2019 University of Minnesota Global Health Case Competition

Flight & Plight: Refugee Health and Well-Being in St. Cloud, Minnesota

Case Writing Team: Minnesota Department of Health, Refugee Health Program

This case is an adaptation of the Emory University case,
"Flight & Plight: Refugee Health and Well-Being in Atlanta"

All characters described within the case are *fictional* and bear no direct reflection to existing organizations or individuals. The case background and history, however, are meant to portray an accurate representation of circumstances of St. Cloud's refugee community. The case scenario is complex and does not necessarily have a correct or perfect solution, and thus encourages a judicious balance of creative yet perceptive approaches.

The authors have provided informative facts and figures within the case and references to help teams. The data provided are derived from independent sources, may have been adapted for use in this case, and are clearly cited such that teams can verify or contest the findings within their recommendations. Teams are responsible for justifying the accuracy and validity of all data and calculations that they use in their presentations, as well as defending their assertions in front of a panel of knowledgeable judges representing different stakeholders

Introduction

"Life of a Family"

Asmaa kept trying to solve the same problem that had worried her since she and her family had arrived in Kenya many years ago. Since the terrible day when they decided to flee, her husband, Ali, could not sleep. Unfamiliar situations or loud noises would sometimes cause him to freeze, temporarily paralyzing him. He was impatient with the children, his mood was often dark, and he would frequently forget things. When the family arrived in St. Cloud, MN, Asmaa had hoped that their new home would ease Ali's worries, but this new place brought more confusion and new difficulties. Soon after arriving in the U.S., Ali began to work to support the family, but his troubles kept getting worse. Asmaa was frightened that he might lose his temper while he was working or that he might wake up frozen, unable to leave the house, and lose his job.

During their regular check-ins, the family's resettlement caseworker had asked about any problems or needs. Asmaa decided to ask for help. The caseworker understood her concern and said that there were special doctors who could help. The closest one that could see Ali was more than an hour's drive away. She needed to figure out how to talk with Ali about seeing the doctor.

Soon after, the children returned from school with a letter written in Somali. Asmaa brought the letter to her sister, who read it to her. The letter said that the children, 3rd-grader Ahmed and 4th-grader Sahra, needed more vaccinations in order to stay in school. Asmaa was confused; the caseworker had said they needed to wait to see a doctor. She worried that the children wouldn't be able to go school. Borrowing her sister's phone, Asmaa called their resettlement caseworker. This time, he told her that their family was in line to see the doctor and that she would need to wait until the appointment. There was no way to see a doctor sooner. In the meantime, he told her to send the children to school. She tried to explain to the children that they would be okay, but she could not answer their questions about what they should tell their teachers. She told them to ask Mohamed, the Somali liaison at their school, for help. When Sahra spoke to Mohamed the next day, he reassured her that this often happens when newly arrived refugees were waiting for appointments. He assured her that they did not need to do anything and that he would explain the situation to their teachers.

Six months passed and life for Asmaa's family was improving in some ways. She scheduled the appointments that the clinic recommended for the children and they were fully immunized. Both of them were doing well at school, with the help of Mohamed. Thankfully, Asmaa had stayed healthy and, with their refugee screening complete, would not need go to the doctor again. Ali had not gone back, either, and his condition had not improved. He was always at work or just sitting still at home. Asmaa still could not figure out how to help him. While he did not

seem to be any worse, her hopes that his health condition would improve by itself in this new place were not coming true.

While Asmaa was glad that the children seemed to be adapting to their new school and making friends, she still felt unsettled in this new community. Now that they had been in the country for more than three months, they no longer had a caseworker to call. There were many neighbor families in the apartment complex, but they all had concerns of their own and warned her to be careful. They told her that there had been a drowning in the community a few years ago[i] and people still talked about a billboard that called refugee resettlement evil[ii]. They said that the people of St. Cloud were sometimes very kind but sometimes did not want them there. Each day she woke up thinking about how she could keep her family strong in this new place.

Prompt for Teams

The city council has recently passed a welcoming proclamation[iii] and some councilmembers have asked St. Dominic College and CloudCare Health to develop programming that will give substance to the proclamation. CloudCare Health is interested in a partnership that helps them provide effective and cost-efficient services to their diverse patients. The new president of the College, Karen Bruno, expressed excitement about the request and sees an opportunity to establish deeper College engagement with the growing and diverse St. Cloud community. In their efforts to create a welcoming and healthy community, the councilmembers wish to improve access to mental health care through primary care, specialty care, or other interventions for all community members. Because of current challenges and disparities, they particularly want to ensure that proposals will support access for the Somali refugee community.

President Bruno is accepting proposals that will help the college achieve these goals in partnership with CloudCare Health and the City Council. As a multidisciplinary group of health experts, you have been ask to work as consultants and submit a proposal. The proposal you submit should provide avenues for St. Dominic College faculty and students to be of service and improve conditions for St. Cloud's refugee communities as well as open new teaching and research opportunities for the college. The president is a first generation college graduate and a champion of diversity. St. Dominic College and CloudCare also value their partnership with the City of St. Cloud and area businesses.

You have been asked to present a well-researched, realistic strategy to enhance health and mental health resources for refugees around St. Cloud. Recent federal policy changes have meant that few new Somali refugees are arriving in the country and have introduced new challenges to those already resettled. Refugee communities face considerable challenges and obstacles on a daily basis. Family reunification has been delayed, so there is increased concern for family members still in refugee camps. There is worry about the potential loss of social and health services, and fear of potential changing consequences for accessing these and other services. These fears and stressors influence all aspects of refugee life and likely encourage low health seeking behaviors, which exacerbates pre-existing medical conditions such as post-traumatic stress disorder and depression. Careful consideration must be given to the health of refugee populations, specifically chronic health conditions that require both subspecialty services and primary care, with adequate consideration for continuity of secondary and tertiary care. Key health determinants should be addressed. Your proposal may also address assimilation, xenophobia, education, employment, and other community-related topics such as language, culture, or crime.

As President Bruno will be presenting the winning proposal to the Board of Trustees, ethical, legal, and financial considerations must be included as part of your team's proposal. You will need to work to convince Bruno of the significance of your strategy or program, including the

direct impact on refugees and the indirect impact on the surrounding community and the college.

Your budget for this project is USD 150,000 for a one-year start up. Attracting donors and in-kind contributions from partners will be required to supplement this budget and to demonstrate the long-term growth and sustainability of your proposed program. Outline one-year and five-year plans for your proposed program and give appropriate thought to what parts of the college community and other organizations, businesses, public entities, etc. you may want to engage to support your proposal.

Background: History of Refugees in the U.S. and the State of Minnesota

Who is a Refugee?

The 1951 United Nations Refugee Convention defines **a refugee** as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and, is unable or unwilling to avail him - or herself of the protection of that country, or to return there, for fear of persecution."[iv] **Internally displaced persons (IDP)** are individuals who have fled their homes, yet have not crossed an international frontier. **An asylum seeker** per the United Nations High Commissioner for Refugees (UNHCR) is someone whose request for sanctuary has yet to be processed.[v]

Comparatively, a migrant may leave their home country for many reasons unrelated to persecution and continues to enjoy the protection of their own government, even when abroad. It is important to note the difference between an immigrant and a refugee: an immigrant relocates based on choice influenced by economic or other factors, whereas a refugee seeks asylum in a country different from their home country due to persecution (or fear of) based on race, religion, nationality, or political opinion.[vi]
It is worth noting that who is a refugee, migrant, asylum seeker, or an IDP is a legal distinction that nation-states, including host countries, use to determine certain rights and privileges.

History and Policy

Protection of refugees has occurred since antiquity. International legal protection for refugees began less than 100 years ago, with the League of Nations, founded in January 1920 as a result of the Paris Peace Conference that ended World War I. It was the first international organization whose principal mission was to maintain world peace. The League appointed a High Commissioner in 1921 to define the status of refugees. This was the birth of international protection of refugees based on international law. The first laws written to afford protection to refugees were in reference to Russian and Armenian people in 1922-1926, defining legal status of refugees, and making recommendations for asylum, work, and travel. Other issues and related treaties included labor conditions, just treatment of native populations, human and drug trafficking, arms trade, global health, prisoners of war, and protection of minorities in

Europe. The League had 58 member countries during the peak of its influence (September 1934-February 1935). The diplomatic philosophy behind the league was a fundamental shift from the preceding 100 years. The League did not have its own armed forces; it depended on the "Great Powers" in its membership to enforce its resolutions, keep its economic sanctions, and provide military support when needed. These sanctions, use of armed forces, and philosophy of preventing aggression led to conflicts of interest for some member nations. In 1946, twenty-six years after its founding, proven unable to prevent another world war, the League was replaced by the United Nations after World War II (WWII).

The history of refugee resettlement to the United States (U.S.) really began after WWII when more than 250,000 displaced Europeans could not return home. This was the first time the concept of "non-refoulement", the notion that countries would not send people fleeing persecution back to their country from which they fled, was adopted. The Displaced Persons Act of 1948 followed this initial resettlement and was the first refugee legislation enacted by Congress.[vii] The U.S. Refugee Act of 1980 was an amendment to two previous Acts: the Immigration and Nationality Act of 1965 and the Migration and Refugee Assistance Act of 1962. Signed by President Jimmy Carter, it was a comprehensive change to the immigration laws intended to improve procedures for the admission and effective resettlement of refugees to the U.S..[viii] International refugee law is defined by the 1951 Geneva (Refugee) Convention, with an added protocol in 1967, expanding law to address refugee displacement across the world.[ix]

Various governmental and nongovernmental organizations oversee the refugee resettlement process; generally, the three main stages are: 1) determination of individual refugee status; 2) overseas processing; and, 3) resettlement in permanent country. Initially, refugees register with the UNHCR in the country they fled into; this begins the process of determining whether they qualify as refugees.[x] UNHCR recommends resettlement options, so refugees have no choice in determining the country they will reside in. The U.S. Immigration and Nationality Act defines refugees as "any person outside his or her country who has a 'well-founded' fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Historically, the U.S. has accepted many vulnerable populations, including survivors of torture and violence and those with extensive medical needs. Since 1975, more than 3.3 million refugees have resettled in the U.S.[x] Each year, the President of the United States determines refugee resettlement priorities and annual admission ceilings for the upcoming federal fiscal year in consultation with relevant agencies. Under President Obama, the federal ceiling was increased in response to the global need. While he set the ceiling at 110,000 for fiscal year 2016, incoming President Trump reduced this number dramatically, setting a new intended ceiling of 50,000 and temporarily halting resettlement with multiple Presidential Executive Orders, amid various legal challenges. During fiscal year 2016, 53,716 people were admitted. Subsequent admission ceilings for fiscal years 2017 and 2018 have been 45,000 and 30,000, respectively; both well below the previous historic low ceiling of 67,000, set by Ronald Reagan in 1986.[xi]

This recent approach to refugee resettlement represents a significant change from practices that had continued under presidents of both parties and through times of geopolitical tension.

It also challenges well-established infrastructure and systems in the U.S., which had evolved to meet the needs of new arrivals with refugee status effectively.

Refugee Vetting and Resettlement

The vetting process for refugees in the U.S. is extensive, lasting 12-24 months, with screening by eight federal agencies, six security database or biometric security checks, a medical screening, and three in-person interviews with Department of Homeland Security officers.[xii]

Once a person or family is selected for U.S. resettlement, the process of selecting a state is a collaborative effort between the State Department; national refugee resettlement agencies, such as Lutheran Immigration and Refugee Services or the U.S. Committee for Refugees and Immigrants and their local affiliates; and local communities. Priorities may be based on reunifying families; selecting locations with established refugee/immigrant communities; or employment prospects for newcomers, which increases likelihood of self-sufficiency.[xiii] Refugee demographics vary by state and between counties or areas within a state, as refugee communities tend to grow as a critical mass as families become established. Consultation between federal, state, and local governments is required for placement of refugees.[xiv] States provide a recommended state resettlement ceiling to the federal government. Understanding how refugee resettlement will affect the community and understanding the organizations and assistance that refugees will need are two large factors that are considered by state and local authorities. Additional considerations can include local factors such as affordable housing and the likelihood of an area becoming a secondary refugee migration destination.

Funding is provided to states for time-limited resettlement services, targeted assistance, and preventative health — assistance is provided directly or through public or nonprofit organizations that provide such services. In addition, some federal funds are available to cover health insurance for up to eight months in the absence of other publicly funded options (which vary by state). The Office of Refugee Resettlement, whose budget for 2018 fiscal year was $1.46 million/year (USD), provides funds to states, allocating money according to number of resettled refugees.[xv]

One year after resettlement in the U.S., refugees apply for Lawful Permanent Residency (green card application), and after another four years are able to become U.S. Citizens.

Health Insurance Enrollment

Upon arrival in the U.S., access to health insurance varies by state. In Minnesota, refugees are eligible for Medical Assistance (MA, Minnesota's Medicaid program) under the same criteria as other Minnesotans. Over 99% of all refugee arrivals to Minnesota qualify for MA. Refugees who qualify for MA must apply for renewal each year. Some clinics or local "insurance navigators" offer assistance with the process, but it can still constitute a significant barrier to on-going insurance for many families.

For those few arrivals who exceed the MA maximum income, typically due to rejoining established family members, they may be eligible for subsidized care through the MinnesotaCare program, another state health insurance program. Family reunification is not a "qualifying event", so newly arriving family members cannot be added to private insurance until

the next open enrollment period. In Minnesota, there are federal funds available to cover screening costs for anyone who is un- or under-insured; these funds do not cover additional medical care.

Refugee Resettlement in Minnesota

In the 2018 fiscal year, 22,491 refugees were admitted into the United States. Of this total, 723 individuals, roughly 3% of all newly admitted refugees, resettled in the state of Minnesota.[xvi] Minnesota has a strong history of refugee resettlement, and has resettled over 100,000 refugees since 1980.[xvii]

Minnesota receives a diverse array of refugees from all over the world, with a majority of recent arrivals coming from Somalia, Burma, and Ethiopia.[xvii] Among the 257 Somali refugees resettled to the U.S. in fiscal year 2018, 33% resettled in Minnesota.[xvi, xvii] Additionally, many refugees move to Minnesota after initially resettling in another state ("secondary refugees"). While the actual number of secondary refugees who move to Minnesota is unknown, the Office of Refugee Resettlement estimated in fiscal year 2014 that Minnesota received the highest number of refugees due to secondary migration.[xviii]

Many refugees resettle in the Minneapolis-St. Paul metropolitan area. However, many cities in greater Minnesota, such as Rochester, Willmar, and St. Cloud, also have sizeable refugee populations.

Refugees in Minnesota contribute to both local economies and the labor force. For example, in Willmar, Minnesota, many businesses in and around Main Street are Somali-owned. A 2017 study by Notre Dame found that after six years of living in the U.S., refugees work at higher rates than U.S.-born individuals. Additionally, after 20 years in the U.S., refugees have payed significantly more in taxes than they have received in benefits.[xix]

St. Cloud Refugee Resettlement

St. Cloud is one of Minnesota's largest cities, located 65 miles north of the Twin Cities Metropolitan Area. Established in 1856, the city originally grew with the founding of a granite quarry and the railroad and became a center for the surrounding agricultural area.[xx] The population is projected to be approximately 68,000 in the city of St. Cloud in 2019, with close to 290,000 in the Greater St. Cloud Metropolitan Area.[xxi]

Since 1999, over 2,000 primary refugees have resettled in the St. Cloud area, with over 90% originating from Somalia. Many other refugees have relocated to St. Cloud after initially resettling in another state or another area of Minnesota.

Refugee Health

Each year, 10 to 15 million people seek political asylum or become refugees in various parts of the world. Most of these displaced persons are from developing countries where infectious diseases (e.g. tuberculosis, hepatitis, malaria, and various parasitic and emerging diseases) are prevalent. When persons with refugee status arrive in Minnesota, they have unique health care needs. Fleeing persecution and conflict in their homeland, newly arrived refugees may have received little or no medical care for prolonged periods prior to resettlement. Often, they arrive

from living in refugee camps, where malnutrition and illness due to crowding and deficient sanitation are rampant.

In addition to infectious diseases, refugees may also have mental health needs upon arrival. Many refugees have experienced or witnessed government-sponsored torture and/or terror. Furthermore, leaving behind all that is familiar and starting a new life in a new country with a different language and culture can create new stressors; it is a testament to human resilience that exposure to trauma does not necessarily lead to mental health disorders. Nevertheless, mental health is an important aspect of well-being and an important consideration in refugee health. Since 2012, 145 refugees have arrived to Minnesota with a known mental health concern such as post-traumatic stress disorder (PTSD), chemical dependency, or depression. Additionally, from 2012-2017, 254 primary refugees were referred to a mental health specialist following their post-arrival refugee health assessment (RHA).

Health Screening Process

As stated above, a medical screening process is a required part of the vetting process for resettlement in the United States. This screening is designed to protect the health of the U.S. population and to detect any inadmissible conditions, such as infectious pulmonary tuberculosis. Anyone with an inadmissible condition is offered treatment and re-evaluated upon treatment completion. Overseas medical examinations expire within 6 months or less, depending on the medical condition of the applicant. In the past several years, overseas screening has expanded to include initiatives with presumptive treatment of malaria and intestinal parasites and a vaccination program.

In addition to the overseas screening, people with refugee status receive a domestic health screening, generally initiated within 30 - 90 days upon arrival in the U.S. In Minnesota, 97 to 99 percent of primary refugees receive a domestic screening examination. The domestic screening takes place over 2 - 3 office visits. It is comprised of the basic elements of any visit to establish primary care, with additional screening to address health risks that refugees have at the population level, due to potential risk factors and epidemiologic differences in their countries of origin.

Domestic screening is implemented at the state level, following national guidelines issued by the Centers for Disease Prevention and Control and the Office of Refugee Resettlement. Key elements of screening include immunization; screening for infectious diseases, including hepatitis and Sexually Transmitted Infections; screening for intestinal parasites; blood lead levels for children through age 16; and additional screening for tuberculosis (including latent tuberculosis).[xxii] The screening also should assess mental health needs. In Minnesota, as in many states, screening clinics are asked to identify the presence of a mental health need or referral, but there is not a standardized mental health screening tool. Minnesota is currently in the pilot stages of a statewide screening protocol for refugee adults.[xxiii]

The purpose of this screening process is first and foremost for treatment and care of refugees but also to monitor and report diseases in specific populations, respond to potential exposures which may have occurred abroad or outbreaks in the U.S., and to advise on local health care for refugee populations resettling in the U.S.[xxiv] After screening is completed, refugees are

encouraged to establish and continue primary care. Given the barriers to establishing primary care without active referrals, the success rate for on-going health care may be lower than that of initial screening.

The barriers preventing refugees from follow-up on their health care are not well documented, yet a study on refugees conducted in San Diego identified logistical issues such as transportation, hours of service, wait times, appointment availability, and childcare needs as recurrent themes in barriers to health care utilization. Language was also perceived to be a major barrier, depending on the language of the refugee population seeking healthcare and the languages spoken by healthcare providers.[xxv]

Refugee Health Services in Minnesota

Refugee health and screening are decentralized in Minnesota; each local county public health entity (LPH) works with the Minnesota Department of Health Refugee Health Program (RHP) to identify the best screening approaches in their jurisdiction. The majority of counties partner with one or more private clinics to complete the screening. Once the RHP receives the overseas screening results from CDC, it is responsible for transferring the medical records to the refugees' county of residence. Then, LPH identifies the screening clinic and connects with the new arrival and/or the resettlement agency caseworker. LPH works with the clinic to schedule the screening visits, and returns the screening results to RHP, which also has surveillance functions.

Health Services in St. Cloud

For the purposes of this case, CloudCare Health is the largest health care system in Greater St. Cloud and it operates the hospital, Urgency Center (urgent care), and emergency room in St. Cloud. Many CloudCare clinics conduct refugee screenings and many new arrivals access primary care and specialty care through CloudCare. Some of their clinics have hired Somali Community Health Workers who fill a variety of roles in serving patients and community. Additionally, Health Partners-Central Minnesota Clinic in Sartell serves the St. Cloud area and conducts refugee screenings.

Multiple health clinics in St. Cloud offer some behavioral health services, including some telehealth. In addition, there are several mental health clinics, and behavioral health is offered at some community agencies. The Center for Victims of Torture, headquartered in the Twin Cities, has facilitated some sessions for care providers and community members.

Despite these resources, the St. Cloud counties of Stearns, Benton, and Sherburne are designated as a Mental Health Professional Shortage Area.[xxvi] In addition to this general shortfall, finding providers that are comfortable working with trauma survivors, with interpreters, and in an inter-cultural context remains deeply challenging.

Social Services

In St. Cloud, many organizations offer services for people with refugee status, including programs targeting youth, seniors, and parents. Such agencies have diverse funding streams, including some with federal funding designed to promote independence and economic self-sufficiency for refugees. In Minnesota, the services described below are generally offered to

refugees who have lived in the U.S. for less than five years. Employability Services are offered to refugee and immigrant populations with services including job placement, orientation, vocational English language instruction, and other services addressing specific job training. English Language Instruction services teach communication (speaking, reading, and writing) for employment obtainment. These courses also target newly arrived refugees. Other services include Head Start for pre-kindergarten children, Parent/School Involvement Services to orient and educate parents on local school systems, and Refugee Youth Programs providing services such as after-school programs. Food assistance programs are offered through various local government and non-profit organizations that are available to low-income populations, including refugees. St. Cloud is home to many nationally known social services agencies such as Lutheran Social Services, Catholic Charities, United Way, Volunteers of America, and others. There are broad services for low-income and unemployed or underemployed people.

Despite the extensive options for social service support, cuts to funding for social service programs have resulted in the existing resources not meeting the demand for things like affordable housing, mental health services, and other supports. Whenever there is a general lack of services, assuring that the services that do exist are available and accessible to refugees has proved challenging. There have been examples of clinic systems simply not making appropriate referrals for refugee clients due to lack of resources (especially with the added burden/cost of interpreter services).

Recent political changes have the potential to greatly influence the continuation of services offered to resettled refugees. The U.S. State Department recently issued a statement indicating that offices expecting to process less than 100 refugees in the 2018 fiscal year will lose authorization and, therefore, will likely close. This will influence availability of social service support to refugees who have resettled as recently as this past year.[xxvii]

Refugee Employment

After refugees have resettled in Minnesota, one of the most important factors determining whether they are able to adjust to life in their new country comfortably is whether each family is able to find a source of employment. Jobs provide income, a support network, and, oftentimes, a sense of security. When refugees enter the U.S., they receive full authorization from the U.S. Department of Justice to obtain employment legally.[xxviii] According to recent studies, refugees in the U.S. pay over $21,000 more in taxes than they receive in benefits over their first 20 years in the country.[xxix] Yet, despite being employed overall at a higher rate than other immigrants, refugees earn a slightly lower average salary of $42,000 per household. One of the primary reasons Somali families have moved to and resettled in St. Cloud is the employment opportunities in factories, agriculture, health care, and other service industries that do not require English proficiency. There are many examples of refugees opening their own businesses, such as a pharmacy, a trucking company, and many food stores. Refugee employment levels also play a role in refugee healthcare, as employment is often correlated

with higher rates of health insurance coverage and increased income can lead to more opportunities for preventative care before major illnesses strike.

Refugee Education

The educational status and opportunities of refugees can be broken down into two main areas: education prior to entering the U.S. and educational opportunities after immigrating. In data from recent years, educational background amongst refugees varied depending on country of origin and gender. Given the long wait in refugee camps prior to resettlement, many of the children arriving were born in refugee camps, with limited educational opportunities. Educational opportunities after immigration to the U.S. are more established, especially for new arrivals under 21. In communities such as St. Cloud, with a high density of Somali refugees, there are various community-based learning programs for both adults and children. Children can enroll in Head Start at age 3 or 4, and then enter the public school system. Many of the public schools in St. Cloud have family liaisons, including several Somali-American staff. Public schools in Minnesota accept student enrollment until the age of 21, which has made a big difference in the lives of refugee arrivals between 18 and 21. This allows those young adults to have an easier transition to work or to post-secondary education upon completion of high school.

Culture in St. Cloud

St. Cloud has, over generations, been a German-Catholic cultural stronghold, and the influx of large numbers of Somali refugees has presented cross-cultural tensions and opportunities for inclusivity that have sometimes dominated local, state, and national politics, news, and conversations. A city council member tried to pass a resolution to ban refugee resettlement in October 2017. Instead of voting on the ban, the city council passed a resolution "in support of a just and welcoming community". New agencies have been created in recent years in St. Cloud, like "#unitecloud", an organization doing community outreach to bring up the difficult conversations about a changing and more diverse community. This local version of the refugee and immigrant issues that are under the national spotlight are sometimes heated and sometimes healing.

Legal Aid for Refugees

For many refugees, legal processes are an ongoing part of regular life. While their initial immigration process can be procedural and filled with paperwork, once they have settled into their new life in this country, many scenarios can arise in which legal counsel can be advantageous or even required. These can include any immigration clarifications, family reunification, adapting to changes in immigration policy, and even in some cases, help with establishing new businesses in the community. This would also include seeking assistance if one becomes the victim of a crime (including, but not limited to, domestic violence). The complicated legal environment of the U.S. can be very difficult for refugees to understand and navigate by themselves.

Traditional legal counsel can be very expensive, but there are reduced cost and pro bono legal resources available to refugees in Minnesota, offered by non-profits, law schools, and reduced-

cost attorneys. The Mid-Minnesota Legal Aid office is in St. Cloud, as well as statewide resources that may be available by phone.

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[ii] Anti-Muslim billboard posted near St. Cloud taken down http://www.startribune.com/anti-muslim-billboard-posted-near-st-cloud-taken-down/369177621/

[iii] St. Cloud City Council approves 'welcoming' resolution http://www.startribune.com/st-cloud-city-council-approves-resolution-for-being-a-just-and-welcoming-community-after-discussion-on-refugee-resettlement-moratorium/452623253/

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[xvii] Minnesota Department of Health, Refugee Health Program, Refugee Health Statistics. http://www.health.state.mn.us/refugee/stats/

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