



# Iowa Refugee Health Program Annual Report 2016

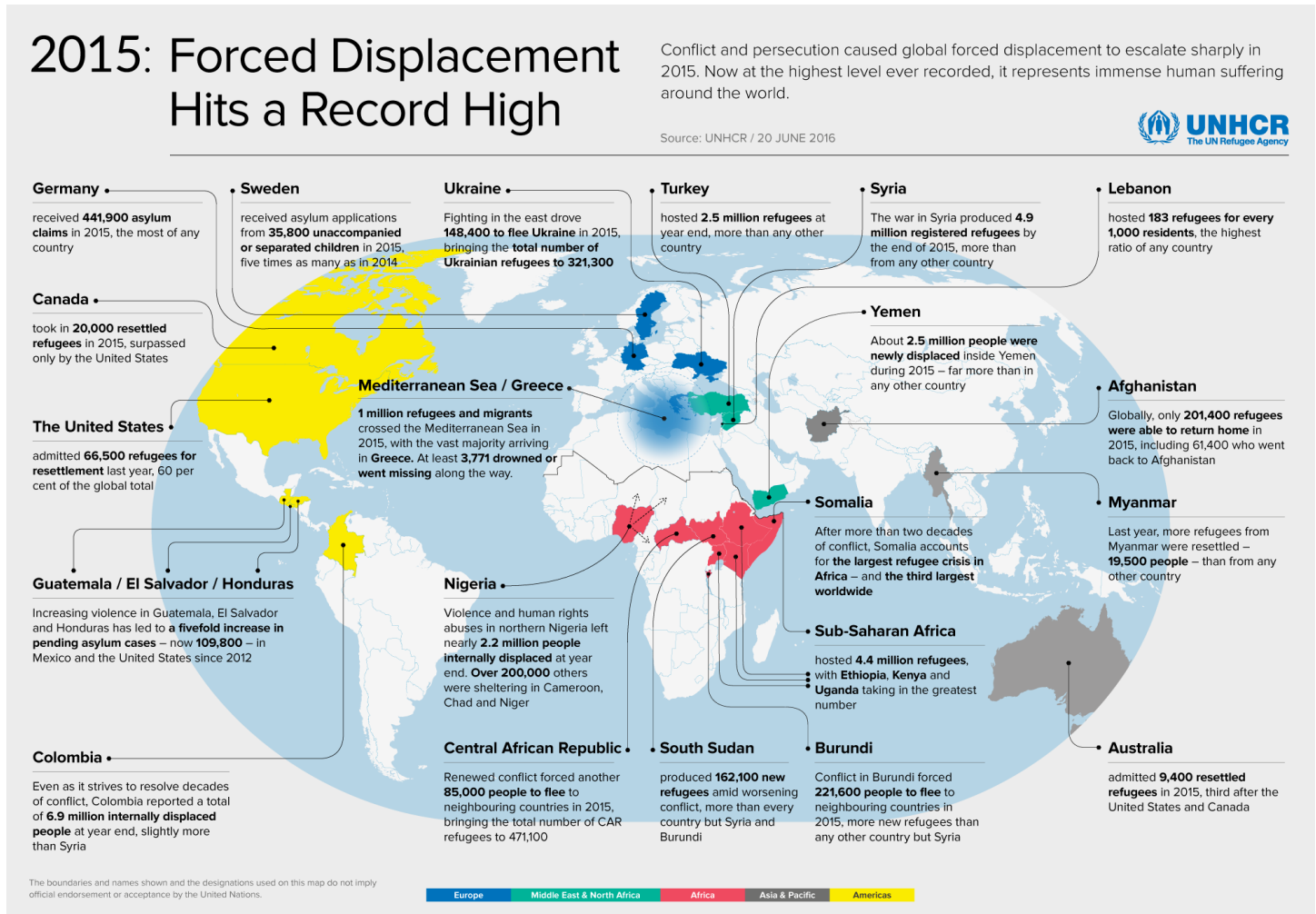


## Contents

<b>Contents</b> .....	1
<b>Introduction</b> .....	2
<b>Purpose</b> .....	3
<b>Demographic and Arrival Data</b> .....	4
<b>Health Assessment Data</b> .....	6
Tuberculosis.....	6
Hepatitis B .....	7
Human Immunodeficiency Virus (HIV) .....	8
Syphilis.....	8
Intestinal Parasites .....	9
Lead .....	10
Major Diagnoses and Referrals .....	10
<b>Summary</b> .....	11
<b>Contact Information</b> .....	11

## Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), an estimated **65.3 million** people are now displaced globally due to conflict, persecution, generalized violence or human rights violations. Among those forcibly displaced are nearly **21.3 million** refugees, over half of whom are children under the age of 18. At the end of 2015, the global number of refugees under UNHCR's mandate was estimated to be **16.1 million**, the highest level recorded in the past two decades. The main source of this increase in recent years has been the conflict in Syria, accounting for more than half of new refugees in 2015.



The United States has responded to the escalating refugee crisis by admitting 84,994 refugees for resettlement in federal fiscal year (FY) 2016 (October 1, 2015-September 30, 2016), an **increase of 21.4 percent** from FY2015. Iowa accepted 995 refugees for resettlement in FY2016, an **increase of 26.4 percent** from FY2015.

Prior to coming to the U.S., refugees have limited access to health care services, food supplies and sanitation, which can have implications for malnutrition, infectious diseases and chronic conditions. Refugees also experience varying levels of trauma, which can effect mental health and emotional well-being, creating additional barriers to successful resettlement. The Iowa Department of Public Health (IDPH) recognizes that health and emotional wellness play an integral role in the refugee resettlement process. The IDPH Refugee Health Program collaborates with local clinics, resettlement agencies and community organizations throughout the state to protect and improve the health and well-being of refugees.



#### Iowa Refugee Health Program responsibilities include:

- ❖ Ensure a comprehensive initial health assessment is completed for each newly arriving refugee\*
- ❖ Communicate CDC refugee health assessment guidelines and updates to private health care providers and local public health agencies
- ❖ Compile, analyze and distribute health assessment data to private health care providers and local public health agencies
- ❖ Coordinate appropriate public health responses to identified refugee health issues

\*For detailed information on the Iowa Initial Refugee Health Assessment, please visit the Iowa Refugee Health Program website at <http://idph.iowa.gov/immtb/rh>.

## Purpose

The purpose of this report is to provide an informational resource for stakeholders, local partners, policy makers and the general public. The data in this report is compiled from information provided by UNHCR, the Office of Refugee Resettlement (ORR), the Centers for Disease Control and Prevention (CDC), the Iowa Department of Public Health (IDPH) and medical clinics throughout Iowa. It includes demographic information and health assessment outcomes for primary refugees who arrived in Iowa during fiscal and calendar year 2016.



## Demographic and Arrival Data

With forced displacement continuing to impact a growing number of people throughout the world, communities in Iowa have responded by welcoming an increasing number of refugees for resettlement. The data depicted in Figure 1 is provided by the Office of Refugee Resettlement (ORR) and shows primary refugee arrivals to Iowa over the past five federal fiscal years (10/1/2011 - 9/30/2016). The number of primary refugee arrivals has gradually increased since 2011, with a total of 3,503 primary refugee arrivals. In calendar year 2016, 1105 primary refugees arrived in Iowa, a **32.8 percent increase** from 2015 (Figure 2). The highest numbers of refugees arrived during the months of July and August.\*\*

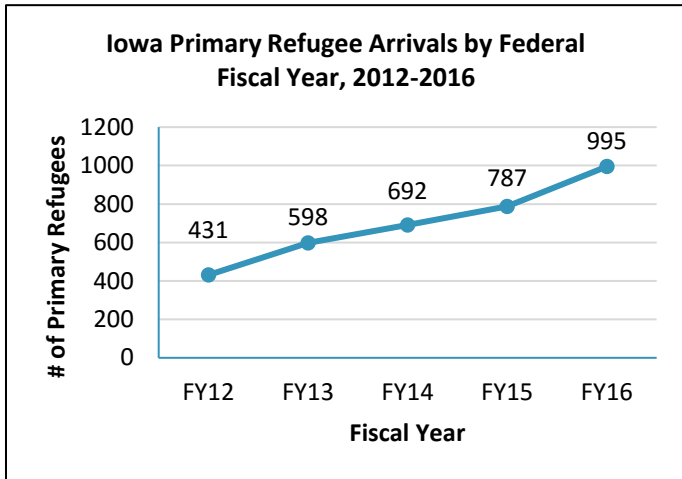


Figure 1: Iowa Primary Refugees by Fiscal Year, 2012-2016

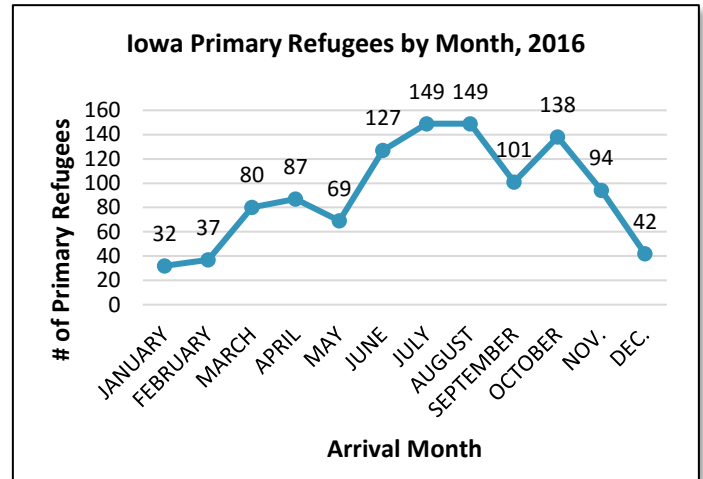


Figure 2: Iowa Primary Refugees by Month, 2016

Refugees arrived in Iowa in 2016 from 14 different nations, with the highest numbers arriving from the Democratic Republic of Congo and Burma/Myanmar (Figure 3). Refugee resettlement occurred in 12 different counties (Figure 4), with Polk County receiving 85.6 percent of all new arrivals.\*\*

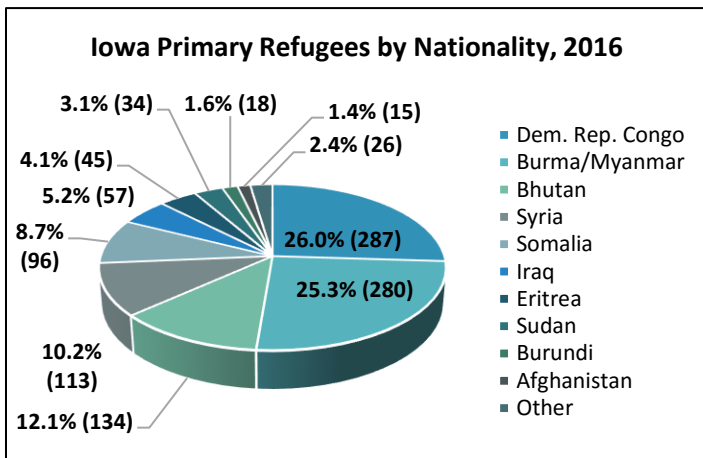


Figure 3: Iowa Primary Refugees by Nationality, 2016. "Other" Includes Nepal, Ethiopia, El Salvador, and India.

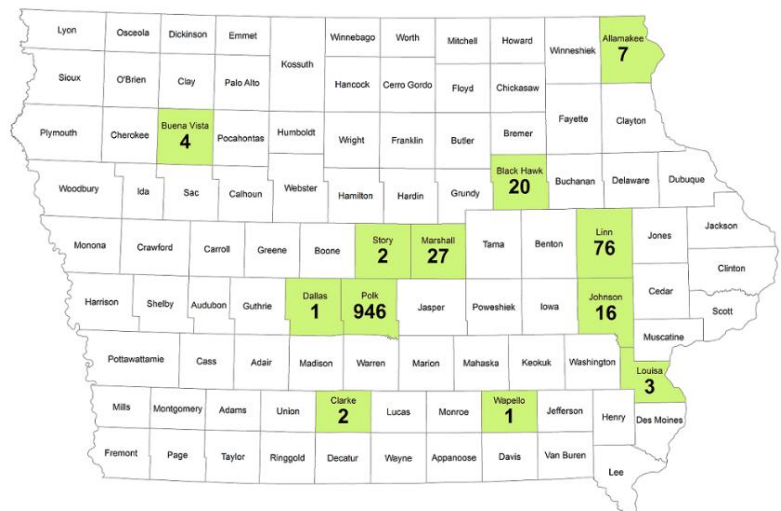


Figure 4: Iowa Primary Refugees by Initial County of Resettlement, 2016

\*\*Please note: Iowa's arrival numbers also include immigrants entering the United States on special immigrant visas (SIVs) from Iraq and Afghanistan. These individuals are given assistance with resettlement and integration, and are eligible to receive ORR benefits and services for the same time period as refugees.

Refugees' ages at time of arrival ranged from 3 months to 88 years. The majority of arrivals (86 percent) were age 40 years or younger, and **54 percent were children and young adults under the age of 21** (Figure 5). For refugee youth under the age of 18, 41 percent were aged 0 - 6, 34 percent were aged 7 - 12, and 25 percent were aged 13 - 18 years (Figure 6). Of the 2016 refugee arrivals, 52 percent were male (578) and 48 percent were female (527).

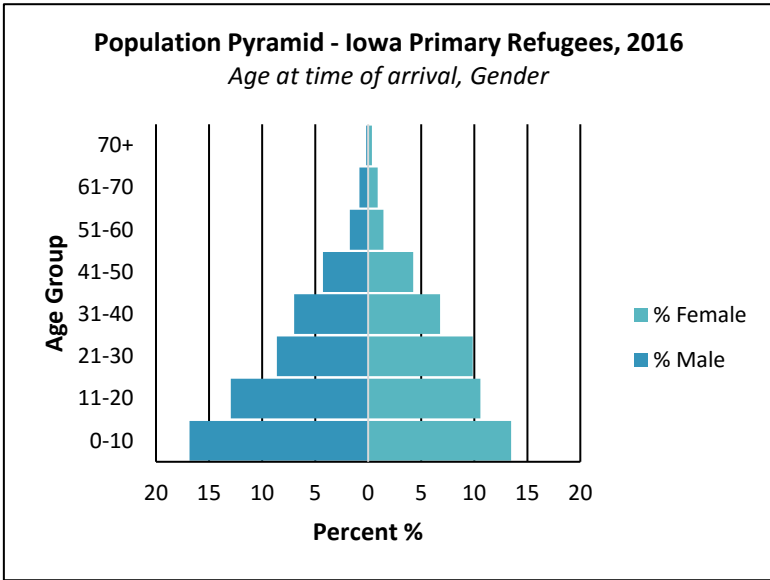


Figure 5: Population Pyramid - Iowa Primary Refugees, 2016

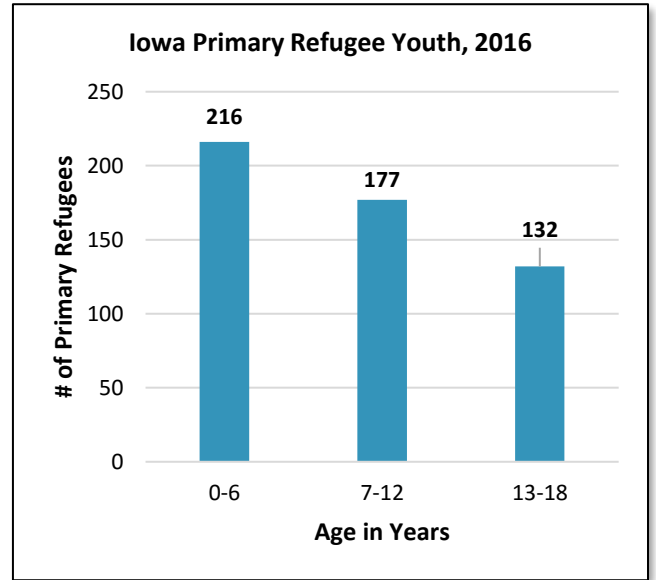


Figure 6: Iowa Primary Refugee Youth, 2016



Refugee youth participate in the SHINE! after school program in Des Moines, Iowa. Photo courtesy of USCRI.

## Health Assessment Data

The Federal Refugee Act of 1980 directs every state to offer a Refugee Health Assessment, but it is not mandatory. Iowa strongly recommends all newly arriving refugees receive this initial health assessment. For CY2016, **96.4 percent of Iowa's primary refugees received comprehensive initial health assessments** (Figure 7). Of the health assessments received, 55.7 percent were initiated within 30 days, 41.8 percent within 31-60 days, and 2.5 percent within in 60+ days (Figure 8).

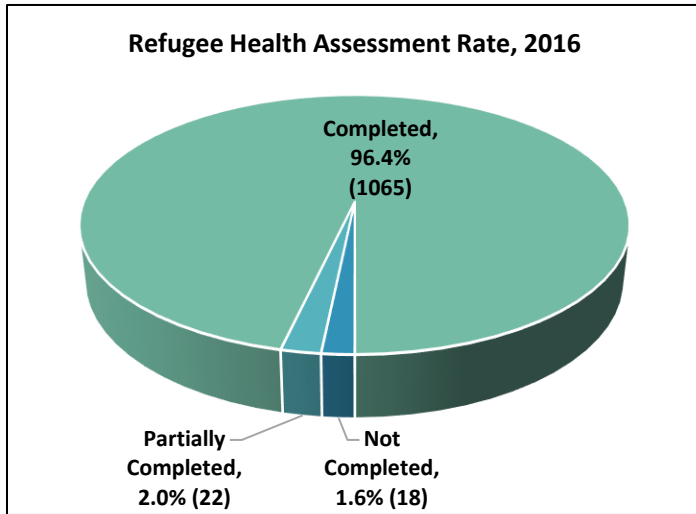


Figure 7: Refugee Health Assessment Rate, 2016

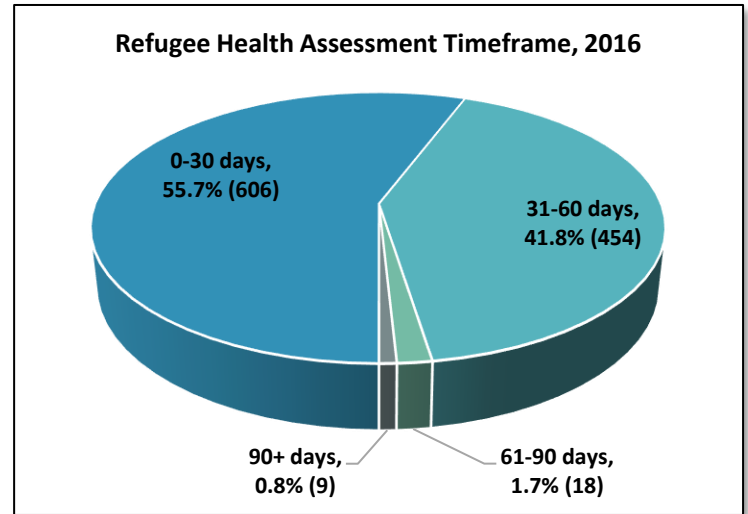


Figure 8: Refugee Health Assessment Timeframe, 2016

## Tuberculosis

Although tuberculosis (TB) rates in the U.S. continue to decline, the case rate among foreign-born persons in 2016 (14.6 cases per 100,000) was approximately 14 times higher than among U.S.-born persons (1.1 cases per 100,000 persons). In Iowa, the 2016 TB case rate was 1.54 cases per 100,000 persons, which is significantly lower than the 2016 national average of 2.8 cases per 100,000 persons. Despite accounting for only 4 percent of the Iowa population, foreign born persons have accounted for 71 percent of the state's reported TB cases in the past 10 years (2007-2016).

### Class B Arrivals

Prior to departure to the U.S., refugees are given a TB class status based on the results of the overseas medical examination. Those who have a class B TB status are flagged for additional follow-up upon arrival to Iowa. In 2016, 84 primary refugees received a class B TB designation (approximately 7.6 percent of arrivals). Of those with a class B designation, **34.5 percent (29) were diagnosed with latent tuberculosis (LTBI)** after being evaluated in Iowa, and one case of active TB disease was identified (Figure 9).

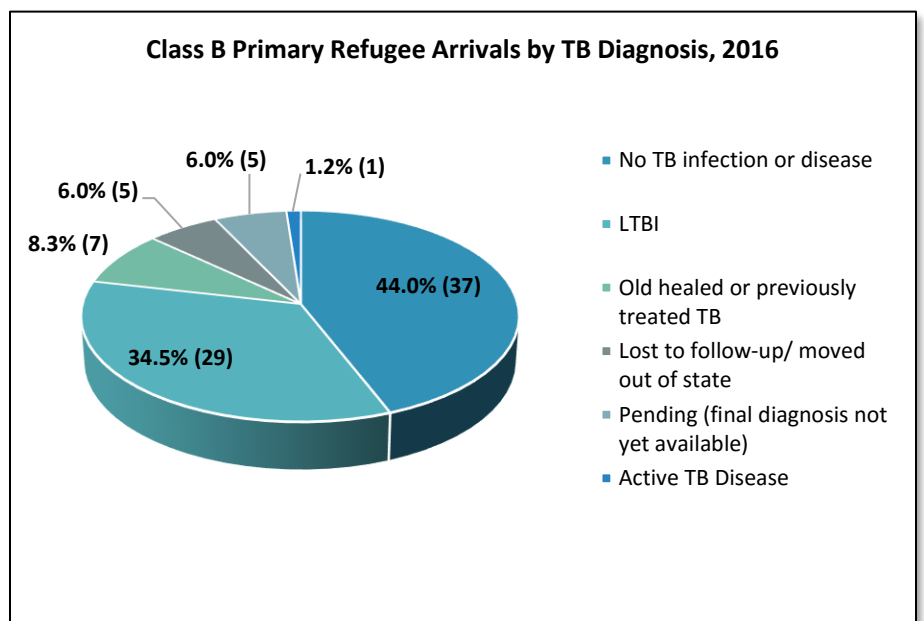


Figure 9: Class B Primary Refugee Arrivals by TB Diagnosis, 2016

## Primary Refugee Arrivals

Although refugees diagnosed with active TB during the overseas medical exam are not permitted to enter the U.S. until they are treated and no longer infectious, all refugees are still screened for TB infection and disease during the initial domestic health assessment. Of the 1054 primary refugees screened for TB in Iowa in 2016 (Figure 10), approximately **16.7 percent (176) were diagnosed with LTBI, and two cases of active TB disease were identified** (Figure 11). TB diagnoses were unable to be obtained for 29 new arrivals (approximately 2.8 percent of those screened), mainly due to loss of contact or inability of patients to return to clinics for chest x-ray appointments. The IDPH Refugee Health Program will continue to coordinate with local health care providers and resettlement agencies to address this concern.

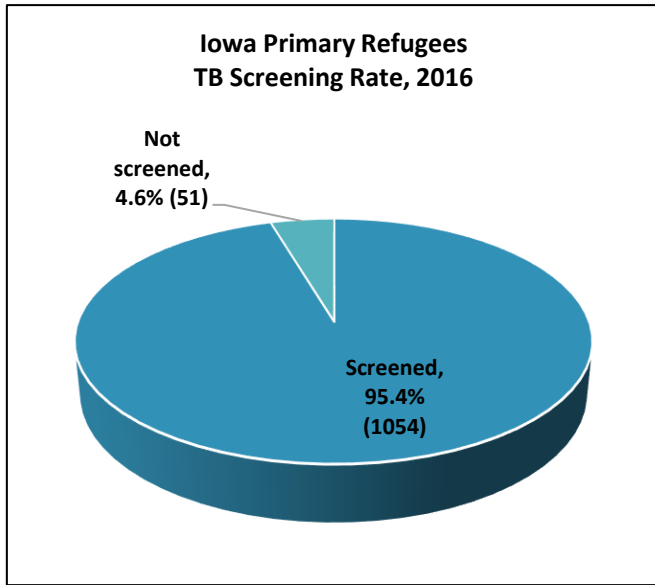


Figure 10: Iowa Primary Refugees - TB Screening Rate, 2016

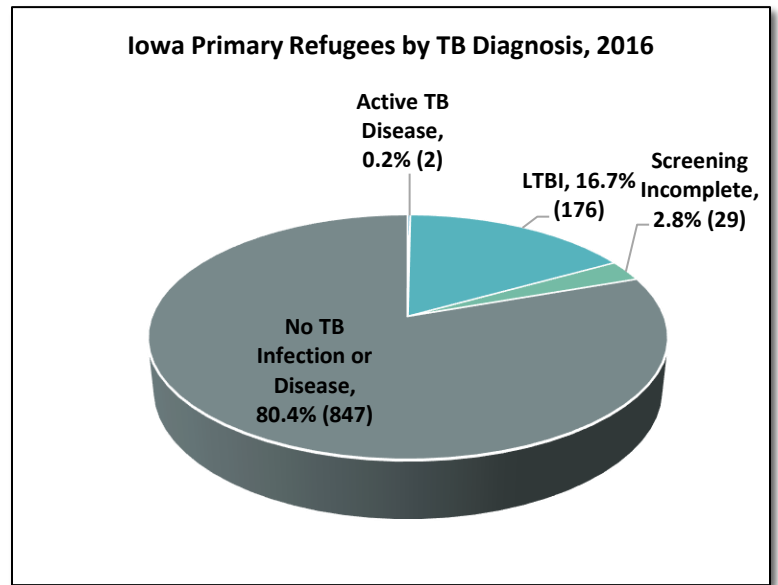


Figure 11: Iowa Primary Refugees by TB Diagnosis, 2016

## Hepatitis B

According to the CDC, hepatitis B infection (HBV) is highly endemic in many regions of Africa, Asia and the Pacific Islands. Since the majority of refugee populations resettling in the U.S. originate from or have lived in countries endemic for HBV, screening should be routinely performed for all newly arriving refugees. In 2015, 3,370 cases of *acute* hepatitis B were reported to the CDC from 48 states and the overall incidence rate was 1.1 cases per 100,000 persons. Forty states reported 14,416 cases of *chronic* hepatitis B. In Iowa in 2016, 341 confirmed or probable cases of *chronic* hepatitis B were reported and 10 cases of *acute* hepatitis B were reported. Of the 1038 primary refugees were screened for the hepatitis B surface antigen (HBsAg +) in Iowa, 37 tested positive (Figure 12).

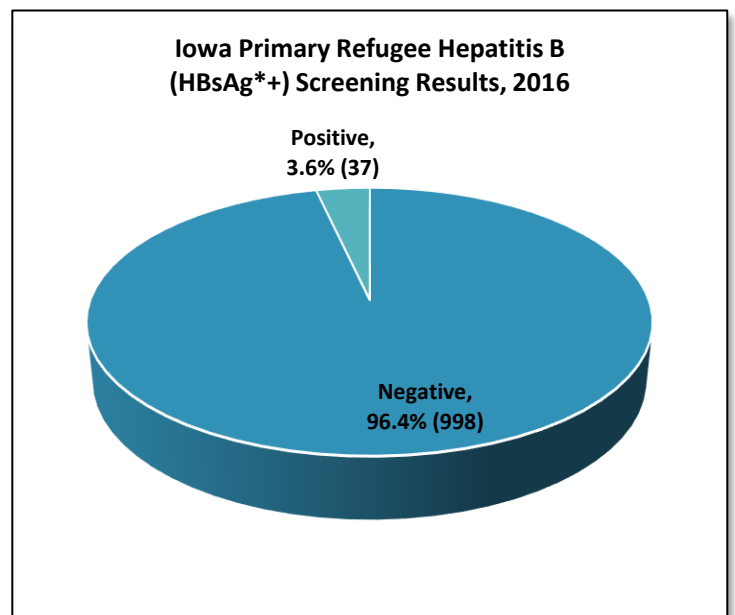


Figure 12: Iowa Primary Refugee Hepatitis B Screening Results, 2016



## Human Immunodeficiency Virus (HIV)

According to the UNHCR, even though conflict, displacement, food insecurity and poverty might leave refugees more susceptible to HIV, displaced populations do not always display higher rates of infection. A variety of complicated factors determine how seriously refugees are at risk for HIV, including:

- Pre-conflict HIV rates among refugees
- HIV rates of surrounding communities in refugee camps
- The level of interaction between refugees and host populations
- The level of drug use in refugee camps and surrounding communities
- Exposure to sexual abuse and violence

Refugees are no longer routinely tested for HIV prior to departure to the U.S. and the virus was removed from the list of inadmissible conditions in January of 2010. However, the CDC strongly recommends universal HIV screening for all refugees upon arrival to the U.S. In 2015, an estimated 39,513 people were diagnosed with HIV in the U.S. and an estimated 124 adults and adolescents were diagnosed with HIV in Iowa. Out of the 997 refugees who were screened for HIV in 2016, only 5 (<1%) tested positive for HIV (Figure 13).

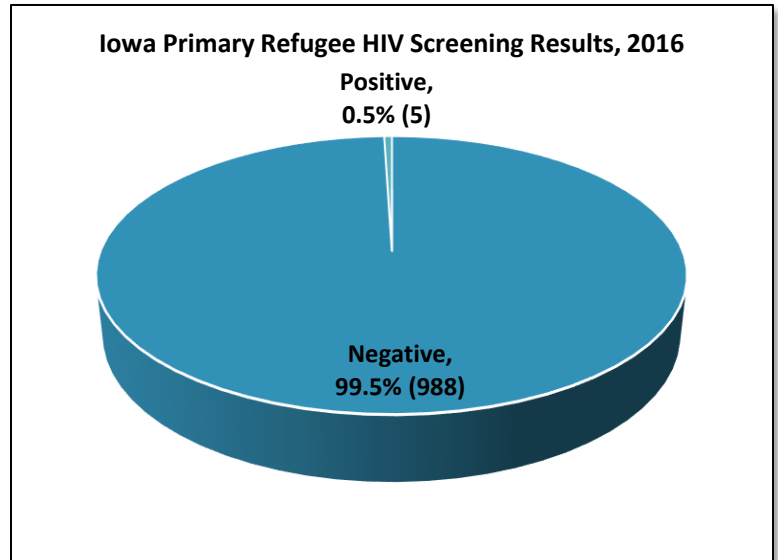


Figure 13: Iowa Primary Refugee HIV Screening Results, 2016

## Syphilis

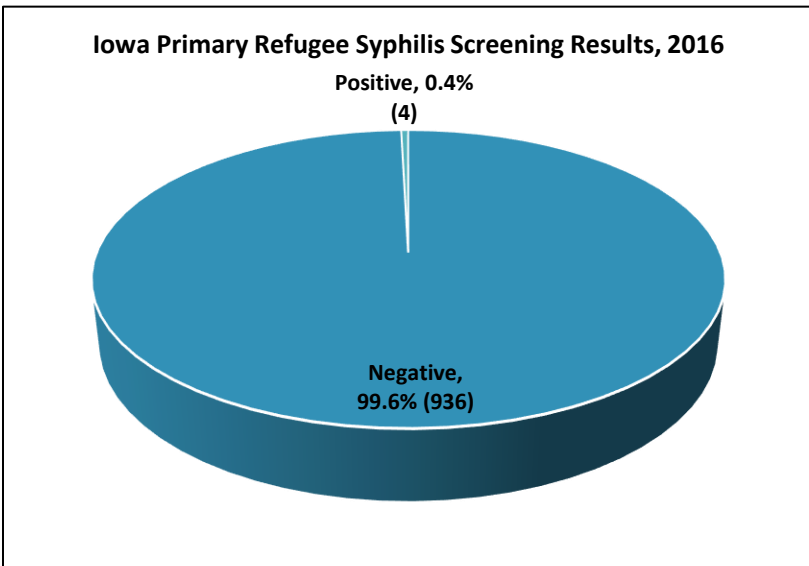
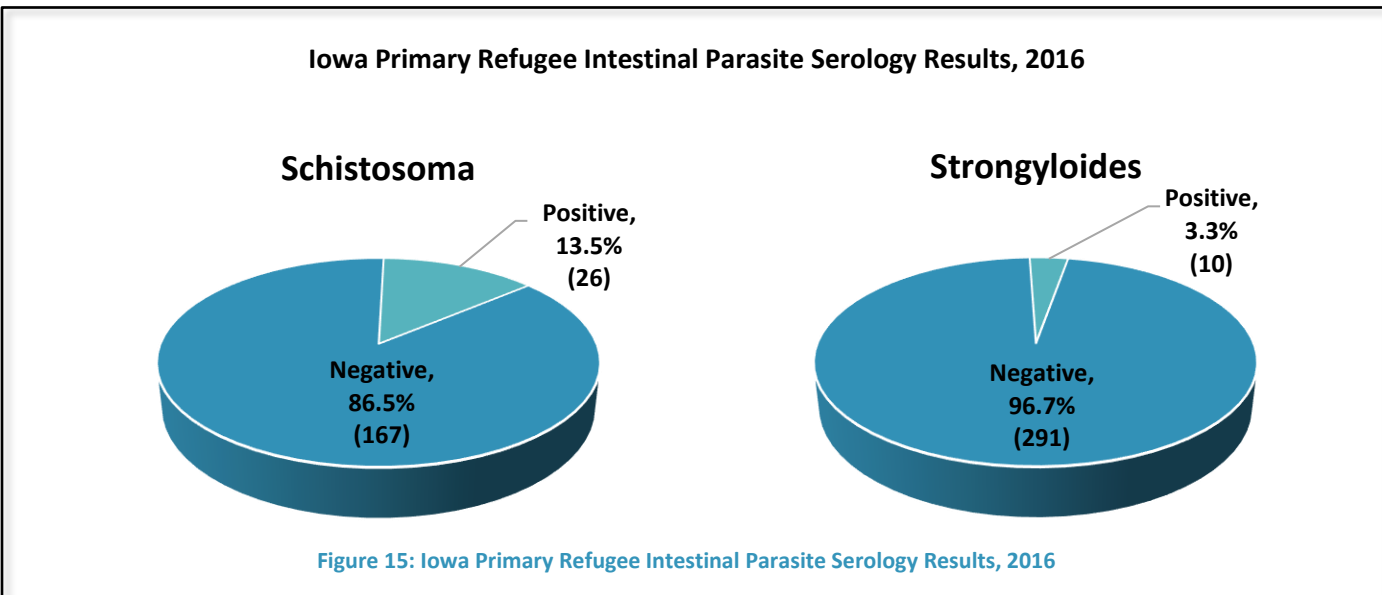


Figure 14: Iowa Primary Refugee Syphilis Screening Results, 2016

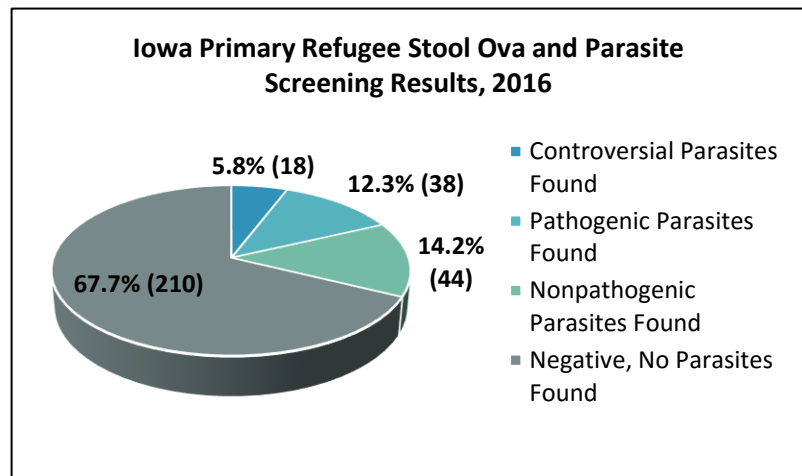
In 2015, 23,872 cases of primary and secondary syphilis were reported in the U.S., yielding a rate of 7.5 cases per 100,000 persons. In Iowa, the rate of primary and secondary syphilis was 2.4 per 100,000 persons. In 2016, less than 1 percent (four) of Iowa's primary refugee arrivals tested positive for syphilis (Figure 14).

## Intestinal Parasites

According to the CDC, intestinal parasites are among the most common infections found in refugee populations. Intestinal parasite screening in Iowa focuses on soil-transmitted helminthic infections (*Ascaris*, *Trichuris*, hookworm), *Strongyloides* and *Schistosoma*. Presently, the majority of resettling populations receive presumptive treatment for parasitic infections prior to departure, making screening upon arrival unnecessary for many refugees. However, screening is still completed for those who have contraindications to presumptive treatment, or for those who exhibit signs and symptoms of infection. In 2016, 26 primary refugees tested positive for *Schistosoma*, and 10 tested positive for *Strongyloides* (Figure 15).



Stool ova and parasite tests were ordered for 310 new arrivals. Of the refugees tested, 38 were positive for at least one pathogenic parasite (Figure 16) and the most common pathogenic parasite detected was *Giardia* (36 cases).



## Lead

According to the CDC, the prevalence of lead poisoning in newly arrived refugee children may be 14 times greater than that of the general U.S. population of comparable age. Malnutrition and anemia heighten lead absorption and the harmful effects of lead toxicity and living in camps or areas with older housing also puts refugee children at greater risk. The CDC recommends conducting lead screening for all refugee children age 6 months to 16 years. In Iowa during 2016, 476 refugee youth were screened for lead poisoning during the initial domestic health assessment, and 29 (6.1 percent) had elevated blood lead levels (Figure 17). Comparatively, 25.66 percent of all children under the age of 6 years were tested for lead poisoning in Iowa in 2015, with only 0.58 percent having confirmed elevated blood lead levels ( $>10\mu\text{g}/\text{dl}$ ).

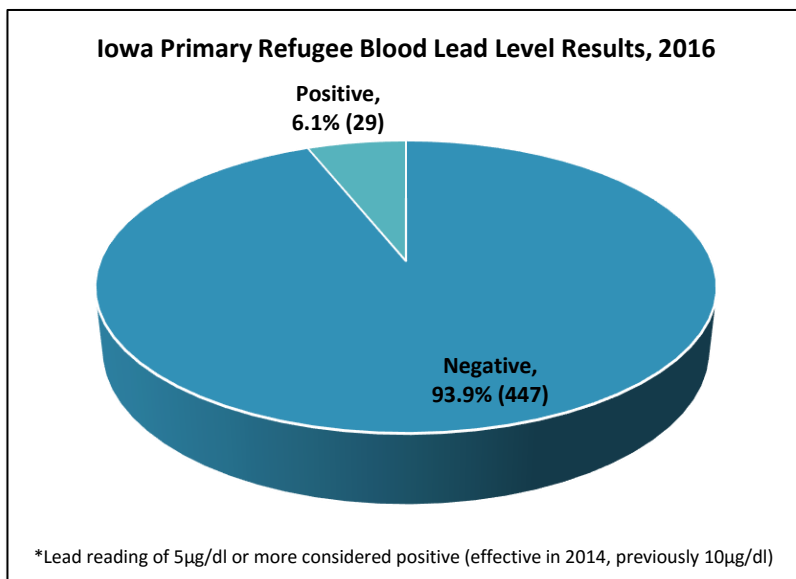


Figure 17: Iowa Primary Refugee Blood Lead Level Results, 2016

## Major Diagnoses and Referrals

During the initial health assessment, providers identify specific health issues and will refer refugees to outside services in order to ensure linkage to continued health care. In Iowa in 2016, the health concern that was reported most frequently during the initial refugee health assessment (other than those presented earlier in this report) was dental problems, with 178 primary refugees receiving the diagnosis. In addition, 171 primary refugees were identified as having nutritional concerns (anemia, malnutrition, underweight, overweight) and 82 exhibited a variety of vision problems ranging from blurry vision to blindness. Other frequent concerns noted during the initial domestic health assessment include: hypertension (39), mental health (26), tobacco abuse (24), hearing problems (24), pregnancy (23) and diabetes (12). The most common referrals made during the initial refugee health assessment were for dental care (321), vision care (89), audiology/ENT (21), obstetrics/gynecology (20), gastroenterology (13) and cardiology (8).



Photo courtesy of Lutheran Services in Iowa

## Summary

Iowa has a strong history of providing aid to vulnerable refugee populations. The state accepted 1105 primary refugees for resettlement in 2016, more than doubling the number of refugees accepted just five years earlier in 2012. Newly arriving refugees are among the most vulnerable populations in the state due to barriers such as language, cultural practices and lack of knowledge regarding basic U.S. health care. The Iowa Refugee Health Program strives to overcome these obstacles by ensuring clinicians have access to current screening and treatment guidelines, as well as health assessment data specific to newly arriving refugee populations.

The executive order titled ***Protecting the Nation From Foreign Terrorist Entry To The United States*** was released March 6, 2017, and lowered the U.S. refugee admissions ceiling from 110,000 to 50,000. As a result, Iowa is expected to receive a reduced number of refugees for resettlement in 2017. Despite this anticipated reduction, the state may experience a rise in the number of refugees arriving with severe medical conditions. Individuals with evidence of health concerns are typically given high priority for resettlement in order to ensure their medical needs are addressed as quickly as possible.

The potential increase in high need medical cases will require even greater collaboration and communication between IDPH, medical professionals and community partners. The Iowa Refugee Health Program will continue to coordinate with medical clinics, resettlement agencies and stakeholders throughout the state to ensure all refugees are connected to quality and comprehensive health care. We recognize health and wellness are vital to successful resettlement. The integration of refugees into the U.S. health care system is critical to making refugees truly at home in Iowa.



Photo by Adam Albright, and courtesy of Lutheran Services in Iowa

## Contact Information

Iowa Refugee Health Program  
Lucas State Office Building  
321 East 12th Street  
Des Moines, IA 50319-0075

- ❖ Jessica Eagan, Refugee Health Coordinator: 515-281-0433  
[Jessica.Eagan@idph.iowa.gov](mailto:Jessica.Eagan@idph.iowa.gov)
- ❖ Allan Lynch, Refugee Health Program Manager: 515-281-7504  
[Allan.Lynch@idph.iowa.gov](mailto:Allan.Lynch@idph.iowa.gov)