Global Health Initiative: Assessment of the Health of the Refugee Population Resettled in Louisville

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ABSTRACT

Background: Every year approximately 2500 refugees enter Kentucky as part of a national resettlement program. Refugees arriving in the United States bring varied health problems that are identified during their Refugee Health Assessment (RHA). The RHA follows up with any condition identified in the overseas medical evaluation and identifies communicable diseases and health conditions that could affect the resettlement. Little research exists regarding the health of refugees after arrival in the U.S. The Refugee Health database, an ongoing data collection tool for the standardized Refugee Health Assessment was used.

Methods: Refugees arriving in Kentucky who received an RHA in 2013 were evaluated. Data collected were entered into a research database and analyzed using SPSS and Tableau.

Results: A total of 1513 refugees were screened. The top five diagnosed health conditions include: dental abnormalities, hypertension, TB exposure, decreased visual acuity and myalgias/arthralgias. Over 50% of refugees were considered overweight or obese, 12.27% had high cholesterol and 42.44% had low HDL levels. 12.98% of adult refugees had a positive TSPOT test, and 33.56% tested positive for parasites.

Discussion: This analysis shows that the main health conditions facing refugees are chronic conditions that require long-term management. While referrals are made for refugees, many are lost to follow-up once they assimilate due to a lack of insurance or lack of knowledge of the US healthcare system. A systematic approach focusing on the problem of long-term follow-up needs to be established in order to address and decrease the impact of chronic health conditions.

BACKGROUND

As part of this resettlement process, refugees arriving in the United States are eligible to receive a domestic Refugee Health Assessment (RHA). The purpose of the medical screening is to follow up with any condition identified in the overseas medical evaluation, identify individuals with communicable diseases of public health importance, identify health conditions that could affect the resettlement process, including employment, and serve as an introduction to the US healthcare system, including establishing a primary care location. In Kentucky, refugees receive an RHA at one of seven clinics—Family Health Centers-Americana, Shawnee Christian Healthcare Center, Home of the Innocents, UofL 550 Clinic, Bluegrass Community Healthcare Center, Fairview Community Health Center and Green River District Health Department. RHAs include a review of overseas medical information, a complete medical and socio-ethnographic history, a physical exam and laboratory screenings. While no national requirements exist for the RHA, the Centers for Disease Control and Prevention (CDC) and the Office of Refugee Resettlement (ORR) provide guidelines for data elements that could be collected. Little research exists regarding the health of refugees after arrival in the US.

METHODS

This study was an analysis of the Refugee Health database, an ongoing data collection tool for the standardized Refugee Health Assessment using the data elements suggested by CDC and ORR. All refugees arriving in Kentucky who received an RHA from January 2013 through December 2013 were evaluated. Data were collected at the clinic sites and entered into a research database (REDCap). Data analysis was performed using SPSS and Tableau.

RESULTS-OVERVIEW

Figure 1. Country of Nationality of Refugees who had a health screening in Kentucky

Demographics

Gender			**Country of Nationality**		
	Female	45.41%		Cuba	39.63%
	Male	54.59%		Iraq	14.79%
Age Range				Bhutan	11.91%
	<15 years	23.13%		Burma/Myanmar	9.97%
	15-24 Years	18.37%		Somalia	8.70%
	25-34 years	23.66%		Democratic Republic of the Congo	6.16%
	35-44 years	17.78%		Sudan	1.74%
	45-64 years	15%		Afghanistan	1.61%
	65+ years	2.05%		Burundi	0.94%
				Ethiopia	0.94%
Language			**Region**		
	Spanish	39.67%		Latin America	39.36%
	Arabic	17.59%		Southeast Asia	21.67%
	Nepali	10.90%		Africa	20.01%
	Somali	8.36%		Middle East	18.95%
	Karen	5.35%			
	Swahili	4.62%			

Figure 2. Demographics of Refugees who had a health screening in Kentucky

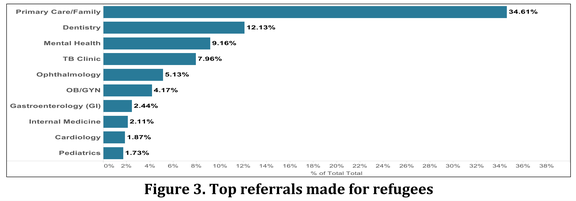

Figure 3. Top referrals made for refugees

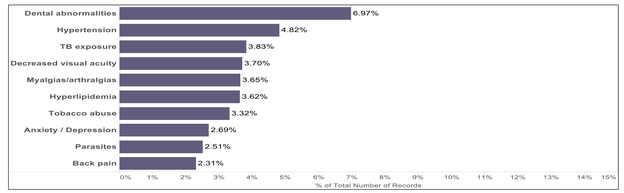

Figure 4. Top health conditions by country of nationality

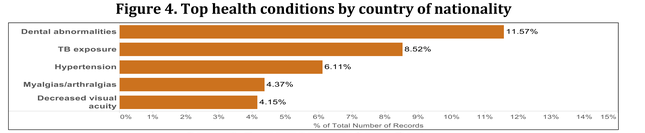

Figure 5. Top health conditions Bhutan

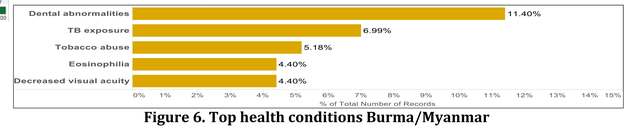

Figure 6. Top health conditions Burma/Myanmar

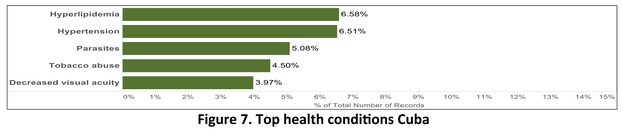

Figure 7. Top health conditions Cuba

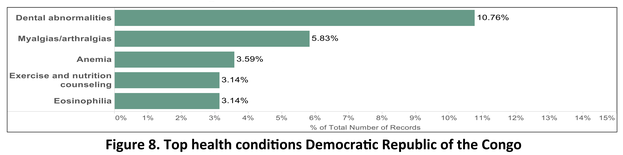

Figure 8. Top health conditions Democratic Republic of the Congo

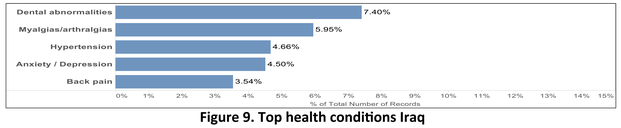

Figure 9. Top health conditions Iraq

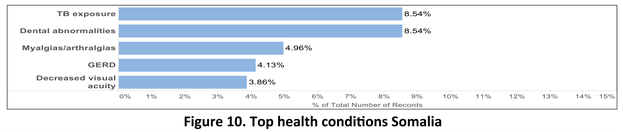

Figure 10. Top health conditions Somalia

RESULTS-INFECTIOUS DISEASES

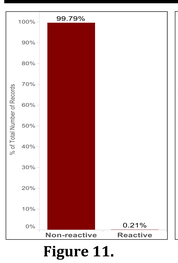

Figure 11. HIV Results

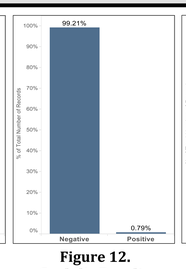

Figure 12. Syphilis Results

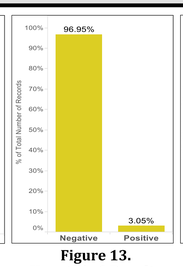

Figure 13. Hepatitis C Results

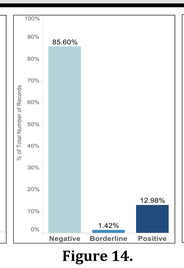

Figure 14. Tuberculosis Results

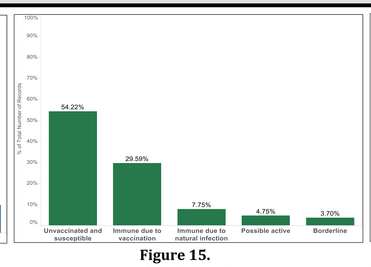

Figure 15. Hepatitis B Results

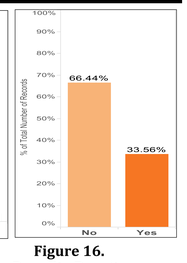

Figure 16. Parasite Results

RESULTS-RISK FACTORS

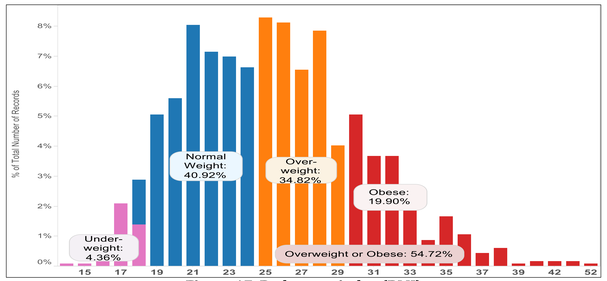

Figure 17. Body mass index (BMI)

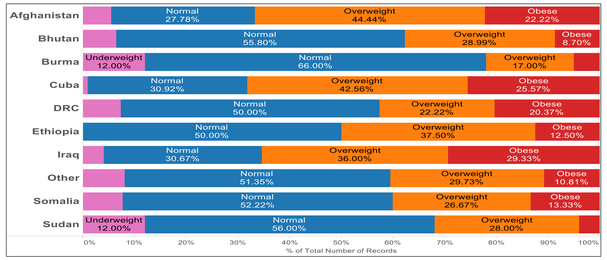

Figure 18. Body mass index (BMI) by Country of Nationality

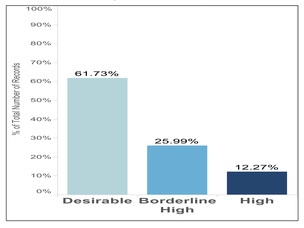

Figure 19. Cholesterol screening results

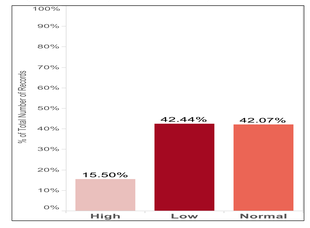

Figure 20. High Density Lipoprotein (HDL) screening results

DISCUSSION

The top health conditions identified in refugees included, dental abnormalities, hypertension, TB exposure, decreased visual acuity, myalgias/arthralgias, hyperlipidemia and tobacco abuse. Over 50% of refugees were considered overweight or obese, 12.27% had high cholesterol and 42.07% had low HDL levels. A total of 12.98% of adult refugees had a positive TSPOT (tuberculosis) test, and 33.56% tested positive for at least one parasite. A total of 0.79% tested positive for HIV, 3.05% tested positive for Hepatitis C, and 4.75% had possibly active Hepatitis B. This analysis shows that the main health conditions facing refugees after arriving in the U.S. are chronic conditions that require long-term management. While referrals are made for refugees, many are lost to follow-up once they assimilate due to a lack of insurance or lack of knowledge of the U.S. healthcare system. Upon review of these results, a systematic approach to solving the problem of long-term follow-up needs to be established for refugees in order to address and decrease the impact of chronic heath conditions.