affiliation. World Relief is one of the ten agencies, and advertises itself as a faith-based, Christian humanitarian organization. Catholic Charities is the local subsidiary of the United States Conference of Catholic Bishops, and again, the religious affiliation is clearly apparent. Although the religious affiliations vary, they are all Christian and all have religiously influenced views on contraception, which usually does not allow for freedom of family planning choice.

The interesting factor here, however, was that the respondents who stated they worked for (or volunteered with) a resettlement agency, but then claimed their organization did not have a religious affiliation, are either unaware of the affiliation, or potentially trying to ignore the affiliation due to the nature of the questions on the survey. Either way, the fact that they are unclear or unaware of the religious affiliation means that they are probably also unclear or

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15 The U.S. government only recognizes ten resettlement agencies (VOLAGs) who receive funding to support refugee resettlement activities. Those ten VOLAGs then can partner with smaller, local resettlement agencies, or establish their own regional offices for resettlement. Nine of the ten agencies are religious/faith-based organizations (eight Christian, one Jewish), thus the majority of refugees being resettled in the U.S., and all of the refugees being resettled in Tennessee, must go through these faith-based, religiously affiliated organizations. The ten organizations are: Bethany Christian Services, Church World Service, Ethiopian Community Development Council, Episcopal Migration Ministries, Hebrew Immigrant Aid Society, International Rescue Committee, US Committee for Refugees and Immigrants, Lutheran Immigration and Refugee Services (now Global Refuge), United States Conference of Catholic Bishops, and World Relief Corporation.

unaware of the organization’s views on family planning, contraception, and abortion. Since all of
the resettlement agencies in Tennessee are connected to, and funded by, religious organizations,
they often ignore or refuse to even discuss contraception or sexual and reproductive health,
which leads to many of them not routinely providing information or referrals for sexual and
reproductive health needs, and rarely directly help refugee women regarding family planning or
contraception.17 These potential limitations could cause incorrect information to be provided to
refugees, or even certain information being withheld due to the religious beliefs of the
organizations or the individuals. This is especially true within Catholicism, and thus Catholic
Charities resettlement agencies, which prohibits all birth control methods, sterilization, abortion,
some miscarriage management techniques, and oral emergency contraception pills, even for
pregnancy as a result of sexual assault.18

Furthermore, during the recruitment process for this study, most of the resettlement
agencies, nonprofits, and hospitals were unwilling to take or support the distribution of the
survey because of their religious affiliations, and because of the nature of content of the survey.
Of the numerous organizations contacted during recruitment for the survey, only two participants
were from nonprofit organizations (excluding the resettlement agencies, which produced the
majority of the respondents), and it is highly likely that the religious affiliations of the nonprofit
organizations played a role in the overall limited participation. It is also probable that the
attempts to reach practitioners for this survey on family planning and contraception were further

17 Tonya Katcher, Rebecca Thimmesch, Alison Spitz, Leena Kulkarni, Neelima Panth, Arlen Weiner, and Michell
Woodford Martin, “Sexual and Reproductive Health Information and Referrals for Resettled Refugee Women: A

18 United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care
Convention Resolutions on Abortion and Women’s Reproductive Health,” Office of Government Relations: The
Episcopal Church (17 May 2019).
limited due to the *Dobbs* decision. After the Supreme Court overturned *Roe*, a “trigger law” went into effect in Tennessee that essentially banned all abortions, but also threatened other aspects of sexual and reproductive health in Tennessee. Thus, support for a research study on family planning and contraception (especially one that discusses abortion) was even more difficult to find. In addition to the trigger law, Tennessee also lost around $7 million when the federal government withheld Title X family planning funds from the state for not being in compliance with federal regulations surrounding the funds (however the Title X funds were eventually directed to Tennessee through a federal grant given to Planned Parenthood of Tennessee and North Mississippi, and Converge: Partners in Access, a nonprofit agency based in Mississippi).  

All of these political concerns in Tennessee over abortion, contraception, and family planning, added to the religious objections from the resettlement agencies and nonprofit organizations created a climate of hostility towards any research or discussions about family planning and contraception access and utilization, and all contributed to the poor number of responses to the research survey.  

The results showed that all participants in the survey stated that they did know who they should refer refugee clients to for sexual and reproductive health assistance. However, since the survey lacked a follow-up question, it is hard to determine exactly who they would know to refer them to for assistance. However, each of the major resettlement cities in Tennessee have a specific hospital system that is designated as the location for refugees to receive their post-arrival screenings. Two of those four hospitals are religious hospitals, with one being directly connected with the Catholic Church. As a result, even if the participants do know where to refer their

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clients for sexual and reproductive health services, chances are they are referring them to those designated hospitals. With the religious affiliation of those hospitals, even when refugees are referred to them, they are still possibly not getting the knowledge and assistance they desire.

With such a small sample size, it is difficult to discern any significant patterns or to make any definitive conclusions from the data, but some minor patterns start to emerge. Participants were mostly aware of the reproductive services or referrals provided by their organizations, and most of the participants claimed that their organizations provided referrals for family planning and contraceptive services (four out of seven respondents), but only two noted that they provided referrals for abortion. Two of the other participants noted that their organization does not support abortion, and did not provide information or referrals, while the remaining three were unsure or unaware. However, as noted above, most of the referrals made, regardless of the religious affiliation of the organization, are to religious affiliated hospitals and clinics, thus possibly limiting the impact of the referrals.

The most significant and interesting results from the survey come from the questions about the role that Dobbs played on refugee access to family planning, contraception, and abortion services. When participants were asked how significant the Dobbs decision was in increasing challenges and barriers to general family planning for refugees, half of the respondents claimed Dobbs was “not at all” significant (n=3 out of 6). When asked about access to contraception specifically, again half of the participants claimed that Dobbs was not at all significant in increasing challenges to access. Interestingly, male respondents were more likely to claim that Dobbs was at least moderately significant, and the female participants were more likely to claim no significance. More research and a larger sample size are necessary to further explore this difference, but it is possible that either religious beliefs and affiliations or less
knowledge of contraception by males may have influenced these answers. This result, however, was also noticeable compared to other recent studies on the impact *Dobbs* has had on contraception. In a study published in early 2024, Kavanaugh and Friedrich-Karnik found statistically significant evidence that “barriers to accessing contraception increased, (and) reports of receiving high-quality contraceptive care decreased,” since the *Dobbs* decision was delivered. While it is possible that these increased barriers have not been noticed by the participants of this survey, the limited data suggests that the participants may be less aware of sexual and reproductive health issues and barriers, which would be understandable, as none of them are medical practitioners, and family planning and contraception services are not part of their standard responsibilities.

When asked the same question about the role of *Dobbs* in increasing barriers to abortion in Tennessee, one participant still claimed that it was not significant at all in increasing challenges or barriers to abortion. Initially this was a somewhat shocking response, as *Dobbs* caused a “trigger law” to go into effect in Tennessee, effectively banning abortion outright in the state. However, after further analysis the respondent who believed that the overturning of *Roe* was not significant in increasing challenges and barriers to abortion was someone who worked for a religious organization that does not support or approve of abortion. It is most likely, then, that since the organization would not support abortion regardless of politics or legality, the restrictions triggered by the *Dobbs* decision would not have an impact on abortion from the respondent’s perspective.

When analyzing the three questions about the impact of *Dobbs* on family planning, contraception, and abortion by participant age, those who are between 35 and 44 years old were
the most likely to believe that *Dobbs* was moderately or very significant in increasing challenges and barriers, whereas those aged under 34 or over 55 mostly found the decision not significant at all. When disaggregated by gender, there were not major differences in the views of the impact of *Dobbs* on family planning or contraception, but female participants held much stronger opinions that the Supreme Court decision was at least moderately significant. Again, the overall restrictions on abortion and sexual and reproductive health access in Tennessee, added to the fact that over 45% of Tennessee counties (43 out of 95 counties) were classified as “Maternity Care Deserts,” may have bearings on all of the respondents, assuming that since access was already limited or forbidden, the *Dobbs* decision did not have the opportunity to make already substantial barriers and more significant.21

Finally, the overarching goal of this survey was to better understand what the greatest barriers refugees face when trying to access family planning, contraception, and abortion services. Participants were directly asked, based on their experiences with refugees, what the single greatest barrier appeared to be. Six participants responded to this question, with three of them claiming financial barriers being the single greatest barrier, while two claimed language barriers and one selected religious barriers. Participants were also given the options of social/emotional, transportation, cultural/knowledge, legal, or “other” barriers, but none of those choices were selected. These results track with previous studies in the literature, which often show that financial and language barriers are the most significant faced by refugees.22


few studies specifically look at barriers to contraception and reproductive health, financial and language barriers constantly are found to the be most significant across all aspects of refugee healthcare. A related issue to language barriers is the literacy rates of the resettled refugees. Although not specifically asked about in this survey, other studies have found that a lack of literacy, even in their native language, can be a significant barrier to accessing healthcare. This was unequivocally echoed by a resettlement agency caseworker, who claimed that the lack of literacy in the native language was an even more significant barrier than not speaking or understanding English, as it prevented even printed materials translated into refugee languages from having any mitigating effects to the access barriers.

The fact that religious barriers was selected was somewhat surprising but does support many of the other findings from this research. Most other sources in the literature that mention religious barriers argue that the religious beliefs of the refugees provide problems when seeking healthcare in the United States (especially sexual and reproductive healthcare). Very few studies have found that the religious views and beliefs of the resettlement agencies, nonprofits, and hospitals of the resettlement country provide the religious barriers, regardless of the religious


24 Summer Awad (Preferred Communities Case Manager, Knoxville Office, Bridge Refugee Services, Inc.) in interview and discussion with author, June 2021.

beliefs of the refugees. This finding, combined with the results of the previous research in this dissertation, opens a new avenue for research to examine the limitations created by this barrier.

**Strengths and Limitations**

The most significant strength of this research is that it is the first and only known study directly asking individuals who work with refugees in Tennessee about their perspectives on refugee barriers to family planning services. This novel approach helps supplement studies that directly ask refugees about their experiences accessing family planning services and can also help show where there may be a disconnect between the views of the refugees, and the perspectives of those who work with them. The survey tool itself also provides the opportunity to expand and replicate the study to more participants and other areas to determine patterns and differences between refugee practitioners in different areas.

This study also has many limitations, but they could possibly be reduced with more time for research. First, the major limitation is the small response rate for the survey. Only having eleven participants reduces the strength and value of the data. While each experience and perspective is valuable, not having a large enough sample size means that each individual response can skew the data in large ways. A second limitation of the study is the fact that it was only made available in English, which was unavoidable due to funding and time. Although most individuals in Tennessee who work with refugees speak English, limiting the survey to that language could serve to omit practitioners who work with refugees and speak other native languages.

The survey also has potential for recall bias, as the participants are asked to reflect on past experiences with refugees, which may be difficult to remember. They also could have recency bias, reflecting on more recent experiences at the expense of earlier experiences with
refugees, or a more general overall experience. There is also the possibility of cultural bias, as respondents may experience their perspectives through their own culture, which may not be representative of the cultures of their refugee clients. This extends to the issue of religious beliefs of both participants and their organizations. Religious beliefs and affiliations could cause participants to skip questions, or answer them in a way that would fit their organizations’ religious beliefs, even if they are not their own personal views. Just as with any survey including self-reporting questions, this survey could lead to other response biases, such as social or cultural desirability bias. Finally, since the survey was open to both employees and volunteers who work with refugees, there is a possibility that volunteers may not know as much about the organizations they are volunteering for, and they may not have as much training working with refugees. This limited knowledge of organizations and refugees, including the cultures they come from, could lead to misinterpreted cultural cues, and biased or misinformed perceptions.

Although there are numerous limitations to this study, the most significant limitation is that of the small sample size.

Policy Implications

As a result of this study and the challenges in recruitment and participation, a few opportunities for policy have emerged. To begin with, it is important that refugees have access to nonprofits and health clinics that are secular to provide more culturally and religiously competent assistance. Although recently, the largest number of refugees resettled in Tennessee come from the Democratic Republic of Congo, which is a majority Christian country, over 70% of refugees resettled in Tennessee from 2002-2022 have come from countries that are a majority religion that is not Christian. In fact, four of the top five, and seven of the top ten countries

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represented in refugee origin are non-Christian countries, including Myanmar (majority Buddhist country, but may refugees come from the Muslim Rohingya populations), Iraq (majority Muslim), Somalia (majority Muslim), and Bhutan (Buddhism). Thus, over two-thirds of the individual refugees resettled in Tennessee are placed by a resettlement agency that does not share their religious affiliation, and they must rely on nonprofits and hospitals who do not share their religious (and as a result, often cultural) views. This is extremely significant for all aspects of resettlement and acclimation, but especially for healthcare, which often has very religious and cultural foundations.

The governments of both the United States, and the state of Tennessee, need to be more proactive in supporting and funding organizations that serve refugee populations that are secular in their beliefs and missions, to better help resettled refugee women obtain the family planning and contraception care they need from a location that will not judge or restrict them based on their religious beliefs. In addition, organizations that work with refugees could provide more training for their employees and volunteers. Five out of seven respondents stated that they had specialized training that they found to be “very helpful” in working with refugees, but the other two respondents had received no training for refugee work. Furthermore, all seven respondents claimed that they believed that extra or specialized training to work with refugees would (n=5) or “maybe” (n=2) allow them to perform their duties better when assisting refugee clients.

Conclusions

Although this research study had noticeable limitations, those limitations should not obscure the fact that some conclusions can still be developed. The ability to access individuals who work or volunteer with refugees to better understand their lives and situations is a significant way to try to provide better assistance and interventions to improve their lives.
Organizations and individuals not participating in or advertising the research due to their religious views limit the amount of knowledge that can be developed and the amount of assistance that can be given. Many of the participants want to help refugees become self-sufficient and successful in their new lives, but the limited training and knowledge they have regarding refugees’ culture, religion, and experiences can hamper their ability to provide efficient and effective care. Refugee women, in the social, cultural, and political climate currently present in Tennessee, are experiencing many threats to their sexual and reproductive health, in addition to the general health and security threats that are ever-present with resettling and starting a new life in a new, foreign land. Unfortunately, the conclusions from this research study support that of the previous research study (previous chapter) that religious beliefs and views of the individuals and their organizations end up producing more barriers to sexual and reproductive health, including family planning services, than they are reducing. The resettlement agencies, health clinics, and nonprofit organizations in Tennessee, could do more to support refugee women in Tennessee by providing more culturally and religiously sensitive training to their employees and volunteers, and not let their religious affiliations prevent them from understanding the family planning needs of their clients. In this way, the organizations and individuals who are providing assistance to refugees can start to remove barriers to family planning access, rather than expanding and exacerbating them.
8. Findings and Conclusions

Introduction

This chapter presents a brief summary of the study, including the interdisciplinary research and the original case studies. It then provides significant conclusions drawn from the data and information presented in the previous chapters and provides a discussion of the findings. The chapter concludes with including implications for research and the disciplines, and with recommendations for further research.

Summary of the Study

Overview of the Problem

Fundamental to the protection and health of refugee women is the promotion of their rights to reproductive self-determination. Access to sexual health services and information is critical to realizing the highest attainable standard of sexual health. Governments and the international community must honor all relevant legal obligations to protect and promote the rights of refugees, including reproductive rights. Refugees face a myriad of challenges and barriers to health after resettlement. They also often have little knowledge of available family planning or contraception options, or where to obtain them after resettlement. Studies have shown that unmet family planning needs “are higher in refugee populations owing to lack of access to contraception, lack of knowledge about various methods, and having other priorities.” As a result, refugee women in Tennessee suffer from high rates of unintended pregnancies,

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stemming from poor and limited access to family planning services, and unmet family planning needs after resettlement.

**Purpose of the Study**

This dissertation aimed to combine the disciplines of history, public health, and public administration/policy to determine, and better understand, how and why refugee women in Tennessee have historically, and continually, had poor and limited access to family planning services. To achieve this, it was necessary to examine what extent the limited access to family planning services has led to unintended pregnancies, and to illuminate the barriers to sexual and reproductive health they face in order to better support the family planning needs and desires of resettled refugees in Tennessee.

A secondary purpose of this study was to examine the role male partners play in supporting or limiting refugee women’s access to family planning services after resettlement. Gender norms across many societies that refugees resettle from often allow men key decision-making power. As a result, although family planning programs are directed at women, and women bear the burden of uptake for family planning, men often continue to be the primary decision makers on whether to use contraception of family planning services, and what type to use. The support and opinions of men directly affect the “choice, adoption, continuation and correct use of family planning methods” in many of the refugees’ home countries, and continue after resettlement. This study, thus, attempted to determine if male partners in Tennessee exert

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the same impact on refugee women’s family planning decision-making that is shown in the literature.

**Review of Methodology**

This dissertation undertook an interdisciplinary approach to better understand the reasons that resettled refugees in Tennessee face barriers to the access and utilization of family planning services. The disciplines of history, public health, and public administration/policy were intertwined to uncover historical and recent trends that continue to impact refugee women. The multidisciplinary approach allowed for theoretical methods and paradigms from the diverse fields to converge on the most complete understanding of the roles different elements play to limit access to sexual and reproductive health, and specifically family planning services, for resettled refugees in Tennessee.

In order to better understand the numerous barriers resettled refugees face regarding access to and use of family planning services this dissertation examined the history behind the barriers and the policies that inform them, the public health approaches to circumvent them, and the role that providers and nonprofits played in both creating and reducing the barriers. It also endeavored to illuminate ways that refugee men and women can increase their knowledge and use of family planning methods after resettlement. The analysis of the situation through the varied disciplines provided a more complete picture of the barriers faced by resettled refugee women when trying to access and utilize family planning services in Tennessee.

A historical background was used to develop an understanding of the refugee resettlement process and how refugees have been treated in society and in policy after resettlement. The historical approach used cultural and social history lenses, with influence from both modernization and feminist theories. The public health discipline supplemented the
historical background to examine social determinants of health (SDOH) that impact the knowledge of family planning methods and barriers to receiving reproductive health care.

Public health was also combined with the discipline of history to examine how the sexual and reproductive health policies instituted by federal, state, and local government have changed over time and the impact they have had on refugee populations. A policy analysis was likewise used to evaluate the course of policy changes through the lens of the Social Construction Theory. The social construction of target populations is a theory that examines characteristics or popular images of groups who are affected by public policy. This approach allowed for the combination of history and public health to not only examine policies, but also the historical contexts behind them. The public administration discipline helped to highlight the role of nonprofit organizations in the resettlement, education, and healthcare of refugee populations. The role of nonprofit organizations was evaluated in the context of their missions and how they interpreted their beliefs and religious principles in relation to their purposes and aims. While usually viewed through Weisbrod’s public good theory, interdependence theory and the theory of impure altruism were also used to more fully understand the role of refugee-serving nonprofits.

**Overview of the Case Studies**

The bulk of the research for this work was based on historical analysis of primary research studies, policies, and reports on refugee access to family planning services. In addition, an analysis of literature reviews and other secondary sources complemented the research. As for the original research, it was obtained from two surveys: first a needs analysis survey of resettled refugees in Tennessee, and second, a survey with resettlement agency and nonprofit organization employees and volunteers, medical and clinical practitioners, and others who work
with resettled refugees. The needs analysis survey was used in concert with the relevant literature to create a baseline of knowledge on the perceived needs and barriers from the refugees themselves. The second survey added a prospective from providers to integrate with the data gathered through the needs analysis survey. Getting the views and opinions of individual stakeholders on all sides of the resettlement, assistance, and medical processes not only allowed for greater understanding of the issues, but also provided opportunities to directly remedy any misconceptions with regard to thoughts and perceptions.

**Synopsis of Findings**

In general, this study found that the challenges and barriers that resettled refugee women in Tennessee face are very similar to those faced by refugee women across the United States. To begin with, research in this study found that public officials in Tennessee suffer from the same issues when it comes to misidentifying and misclassifying refugees, leading to skewed public perspectives. These skewed perspectives serve to add additional barriers to resettled refugees. Beyond misclassifications, cultural and linguistic barriers were found to be the overall greatest barriers faced by refugee women when trying to access and utilize family planning and contraception services. Importantly, these barriers were found to occur both ways, meaning that both the culture of the refugees and the popular U.S. culture produce barriers.

This study also found that political and policy barriers created numerous challenges for reproductive healthcare access and utilization. Due to the strict laws and policies in Tennessee, especially after the Supreme Court’s opinion in *Dobbs*, sexual and reproductive rights are extremely limited for all women in the state, regardless of refugee status. Arguably, the findings of this study suggest that the laws and policies in Tennessee may be as significant as cultural and linguistic barriers when it comes to sexual and reproductive health.
Additionally, this study found that the role of male partners of refugee women did not play as strong of a role in the reproductive decision-making process. Although this finding suffers from an extremely small sample size in this research, it was most likely a result of the more recent nature of conflicts that refugees were escaping, which led to many women being resettled in Tennessee without male partners.

Finally, one interesting and significant finding from this research concerns the role of refugee-serving nonprofit organizations. Although these organizations are specifically in place to help refugees achieve the highest possible degrees of success and health in resettlement, and should provide the greatest assistance in alleviating barriers, in Tennessee this was not found to be the case. Rather, due to the near universal nature of Christian-affiliation among the refugee-serving nonprofits, they ended up constructing more barriers than they eliminated.

**Findings Related to the Literature**

In the literature concerning refugees and their definition and status, refugees are often grouped together with asylum seekers, internally displaced persons, immigrants (both legal and “illegal” or undocumented), migrants, and individuals with Temporary Protected Status. The generic “immigrants” label often encompasses all of these groups, which leads to many issues within American society. Moreover, discussions in American politics and society often lump all of these groups together, especially when it comes to public health, doing a major disservice to refugees in particular. As a result, research on refugees in the United States often fails to appreciate the unique situation of refugees compared to other immigrants and migrants. This results in less access to healthcare, more blaming of refugees for societal issues, and an overall added level of discrimination for refugees, who are guaranteed more rights after resettlement than most other categories of immigrants and migrants.
The current study also found this to be the case in Tennessee in particular. The most glaring evidence of this comes from the Tennessee General Assembly, the state’s legislative branch. In 2021 the Tennessee General Assembly appointed a joint committee to study the “refugee issue” in Tennessee. Although the project was titled the “Joint Study Committee on Refugee Issues,” the actual work of the committee was based on investigating the federal government’s “immigration program within Tennessee,” and was directed to determine and evaluate the number of “migrant children” being relocated to Tennessee, or being “flown into Tennessee and subsequently relocated to other states” by the federal government. This entire committee was formed to examine the issue of illegal immigration and unaccompanied minors in Tennessee, and had nothing to do with “refugees.” None of the directives nor the recommendations were related or relevant to refugees in Tennessee, and in reality, the only time refugees were discussed, was when the committee called in the directors of the VOLAGs in Tennessee to get information and answers to their questions. The fact that the committee was called the Joint Committee on Refugee Issues clearly shows that experienced politicians often do not fully understand the definitions and classifications of refugees. When politicians inappropriately title studies like these “refugee” issues, they are controlling the perception of

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6 As one might imagine, the questions asked of these VOLAG directors did not provide any relevant information to the committee, because most of the questions were related to unaccompanied minors, populations that are not refugees, and are not served by the VOLAGs.
refugees in the general public, and gatekeeping knowledge to shape public opinions and the policy agendas.\(^7\)

In the United States, racial and ethnic minorities experience a greater proportion of unintended pregnancies than white women, and U.S. nativity status was found to also contribute to racial and ethnic disparities in unintended pregnancies.\(^8\) Although the literature on unintended pregnancies in Tennessee is limited, this trend is mostly accepted as true as well. This study did produce some findings, mostly anecdotal, that this was the case, and that refugee women in Tennessee have a higher rates of unintended pregnancies. Almost all of the current literature points to the fact that better access to and utilization of family planning services is the best and most effective way to reduce unintended pregnancies and to improve the overall health and wellness of communities.\(^9\) Although limited and anecdotal, this study tends to support previous literature that access to family planning has been clearly shown as a low-cost way to help decrease unintended pregnancies, which in turn would lessen the medical, social, and economic burdens that can develop as a result.


In order to reduce unintended pregnancies in refugee population, the barriers to family planning services must be understood, so they can be reduced or eliminated. This research found evidence that echoes the current literature that cultural and linguistic barriers are the most significant barriers faced in the pursuit of family planning services.\(^\text{10}\) Both of the research surveys designed for this study found that cultural and linguistic barriers were extremely significant, only trailing personal beliefs in the survey of refugees and financial barriers in the survey with practitioners. Furthermore, personal beliefs and financial barriers are very likely based on or related to cultural beliefs, suggesting a stronger connection. The most significant cultural barriers were related to cultural differences between refugees’ home countries and the United States. Not being familiar with how the U.S. healthcare system works, not knowing how to schedule appointments, and not knowing what to say to practitioners were the major cultural issues that often were related. In addition, many refugee cultures require women to only see female practitioners, which was also mentioned directly by the one participant of the refugee survey.\(^\text{11}\) In addition, many refugees have found American practitioners to be lacking in cultural awareness and cultural competency, and seemingly rushed or disinterested during appointments. Linguistically, not being able to speak or understand English was a major barrier to care. When English was known by refugee patients, often the complicated medical jargon still prevented full understanding. The same was true when interpreters were present. They could often translate the


\(^{11}\) Although not captured directly by the survey, this was related multiple times in an informal discussion between the participant and the researcher before she completed the survey.
words, but not the meaning of what was being said. This again supported what was evident in the literature.\textsuperscript{12}

An interesting finding concerning barriers that is slightly different than found in the literature, is that respondents to the practitioner survey (case study two) reported that financial barriers were the greatest challenge both for their organizations, and for their refugee clients. While financial barriers were not specifically noted as being one of the most significant in the literature, there are a couple of reasons for this disparity. Some of the other research did not include financial barriers as an option for their studies, and others combined financial with insurance. As noted above, many of the financial concerns are also directly related to cultural ones, such as cultural differences in the roles for women in the workforce, which would directly impact finances. Another potential reason for the disparity may be a result of the COVID-19 pandemic. The large majority of the research concerning refugee barriers was carried out before the onset of the pandemic. With this research survey occurring after the pandemic, the changes in financial situations, aided by the growing rates of inflation in the post-pandemic years, could have made financial barriers more front of mind to the participants through recency bias.

This study also found that political and policy barriers created numerous challenges for reproductive healthcare access. The strict laws and policies in Tennessee, especially post-\textit{Dobbs}, have created limited opportunities for all women regarding sexual and reproductive health. While this may be similar in other states that have similar restrictions, in Tennessee, these barriers are arguably as significant as the cultural and linguistic ones. This is especially true when coupled with the hostile nature towards refugees and immigrants, which often keep refugees from even

seeking care, for fear of loss of benefits, or even deportation. There is almost no literature at all about refugee women and sexual and reproductive health, contraception, or abortion in Tennessee, but research on resettled refugees in general has shown that nearly 60% of reproductive-age women worldwide live in countries where abortion is broadly legal (including Ukraine, Colombia, and Rwanda – three countries where a large number of refugees to Tennessee arrive from), and since 1994 over 60 counties have liberalized abortion laws (including the Democratic Republic of the Congo, Bhutan, and Ethiopia – three more countries where the majority of refugees resettled in Tennessee arrive from). This overturning of Roe, coupled with the trigger law, completely eliminated the option of abortion as a means of family planning and public health in Tennessee, and led to more unintended pregnancies and poorer health outcomes for refugees.

In regard to male partners, this study was limited due to the low participation rate on the first survey. The literature shows that in most family planning programs, the presence of men is “negligible,” even when the role of men in family and healthcare decision-making is usually supreme. Gender norms across many societies from which refugees originate often allow men key decision-making power. As a result, family planning programs are directed at women, who bear the burden of uptake for family planning, while men continue to be the primary decision makers on whether to use contraception of family planning services, and what type to use. Throughout the literature, male partner objection to family planning was found to be a significant barrier, and men’s poor knowledge about sexual and reproductive health and family planning


15 Seth et al., 2022.
emerged as the most common issues. Unfortunately, some of the main reasons for the lack of male knowledge comes from the fact that most men often receive their information from friends or television and radio, rather than medical professionals, or they are just not interested and do not see it as their responsibility.

In the refugee survey of this study, the refugee respondent related that her partner was somewhat involved in the family planning decision-making process, which is what she desired, and what she believed that he desired as well. Her implication, during an informal discussion before partaking in the survey, was that her partner was only as interested as he needed to be, though it was not clear if that was due to lack of interest, knowledge, or for other reasons. The more significant discovery from the survey and informal discussion was that her partner, and the partners of many of the refugees that she knows in her community, were not resettled with them. This participant was from Ukraine, and her partner, along with many other Ukrainian refugee women’s partners, did not apply for resettlement because they remained to fight in the ongoing war with Russia. This trend appears to be more common with many refugees from many places, as the situations they are fleeing from are more commonly war, which often requires the men to stay and fight.

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In the practitioner (second) research survey, all of the participants who provided information on family planning services to refugees noted that it was always females who attended alone. There was not any indication or recollection of any males attending any of the appointments or visits, nor were any male or female family members or friends in attendance. These results, while limited, also fit a trend in the literature of a lack of male involvement in the information gathering process, even if they may be more involved in the family planning decision-making processes.\textsuperscript{18} Since men have traditionally served as the healthcare system’s gatekeepers in the developing countries from which they fled, but they are less likely to resettle in the current climates of conflict, it also suggests alignment with Chalmiers’ findings that resettlement often transforms familial power dynamics, and offer women new avenues for negotiating contraception use with husbands.\textsuperscript{19} Whether it be due to disinterest, lack of knowledge, or the fact that they are not physically resettling with refugee women, the research in this study suggests that male partner influence is similar, if slightly less, than it was pre-resettlement.

\textit{Unexpected Findings}

One of the major assumptions of this study was that the refugee-serving nonprofit organizations (including the VOLAGs) in Tennessee would provide the greatest assistance in


alleviating the barriers that refugees faced when trying to access sexual and reproductive health, contraception, and family planning services. These organizations are specifically designed to assist refugees in all aspects of their resettlement, so healthcare in general, and family planning services specifically, should be easier to access with their assistance. Surprisingly and unexpectedly, this was not the case.

Religious-affiliated organizations have a long history of involvement in refugee resettlement in the United States. Much of this is due to their religious values of showing hospitality to strangers, assisting those in need, and valuing human life. They even routinely publish literature describing “God’s calling” to “His people” to provide comfort and aid to refugees. These faith-based organizations also usually have more access to donors and resources by tapping into their congregations and networks. These facts all allow the religious affiliated VOLAGs and nonprofit organizations to be successful in refugee resettlement assistance. However, their religious values and beliefs can also produce barriers, especially to sexual and reproductive health.

As previously noted, the U.S. government, through the ORR and PRM, only recognizes and funds ten resettlement agencies in the United States, and nine of the ten are faith-based or religiously affiliated. The International Rescue Committee (IRC) is the only secular VOLAG, and of the other nine, eight are affiliated with Christian churches or denominations, and one has a Jewish affiliation. In Tennessee, there are four VOLAGs operating, one in each of the four major cities of Chattanooga, Knoxville, Memphis, and Nashville. All four of them have a Christian affiliation: two Episcopal, one Evangelical, and one Catholic. These faith-based organizations all

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have religiously influenced views on contraception and family planning, which often limits discussions of family planning and access to contraception.

Since all of the resettlement agencies in Tennessee are connected to, and funded by, religious organizations, they often ignore or refuse to even discuss contraception or sexual and reproductive health. This is significant because the “complex environment of pressures” put on practitioners leads many of them to not routinely providing information or referrals for sexual and reproductive health needs, and they rarely directly help refugee women regarding family planning or contraception.21 Although most employees and volunteers of faith-based VOLAGs do not see a contradiction between their religious mandate and the non-proselytizing resettlement work they do, religious beliefs and practices still make their way into their work. In a study on the role of religious organizations in refugee resettlement, one member of a Christian faith-based VOLAG claimed that while resettling and assisting refugees, “you need to do both” provide social services and “evangelism and spiritual conversion.”22 When the resettlement agencies do provide referrals, they are usually more “generic” than specific for sexual and reproductive health, and refugee clients are often told they can start with the local hospitals or clinics.

Each of the VOLAGs in Tennessee has a partnership with a local hospital, which provides the post-resettlement screening of the refugees, and often become the first point of contact for refugees thereafter. However, two of the local hospitals that refugees are referred to are Catholic hospitals, who have the same views and follow the same ERDs as the Catholic


22 Nawyn, 2005: 12.
VOLAGs. As a result, the majority of refugees in Tennessee who are trying to get access to family planning services or contraception are not getting information or services from the resettlement agencies, and are being referred to hospitals who are also often not providing information or services, at least not the complete range of possible services available. Thus, refugees are forces to look elsewhere in the community for comprehensive family planning services, which brings back many of the cultural, linguistic, and financial barriers that the VOLAGs are in place to reduce.

In addition to the official resettlement agencies in Tennessee, there are six additional nonprofit organizations that are dedicated fully, or in large part, to assisting refugees. Of these six organizations, half of them are also faith-based and have direct connections to, and funding from, Christian religious denominations. In addition, a majority of all hospitals in Tennessee are religiously affiliated, thus adding more barriers. Since Catholic hospitals must follow the aforementioned ERDs, they often do not provide common reproductive services that are critical to women’s sexual and reproductive health and are creating an environment that is less safe than other medical settings.

An additional religious issue arises outside of the hospitals and health care centers. Officially, in Tennessee, in order to have “access” to the resettled refugees, all of the organizations must be aligned with the four resettlement agencies, so even if they are not explicitly a faith-based organization, they must at least be aware of the opinions and directives of the church-based resettlement agencies. Technically, all of the nonprofit organizations must be

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23 The two Catholic hospitals are located in the two cities in Tennessee, Nashville and Memphis, where the majority of the refugees are resettled in the state.

non-proselytizing to secure their government funding and relationships, but most of the
organizations avoid any conflict over contraception and family planning by simply not
discussing it, so that their religious beliefs do not appear to be influential. Rather, they just direct
any health care concerns from their clients to the health clinics or hospitals, who are arguably
less-directly influenced by their religious positions, unless they are a Catholic hospital or clinic.

More generally, the religious affiliations of VOLAGs and nonprofit organizations have
broader effects on refugee populations in Tennessee. From 2002 until 2022, over 70% of
refugees resettled in Tennessee have come from countries where Christianity is not the majority
religion. In fact, seven of the top ten countries represented in refugee origin are non-Christian
countries, including Myanmar (majority Buddhist country, but may refugees come from the
Muslim Rohingya populations), Iraq (majority Muslim), Somalia (majority Muslim), and Bhutan
(Buddhism). Of course, there could be Christians in many of these countries that are becoming
refugees due to religious persecution, but as many as two-thirds of the individual refugees
resettled in Tennessee are placed by a resettlement agency that does not share their religious
affiliation, and they must rely on VOLAGs, nonprofits, and hospitals who do not share their
religious (and as a result, often cultural) views. This is extremely significant for healthcare,
which often has very religious and cultural foundations, but also for all aspects of resettlement
and acclimation.

Numerous studies have shown the importance of religion on the well-being, happiness,
and health of resettled refugees. Rödlach found that for refugees, belonging to a religious
community after resettlement facilitates access to support and results in improvements in various

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measures of health and well-being. Other studies have found that faith and religious or spiritual beliefs play a significant role in the mental health, integration, and overall well-being of resettled refugee populations. The is also a growing literature on refugee religion and well-being that has shown that even just the ability and ease to practice religion, regardless if they actually practice it, has a significant impact on their happiness. All of this evidence is great for refugees, but unfortunately, in Tennessee it is mostly great only for Christian refugees. Increasingly, newly arriving refugees in Tennessee are Muslims or Buddhists, which means they are often immediately missing that feeling of community and connection related to religion. While this may change over time as many refugees are resettled into communities where there are others from similar backgrounds, the initial stress over religious differences can impact both mental and physical health. This is especially true when considering that in the past churches and religious organizations sponsoring refugees of different religions have coercively proselytized, expecting refugee conversion in exchange for assistance.

This is extremely significant for all aspects of resettlement and acclimation, but especially for healthcare, due to its religious and cultural foundations. To better help resettled

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refugee women in Tennessee obtain the family planning and contraception care they need from a location that will not judge or restrict them based on their religious beliefs, changes must be made. Refugee women, in the social, cultural, and political climate currently present in Tennessee, are experiencing many threats to their sexual and reproductive health, in addition to the general health and security threats that are ever-present with resettling and starting a new life in a new, foreign land. Unfortunately, one of the strongest, and most unexpected, conclusions from this research study implicates the agencies and organizations that should be reducing barriers to actually be the ones constructing them. The resettlement agencies, health clinics, and nonprofit organizations in Tennessee, which are specifically designed to help refugees, are among some of the greatest barriers themselves, due to religious affiliations and politics, when it comes to refugee women in Tennessee accessing contraception and family planning services.

**Conclusions**

**Implications for Scholars and the Field**

This study has contributed to the literature on refugee health and has uncovered some implications for scholars and for the interdisciplinary field of refugee studies. The major strengths of this research start with the fact that this is the first and only known survey directly asking refugees in Tennessee about their knowledge and use of family planning services, and the first and only known study directly asking individuals who work with refugees in Tennessee about their perspectives on refugee barriers to family planning services. There is a dearth of research and literature on refugees in Tennessee in general, but especially when looking at healthcare and access to services, from both the client and provider side. In order to address the particular difficulties and vulnerabilities that this underprivileged group faces, their participation
is crucial.\textsuperscript{30} Getting information directly from the perspectives of refugees and providers affords an opportunity to get the most accurate and authentic information. This novel (for Tennessee) approach helps combine both sides of the story, and can also help show where there may be a disconnect between the views of the refugees, and the perspectives of those who work with them. The survey tools themselves also provide the opportunity to expand and replicate the study to more participants and other areas to determine patterns and differences between refugees and practitioners in different areas.

This study also found that it is important to find successful ways to reach refugees in the community for their input into the research. There are many gatekeepers who can open or prevent access to refugees in society. Building strong relationships with the VOLAGs, nonprofit organizations, and state-level refugee coordinators is necessary before undertaking any research. However, even when those relationships are developed and positive, the religious nature of the organizations and the topic of the research can still produce further barriers. Based on the attempted research for this study, regardless of relationships or intentions, if the gatekeepers do not approve of the subject matter of the research, access to refugee populations will be much more difficult to obtain.

The research and policy analysis in this study also found that in order to truly help refugees after resettlement, it is important and imperative to better educate policy makers on the differences between refugees and other migrant or immigrant groups. While this is a widely known problem in the literature, the inability of politicians and policy makers to properly identify and represent refugees adds to the political, policy, and legal barriers they face.

Finally, this work shows the importance of raising the awareness of the “multiple discriminations” faced by refugee women, especially surrounding reproductive health care access. They are often “triply marginalized” due to economic, racial or ethnic, and gender issues, and those issues all combine to limit sexual and reproductive healthcare access. As a result, there has been, and still remains, a “gap in care for refugee women,” and they lack the proper access to reproductive health services, including contraception and family planning. Without continually highlighting the barriers and discriminations, and developing interventions to circumvent them, refugee women will never get the care they need.

**Recommendations for Further Research**

The research from this study has also opened the doors for further research regarding refugees and reproductive health in Tennessee. The first recommendation is that more research on refugees and their experiences in Tennessee in general needs to be undertaken. There are very few studies on refugees in the state, and almost none on their access to healthcare in general, or sexual and reproductive health specifically. In order to successfully undertake this research, the findings of this study recommend that potentially the best way to research refugee women’s sexual and reproductive health would be to design studies that include questions about family planning, contraception, and abortion within a larger study on refugee healthcare, or even refugee assimilation and acculturation. These larger studies may be more likely to get support

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and cooperation from the gatekeepers as opposed to those that are specifically, and only, about sexual and reproductive topics.

More research is also needed to compare refugee women with U.S.-born women in Tennessee, to see if the strict laws and policies in the state impact them equally. Since Tennessee has numerous restrictive policies concerning women’s reproductive rights, it would be beneficial to better understand the differences between refugee and native-born women. In the same vein, further research is needed to compare the family planning and contraception access of refugees in Tennessee with refugees in other states. Since access and barriers are shaped by federal, state, and local policies, finding the divergences between access in different states could allow for both targeted interventions for specific states and general interventions that would work across state boundaries.

A final recommendation for further research concerns the role of the religious VOLAGs, nonprofits, and health centers in Tennessee. It is important to determine and understand how much the religious affiliations of these organizations influence their policies, but also how much they influence the individuals who work or volunteer for them, and work directly with refugees. Having this better understanding would allow for decisions to be made about the role of religious affiliated organizations in refugee resettlement and assistance, and to make sure they are adhering to the non-proselytizing requirements that determine their funding.

**Concluding Remarks**

The lack of sexual and reproductive health is one of the leading causes of death, disease and disability among refugee women and girls, both during flight and after resettlement. 33 One of

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the most significant issues that resettled refugee women face is a high number of unintended pregnancies. Unintended pregnancies can lead to worse health outcomes, lack of reproductive self-determination, and also play a major role in maternal mortality rates. In Tennessee, sociocultural norms, misguided information, lack of political will, religious affiliations of organizations, and a lack of appropriate policies to meet the sexual and reproductive needs of refugees restrict access to contraceptives, family planning, and sexual and reproductive health services. All of this leads to higher rates of unintended pregnancies among refugees in the state.

Refugee women in Tennessee have high rates of unintended pregnancies and poor access to sexual and reproductive healthcare, especially family planning services, due to the confluence of many barriers. The traditional cultural, linguistic, and logistical barriers faced by refugees everywhere are heightened by political and policy barriers in Tennessee. Within the state, refugees also face additional barriers due to the religious nature of most of the VOLAGs, nonprofit organizations, and hospitals. The role of male partners in Tennessee appears to be very similar to pre-resettlement, except for the fact that many refugee women are being resettled without male partners, due to the nature of the conflicts displacing them. However, any additional autonomy gained by refugee women due to the absence of male partners is lost in Tennessee by the additional barriers produced by religious organizations and state policies.

All women, including resettled refugee women, have the right to decide on the number, spacing, and timing of their pregnancies, and they deserve to have proper and adequate information to achieve their desires. Unfortunately in Tennessee, the barriers for refugees in accessing and utilizing family planning services are great due to politics and policies, and the VOLAGs and nonprofit organizations that are specifically in place to help them in resettlement
are doing them a disservice when it comes to sexual and reproductive health, family planning, and contraception due to their own institutional religious affiliations.


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