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Robert B. Stroube, M.D., M.P.H., Health Commissioner
John S. Marr, M.D., M.P.H., State Epidemiologist
Elizabeth Barrett, D.M.D., M.S.P.H., Editor
Vickie L. O'Dell, Layout Editor

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Virginia Department of Health Refugee Health Program

Background

Each year, thousands of persons leave their homelands to settle in new and distant lands. Among these are refugees, defined as persons forced to flee their country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group. Many refugees spend months or years in hastily set up refugee camps, awaiting the right to return home or to resettle in a new country. The US has a long history of accepting refugees from around the world. During the years following World War II, refugees were designated as a distinct class of legal immigrants in need of humanitarian protection and safe haven.

The term refugee refers to several immigrant groups (Table 1), each of which has a different legal status. All are eligible for benefits administered by the Office of Refugee Resettlement (ORR) in the US Department of Health and Human Services. In the US, many refugees are assisted in their resettlement process by humanitarian or faith-based voluntary agencies. Funding available through ORR assists these agencies with the resettlement process.

Initial Health Screening

Prior to resettlement in the US, refugees must receive a medical examination overseas. The examination is designed to identify medical conditions that may deny the person entry into the US. Presently, these excludable or classified conditions are defined as:

- A communicable disease of public health significance (*e.g.*, potentially infectious tuberculosis, certain sexually transmitted diseases, HIV infection/AIDS, Hansen's disease);
- A current or past physical or mental disorder that is associated with harmful behavior;
- Drug abuse or addiction.

On a case-by-case basis, refugees with certain excludable medical conditions may be granted a waiver if funds are available for their health care.

Refugees normally arrive in the US at one of the eight international airports where quarantine inspectors are assigned. Each quarantine station has responsibility for all ports of entry in an assigned geographic area. All arriving passengers and crew are observed for signs and symptoms of illness. Passengers meeting certain criteria may be questioned or detained. Arriving refugees, particularly those with known classified conditions, have their medical documents and immunization records reviewed for completeness. They are reminded to report to the local health department where they intend to resettle for evaluation of that condition and for a health assessment. The quarantine stations send a "Notification of Arrival" and medical documentation to the state health department in which the refugee plans to resettle.

In Virginia, the Refugee Health Program within the Division of Tuberculosis (TB) Control receives these Notifications of Arrival. Since 1997, demographic information from these notifications has been entered into a program database, prior to their distribution to local health departments. This

Table 1. Definitions

Refugees - Persons forced to flee their country of origin because of a well-founded fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group.
Asylees - Foreign nationals who cannot return to their country of origin due to a well-founded fear of persecution because of race, nationality, or membership in a particular social group. Asylees apply for and receive this status after entering the US, while refugees apply for and receive their status before entering the US.
Cuban and Haitian entrants - Persons of Cuban or Haitian origin granted parole status or special status under US immigration laws.
Amerasians - Persons of Asian and American descent, primarily those fathered by American servicemen and born between 1/1/62 and 1/1/76.
Unaccompanied minors - Refugee children (<18 years old) who arrive in the US unaccompanied by a parent or other close adult relative and who require foster care.
Victims of trafficking - Persons who have been victims of trafficking by force, fraud, or coercion. This group was included in the refugee designation as of 2000.

refugee database allows for the tracking of refugee arrivals to the various health departments within Virginia. The database also collects basic health information so that emerging trends in this population may be identified.

Health Assessment in Virginia

Upon arrival in the US, most refugees receive a health assessment, which should be performed as soon after arrival as possible. This health assessment is designed to identify and eliminate health-related barriers to successful resettlement while protecting the health of the US population. For many years, local health departments in Virginia have provided some level of health assessment services to newly arriving refugees. These services had been paid for by the refugee or out of local health department budgets. With incorporation of the Refugee Health Program into the Division of TB Control in 1997, a statewide protocol and standardized health assessment were implemented. Federal funds are provided to each state to underwrite the cost of these assessments, which are typically provided by local health departments and less frequently, by private providers. The state Refugee Health Program coordinates, facilitates, and monitors the provision of initial health assessment services to newly arrived refugees.

There are four levels of health assessments ranging from an evaluation for TB to a complete assessment that includes case management. Level I, the evaluation for tuberculosis disease or infection, includes an assessment for clinical signs and symptoms, placement and reading of a tuberculin skin test, a chest radiograph, and therapy as indicated. Level II includes a more complete patient assessment, some laboratory testing as indicated, and an assessment of immunization status. Level III includes listening to heart and lung sounds and any further testing appropriate for age, such as developmental testing for young children and evaluation for anemia, cardiovascular disease, cancer, and sexually transmitted diseases. Level IV is case management. Many refugees require some level of case management by a public health nurse; Level IV was designed to provide for this.

Refugees in Virginia, 1998-2001

This section summarizes data collected on refugees who have settled in Virginia from January 1998 through December 2001. During this time, 8,576 persons with refugee status entered the Commonwealth. Of these, 1,662 (19%) claimed Bosnia and Herzegovina as their country of origin. Other common countries of origin include Somalia (13%), Sudan (9%), Vietnam (7%), Afghanistan (7%), Serbia (6%), Ethiopia (4%), Iraq (4%), Sierra Leone (3%), Liberia (3%), Cuba (3%), and Iran (3%). Sixty-five countries comprise the remaining 16%. The regions of the world from which Virginia refugees originated are summarized in Figure 1.

Areas of Resettlement

From 1998-2001, the majority of new refugees (55%) resettled in northern Virginia, predominately in the counties of Fairfax and Arlington and the city of Alexandria. Central Virginia, predominately Henrico County, became home to 17% of new refugees. This was followed by the northwest region (13%), primarily the Charlottesville and Harrisonburg areas. The southwest region, particularly the Roanoke area, became home to 737 (9%) refugees. And lastly, the Hampton Roads area of the eastern region received 6% of new refugee arrivals for this period.

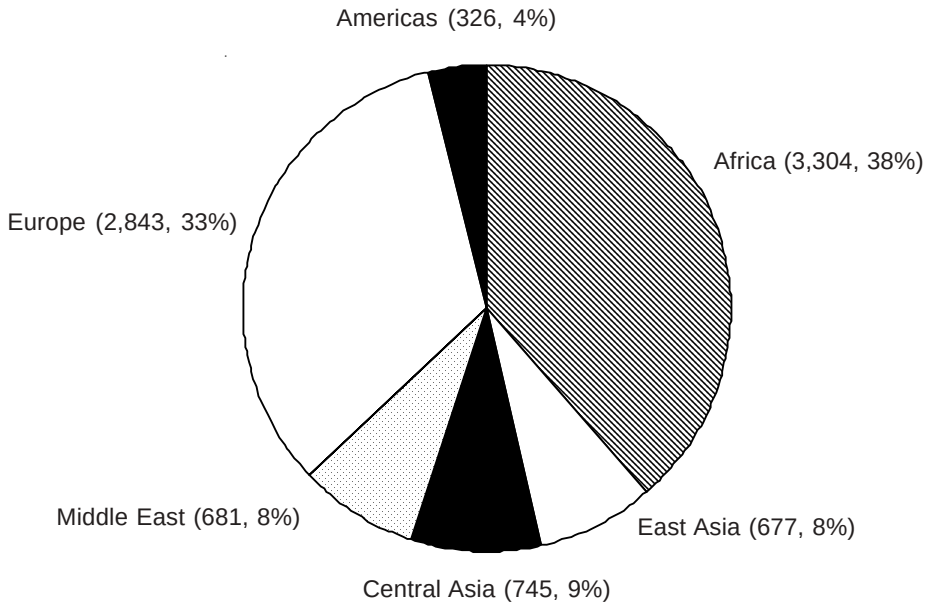
Health Assessments Performed

Our data show that 6,321 (74%) of all entering refugees received at least a Level I initial health assessment by a local health department. These assessments were provided from 6 days to over 3 months (median=30 days) from the time of arrival into the US. An objective that ORR has set is that refugees receive a health assessment within 30 days of arrival into the US. Program data also indicate that 1,534 (18%) of refugees did not receive health assessment services from local health departments. Many of these refugees declined a health assessment, some received their health assessment from a private provider, and some resettled in another state upon arrival in the US, while some could not be located. For the remaining 8%, it is unknown whether they received a health assessment.

Health Needs

Ten percent (867) of refugees entered the Commonwealth with an excludable or classified health condition identified during their overseas examination. These included 273 persons with radiographic evidence of inactive TB and 50 persons with radiographic evidence of active TB but negative sputum smears. Eleven persons had HIV infection. Other health conditions identified in the overseas examination included hypertension, diabetes, cancer, developmental delays, traumatic wounds, amputations, and scarring.

Figure 1. Region of Origin, Refugees Coming to Virginia, 1998-2001 (n=8,576)



An evaluation for TB was done on all of the 6,321 refugees who received a health assessment in Virginia. Of these, 77 (1%) were diagnosed with either suspected or confirmed tuberculosis disease and 3,273 (52%) refugees were diagnosed with latent tuberculosis infection. Local health departments reported that ongoing follow-up was required for 3,653 (58%) of those assessed.

A review of necessary immunizations is included in a Level II exam, which was conducted on 5,381 (85%) of the 6,321 refugees who received a health assessment. Immunization of refugees against vaccine preventable diseases is not only good public health practice, but also now the law. Refugees are required to show proof of immunizations to change their legal residency status. Health departments are encouraged to begin providing immunizations as refugees present to them, stressing the need for follow up and maintaining their records. Exploring new partnerships with local private providers for follow up of identified health needs is critical, as health departments no longer provide primary care.

Following TB conditions and the need for immunizations, dental health was identified as the most common problem for refugees. Identifying local resources to provide dental care for this group is crucial to oral and overall health. Other common health conditions in entering refugees are described in Table 2. In addition, 10% of refugees were referred for treatment of parasites and 4% were referred for a hepatitis B or C finding. These data do not fully represent health needs of the total refugee population because not all health departments provide a Level II or higher health assessment.

Program Needs and Resources

The VDH Refugee Health Program is concerned that all refugees are not receiving an assessment of their immunization status. Plans are underway to increase the minimum required in a Level I health assessment. In addition to the evaluation for TB, Level I will likely also include an assessment of the refugee's immunization status.

Mental health has been an identified problem for many refugees. As survival is a coping mechanism for the refugee, the need for mental health care may not manifest until the refugee has been in the US for a period of time. Health professionals are encouraged to be available for counseling and treatment as these needs arise in the refugee. ORR has funded several projects nationally to provide services for victims of torture. A Program for Survivors of Torture and Severe Trauma is located in Falls Church, Virginia. Contact the Center for Multi Cultural Human Services at 703-533-3302.

Considering the many countries of origin, the resources needed to provide services in many languages and dialects is overwhelming for providers. Providing culturally and linguistically appropriate services is a continuing challenge as the US population becomes increasingly diverse. Humanitarian or faith-based voluntary agencies and Virginia's Area Health Education Centers may be of assistance to local health departments, as well as other health providers, in meeting the health needs of Virginia's new refugees.

Refugee admissions, like all immigration into the US slowed after the events of September 11, 2001. Each year in October the president, based on recommendations from the Secretary of State, declares the number of refugees the US will accept that year. The Bush administration had declared that the US would accept 70,000 refugees in 2002. It is evident that number will not be reached, but in an ever-changing world, refugee admissions can change at any time. Since August 2001, the VDH Refugee Health Program has had a full time dedicated coordinator. If you would like more information regarding the VDH Refugee Health Program, please call the program coordinator, Anna T. Davis, RN, at 804-692-0809 or email atdavis@vdh.state.va.us.

Submitted by: Anna T. Davis, RN, Refugee Health Coordinator, Division of TB Control, Virginia Department of Health.

Table 2. Health Conditions Identified and Immunizations Needed in Refugees, Virginia, 1998-2001 (n=5,381 persons)*

Condition	Number (Percent)
Dental needs	2,120 (39)
Vision or hearing problems	567 (11)
Low weight	361 (7)
Anemia	348 (6)
Pregnancy	84 (2)
Mental delay or abnormality	23 (0.4)
Immunizations	
Measles, mumps, and rubella	3,954 (73)
Diphtheria, tetanus, and/or pertussis	3,835 (71)
Varicella	2,011 (37)
Polio (IPV)	1,683 (31)
Influenza	249 (5)
Pneumococcal	214 (4)
Hepatitis B	10 (0.2)
Haemophilus influenzae type b (HIB)	0

**Includes all refugees who received a Level II health assessment.*

Cases of Selected Notifiable Diseases Reported in Virginia*

Disease	Total Cases Reported, December 2002: State	Regions: NW	N	SW	C	E	Total Cases Reported Statewide, January through December: This Year	Last Year	5 Yr Avg
AIDS	129	29	23	15	11	51	866	970	982
Campylobacteriosis	98	16	24	27	13	18	678	583	628
E. coli O157:H7	4	0	1	3	0	0	66	52	73
Giardiasis	69	10	30	11	10	8	375	417	459
Gonorrhea	820	25	47	99	268	381	10,551	11,082	9,702
Hepatitis A	24	2	13	2	5	2	164	167	198
B, acute	30	1	5	6	5	13	219	213	148
C/NANB, acute	0	0	0	0	0	0	15	3	11
HIV Infection	138	19	38	16	35	30	992	976	901
Lead in Children†	75	8	4	13	32	18	860	667	683
Legionellosis	3	0	2	1	0	0	33	39	36
Lyme Disease	53	1	43	1	1	7	255	156	113
Measles	0	0	0	0	0	0	0	1	5
Meningococcal Infection	5	1	1	3	0	0	46	46	51
Mumps	0	0	0	0	0	0	5	8	13
Pertussis	35	23	1	3	3	5	168	272	117
Rabies in Animals	38	8	11	9	6	4	591	502	579
Rocky Mountain Spotted Fever	1	1	0	0	0	0	41	40	21
Rubella	0	0	0	0	0	0	0	0	<1
Salmonellosis	111	15	44	25	11	16	1,279	1,368	1,186
Shigellosis	133	2	17	6	53	55	1,060	784	399
Syphilis, Early§	12	0	8	1	2	1	165	235	372
Tuberculosis	62	4	20	10	13	15	315	306	324

Localities Reporting Animal Rabies This Month: Albemarle 1 skunk; Alleghany 1 bobcat; Appomattox 3 skunks; Amelia 1 raccoon; Augusta 1 sheep; Bedford 1 raccoon; Buena Vista 1 cow; Caroline 1 skunk; Dinwiddie 1 raccoon; Fairfax 1 fox, 7 raccoons, 2 skunks; Gloucester 1 raccoon; Hanover 1 skunk; James City 1 raccoon; Lynchburg 2 skunks; Mecklenburg 1 raccoon; Northampton 1 raccoon; Petersburg 1 dog; Prince William 1 raccoon; Richmond County 1 cat; Roanoke County 1 skunk; Stafford 1 cat, 2 raccoons, 1 skunk; Sussex 1 raccoon; Wythe 1 skunk.

Toxic Substance-related Illnesses: Asbestosis 56; Lead Exposure 8; Pneumoconiosis 6; Mercury Exposure 2; Cadmium Exposure 1.

*Data for 2002 are provisional. †Elevated blood lead levels ≥10µg/dL.

§Includes primary, secondary, and early latent.

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Office of Epidemiology
P.O. Box 2448
Richmond, Virginia 23218
http://www.vdh.state.va.us
Telephone: (804) 786-6261

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