

Resettlement of Refugees From Africa and Iraq In Rhode Island: The Impact of Violence and Burden of Disease

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The Office of Minority Health at the Rhode Island Department of Health formally initiated the Refugee Health Program (RHP) in August 2004. The goal is to ensure that refugees and asylees enter into a comprehensive system of care that responds to their unique health care needs by addressing three main components: coordination of care, education and training, and surveillance and epidemiology.

Refugees are provided only eight months of insurance via Medicaid. No medical coverage is provided after they attain legal status, which takes approximately one year after their arrival in the United States. Timely medical care is an integral part of the refugee resettlement process. This discussion compares the burden of disease between recently resettled Africans and Iraqi refugees in Rhode Island.

REFUGEES IN RHODE ISLAND

The Federal Refugee Act of 1980 defines a refugee as a person who is outside of his/her country of origin and is unable or unwilling to return to that country because of the experience or legitimate fear of persecution on the grounds of race, religion, nationality, membership in a particular social group, or political affiliation.¹

Since 1990, Rhode Island has resettled 4,779 refugees including 133 in 2008. Figure 1 reflects the fluctuation of refugees from year to year. This varies with the stability of countries, international affairs and policies. For example, the African continent has been plagued by ongoing civil wars, political unrest and natural disasters, causing the most horrific refugee crisis in recent memory. Although peace agreements in such countries as Angola and Sierra Leone have enabled many African refugees to repatriate, displacement in the Democratic Republic of Congo, Burundi, and Liberia continues. During 2008, Rhode Island continued to resettle refugees (n = 89) from several African countries including Burundi (31), Somalia (19), Tanzania (13), Democratic Republic of Congo (8), Ethiopia (4), Liberia (4), Eritrea (3), Kenya (3), Rwanda (3) and Sierra Leone (1). The decrease in refugees from the 1990s is a reflection of national policies and cutbacks. There is now an expectation that the numbers will rise

with changes in administration.

BURDEN OF DISEASE

Information regarding the burden of disease in refugee populations is collected through the medical report (Medical Examination for Immigrant or Refugee Applicant) provided by the US Department of State. The US State Department Panel of Physicians examines refugees in their country of exit, approximately sixty days prior to their departure. This five-page report provides a good basic profile of the refugee's health before his/her departure and targets conditions that require follow-up when the refugee is resettled.

Physicians in Rhode Island hospitals complete the Rhode Island Refugee Health Screening Form within 30 days after the refugee's arrival in Rhode Island. The form, developed by the Rhode Island Department of Health in partnership with a network of providers, targets the most important health conditions for refugees in the United States, e.g., tuberculosis (TB), hepatitis B, hepatitis C, elevated blood lead levels, sexually transmitted infections, anemia, malaria (if symptomatic), parasites, mental health illness, etc.

The Refugee Health Program produces an annual report based on the quarterly reports reflecting the number of refugees who entered the country during that period, countries of origin, sex, age distribution and Class A/B conditions according to the Medical Examination Classification. Class A conditions include the following: HIV/AIDS; active, infectious TB; untreated syphilis, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum; Hansen's Disease (lepromatous or multibacillary); and addiction or abuse of specific substances

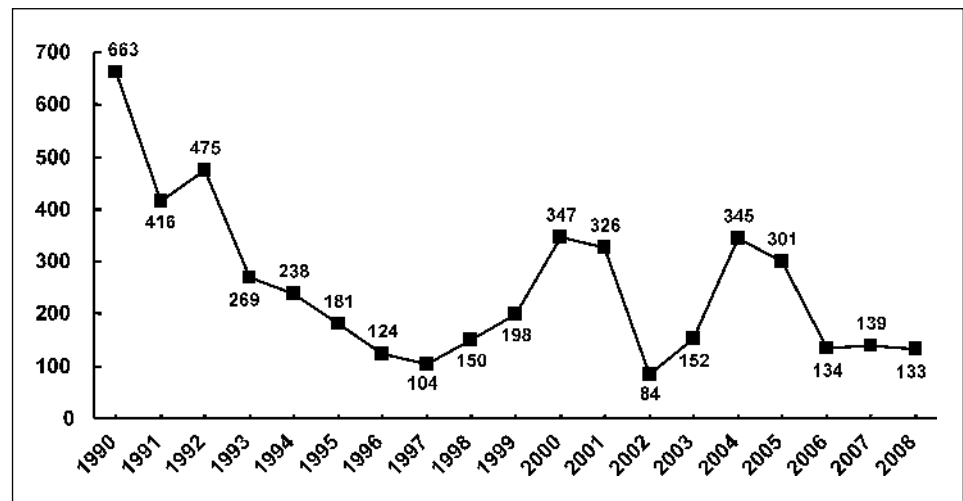


Figure 1: New Refugee Arrivals to Rhode Island, 1990-2008.

with harmful behavior. Class B conditions include the following: active, non-infectious TB; inactive TB; other sexually transmitted diseases; current pregnancy; Hansen's Disease with prior treatment; and any physical or mental health disorder without harmful behavior or history of such behavior unlikely to occur. During 2008, the majority of the 133 refugees to Rhode Island had conditions that fell into Class B (n = 108).

AFRICAN REFUGEES

African refugees have had little or no access to health services, and many have suffered from malnutrition, as well as typhoid, cholera, dysentery and malaria. In Rhode Island, during 2008, 33 (25%) of the 133 refugees had a history of malaria based on the medical reports and health screenings. Resettlement to the United States of malaria-infected refugees can pose problems for both the refugees and their resettlement communities. According to "Malaria in East African refugees resettling to the United States: development of strategies to reduce the risk of imported malaria," epidemiologic data were reviewed and malaria prevalence surveys conducted.³ Nonetheless, the risk of malaria continues to be of concern in resettlement communities and is the leading cause of death among refugees.

Refugees also constitute one of the most difficult populations to reach with HIV/AIDS prevention and care services in Africa. Little is known about HIV infection and risk behaviors of refugees living in refugee camps.⁴

Female genital mutilation, performed on girls ranging from infancy to puberty, may have medical complications; e.g. severe pain, shock, infection, bleeding, acute urinary infection, tetanus, and death. In Africa, an estimated 80 million girls and women have undergone female genital mutilation.⁵ Rhode Island health care providers should be aware of the practice, because its complications may require immediate treatment or have other medical implications.

IRAQI REFUGEES

Rhode Island started the resettlement of Iraqis at the beginning of 2008, when 39 (29%) of the 133 refugees to Rhode Island came from Iraq. The most frequent diseases or medical issues among Iraqis have changed from chronic diseases (e.g., cardiovascular disease, diabetes, etc.) to conditions resulting from violence (e.g., bombings, gunfire, etc.).

Malnutrition and catastrophic sanitary conditions contribute to other diseases and illnesses including diarrhea, pneumonia, malaria and typhoid. Additional health risks include the hazards from chemical, biological, and radioactive pollution during prior conflicts. Water and sewerage capacity have never been fully restored. Of particular concern is the cluster of cancers and genetic defects, which some suggest are associated with depleted uranium (DU) usage in anti-tank weapons.⁶ Although Iraq had one of the most advanced health systems in the region, it has been in decline for several decades.⁷ Poor standards of care and inefficient referral systems are all in part due to pre-existing corruption, neglect, shortages and sanctions.⁸ In addition to the physical effects of war on the Iraqi population, high numbers also suffer with mental health illnesses.⁹

CONCLUSIONS

The number of refugees coming to Rhode Island has fluctuated over the past ten years, and the countries of origin have also changed. Currently most (96%) refugees in Rhode Island come from Africa or Iraq. While malaria represents the greatest burden of disease, these refugees have also suffered severe psychological trauma. Health care providers should be aware of the severity of these problems and that these refugees are legally entitled to only eight months of medical coverage. The Refugee Health Program continues its work to: improve reporting of refugee health screening data; increase refugee access to culturally and linguistically appropriate services; and provide resources that assist health and social service providers to provide comprehensive care that is responsive to the needs of refugees.

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The authors have no financial interests to disclose.

