Council of State and Territorial Epidemiologists
Position Statement

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Committee: Executive

Title: Refugee Health Care: Improving overseas and domestic health assessment and management of U.S.-bound refugees

Statement of the Problem:
Thousands of refugees are resettled in the United States annually without access to proven preventive health measures, leading to health disparities and excess burden on the receiving communities.

Refugees are extremely vulnerable populations who are marginalized from preventive and treatment health-care services in their home country and countries of temporary asylum. The United States resettles approximately 50,000-70,000 refugees annually; of this number, 20,000 are from Africa and 15,000 from Asia. In the last decade, the percentage of U.S-bound African refugees has increased from 8% to 35%. These refugees have more complex health-care needs than earlier populations of European refugees: they have lower baseline vaccination rates and higher rates of other infectious diseases, including tuberculosis, HIV, malaria, and intestinal parasites. The current overseas and domestic health assessments for refugees require complex coordination across multiple governmental and nongovernmental organizations.

Overseas, refugees receive a very limited health assessment that focuses on identifying inadmissible conditions,[1] which--except for HIV--are defined by DHHS regulations. This assessment fails to address many important public health problems, notably vaccine-preventable diseases, malaria, intestinal parasites, state of the art diagnosis and treatment of tuberculosis, HIV and other emerging infectious diseases. The assessment, which is conducted by physicians from the International Organization for Migration, is funded by the Bureau of Population, Refugees and Migration, Department of State, and is under the technical guidance and oversight of the Division of Global Migration and Quarantine, Centers for Disease Control and Prevention (CDC). CDC has established a small pilot program for expanded assessment, which has proved successful for targeted groups of refugees and specific conditions, such as malaria, intestinal parasites, vaccine-preventable diseases and tuberculosis.

After resettlement, no standardized domestic health assessment is required. In a survey of refugee health assessments conducted among refugee arrivals in nine metropolitan sites in the United States, only 76% of refugees received a domestic health assessment after arrival and only 55% received a physical exam as part of the assessment. Refugees are eligible for 8 months of health-care coverage through Refugee Medical Assistance, funding provided by the Office of Refugee Resettlement, Department of Health and Human Services. Services covered by Refugee Medical Assistance vary by state and county. Routine vaccinations remain one of the biggest gaps. In 1996, immigration law was revised to require routine vaccinations for U.S.-bound immigrants.

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[1] The inadmissible conditions are specifically listed as chancroid, gonorrhea, granuloma inguinale, HIV infection, infectious Hansen's disease, lymphogranuloma venereum, infectious syphilis and active tuberculosis, mental health disorders with harmful behavior and drug abuse or addiction.

However, refugees were not included in the revision; therefore, unlike immigrants, refugees are not required to have any vaccinations before resettlement.

In the last 2 years, U.S. local and state health departments and CDC have responded to nine domestic and international outbreaks of infectious diseases among African and Asian U.S.-bound refugees, including measles, rubella, varicella, cholera, hepatitis A, O'nyong-nyong fever, and multi-drug-resistant tuberculosis. CDC also assisted with establishing surveillance for viral respiratory disease in camps with Asian refugees emigrating from areas of widespread avian influenza transmission. These outbreaks, which were associated with importation of infectious diseases in the U.S. and secondary domestic transmission, including hepatitis A, varicella, multi-drug resistant tuberculosis and congenital rubella syndrome, have taxed the resources of state and local health departments and represent an obstacle to the U.S. plans for elimination of vaccine-preventable diseases, including measles and rubella. In addition to the public health resources for outbreak response, these outbreaks halted resettlement and cost the Department of State hundreds of thousands of dollars in flight cancellations and other expenses; all these expenses could be reduced by investing in appropriate, cost-effective preventive health tools, such as routine vaccination.

The consequences of inadequate overseas and domestic health care continue to present challenges to state and local health departments and clinicians years after resettlement. For example, a 2003 investigation involving Lost Boys and Girls Sudanese refugees who were resettled in the U.S. in 2000-2001 showed that 44% and 46% were infected with strongyloides and schistosomiasis, respectively, years after resettlement. As a result of this investigation, CDC issued a recommendation for presumptive treatment for schistosomiasis and strongyloides for Sudanese refugees who have resettled in the U.S.. There are more than 20,000 Sudanese refugees in the U.S. dispersed throughout the country; many have no health insurance or primary care clinicians. State and local public health officials are currently confronting the challenges of how to locate and ensure treatment of these refugees.

Statement of the desired action(s) to be taken:
To reduce health disparities affecting refugees resettled in the U.S. and to prevent the importation of infectious diseases, the following actions should be taken:

1. Implement proven prevention tools, accompanied by access to overseas health services for U.S.-bound refugees. Costs for these services overseas are lower than in the U.S., and performing screening and treatment overseas will prevent importation of infectious diseases.

    a. The highest priority should be given to 1) the initiation of ACIP-recommended vaccinations before resettlement, 2) the expansion of diagnosis and treatment for active tuberculosis to meet U.S. standards, including evaluation for multi-drug-resistant tuberculosis in those with active tuberculosis disease and 3) the provision of directly-observed treatment consistent with W.H.O standards before resettlement.

    b. The second priority should be expansion of the currently limited presumptive treatment program for malaria and intestinal parasites. All U.S.-bound refugees who are at high risk for malaria and intestinal parasites should receive treatment before resettlement.

   c. The third priority should be the enhancement of overseas patient education activities.

2. Enhance the CDC quality assessment program of overseas panel physicians including International Organization of Migration.

   a. Conduct an evaluation of the current CDC quality assessment program.

   b. Set up a formal system to receive ongoing feedback from domestic assessments, in order to identify and remedy gaps in overseas health screening processes.

3. Conduct overseas surveillance for emerging public health threats, such as viral respiratory diseases (e.g., avian influenza H5N1) among U.S.-bound refugee populations.

4. Fully fund the development, implementation and maintenance of the Electronic Disease Notification (EDN) Data System. This is critical for improving the timeliness and completeness of notifications and for allowing evaluation and interventions at the policy and individual refugee level.

5. Provide funds to states to conduct the necessary domestic follow up of refugees including screening, diagnosis, and treatment.

6. Establish a multi-agency working group (possible partners include representatives of the Department of State; Office of Refugee Resettlement, Office of Global Health Affairs, CDC, Department of Health and Human Services; International Organization for Migration; Council of State and Territorial Epidemiologists, Association of State and Territorial Health Officials, National Association of County and City Health Officials, National Tuberculosis Controllers Association and the Association of State Refugee Health Coordinators to:

   a. Define comprehensive recommendations for overseas and domestic health assessments and preventive and therapeutic interventions for refugees.

   b. Improve interdepartmental coordination of overseas and domestic health-care services covered by the Department of State and Department of Health and Human Services, respectively.

   c. Identify areas for policy and regulatory changes to optimize overseas and domestic health assessments.

Public Health Impact:
The adoption of the action items would reduce the infectious disease burden on receiving communities in the United States, prevent the importation of communicable diseases by U.S-bound refugee populations, decrease morbidity and mortality associated with infectious diseases among refugees resettled in the U.S., and improve the health of 50,000-70,000 refugees that are resettled in the United States.

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