Illinois Refugee Health Program

2015 Annual Screening Summary Report

Illinois Arrivals, Federal Fiscal Year 2015

Center for Minority Health Services

Welcome!

This report provides demographic information and results from the domestic health screenings for refugees arriving in Illinois during Federal Fiscal Year 2015 (10/1/2014– 9/30/2015). It also contains comparison surveillance data from FFY 2014 & FFY 2013.

Our annual report is intended to give our providers and stakeholders a summary of demographic and health screening results for Illinois refugees in FFY2015. These can be used to inform program partners on health conditions affecting newly arriving refugees identified during the initial health assessment.

February 2016

Prepared by Anne Bendelow, MPH

About the Program:

The Illinois Refugee Health Screening Program's objective is to protect the health of the community at large and promote the health of newly arriving refugee populations. Every year, 50,000-80,000 refugees are resettled in the United States. The Immigrant and Nationality Act defines a refugee as a person who is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Many refugees come from areas of the world with sub-standard living conditions, minimal preventive healthcare, and endemic conditions such as tuberculosis (TB), hepatitis B, malaria, and parasitic infections. In addition to treatment for communicable diseases, many also require immunizations, treatment for psychological disorders, and other health services.

The Office of Refugee Resettlement (ORR) is responsible for the provision of medical screening and initial medical care for all newly arriving refugees and other program-eligible clients (asylees, parolees, special immigrant visa holders, and victims of trafficking). ORR collaborates with states to administer resettlement services, including medical screenings. The medical screening includes screening for communicable diseases of potential public health impact, follow-up with medical issues identified in the overseas medical screening, screening for other health conditions that could adversely impact resettlement and referral for ongoing health care/health issues identified on screening.

The purpose of the medical screening is to:

1) Protect the health of the community at large

2) Promote better health in refugee populations

3) Facilitate effective resettlement

4) Reduce costs of health issues later in life through early identification and intervention

The goal of the Refugee Health Program ("RHP") is to provide eligible clients with **culturally and linguistically appropriate comprehensive health assessments**, including follow-up and referrals for health conditions identified in the assessment process. The RHP is located at the Center for Minority Health Services at the Illinois Department of Public Health and it is contracted by the Illinois Department of Human Services to provide these services.

There are five contracted medical providers: three local health departments and two private clinics that conduct the initial health assessment and provide follow-up care or referrals as needed. The Office of Refugee Resettlement and U.S Centers for Disease Control and Prevention (CDC) provide guidelines for domestic follow-up evaluation in newly arriving refugees

About this Report:

The RHP uses a web-based application, the Refugee Health Assessment Program for Illinois (ReHAPI), to collect demographic data and screening results from the health assessments. Medical providers conducting the health assessments enter demographic and screening results into ReHAPI. Data on FFY 2015 arrivals were pulled from ReHAPI to create this report by the Refugee Epidemiologist in January 2016. The RHP also receives notifications of refugees arriving in Illinois via the Centers for Disease Control and Prevention's Electronic Disease Notification (EDN). EDN contains demographic information on all refugee arrivals to the United States, as well as overseas medical screening records. All data included in this report is from ReHAPI and/or EDN. All eligible clients (refugees, asylees, parolees, special immigrant visa holders, and victims of trafficking) will herein be referred to as refugees or arrivals.

All data, tables, and figures reflect FFY 2015 arrivals unless otherwise specified

All photographs are from UNHCR unless otherwise specified.

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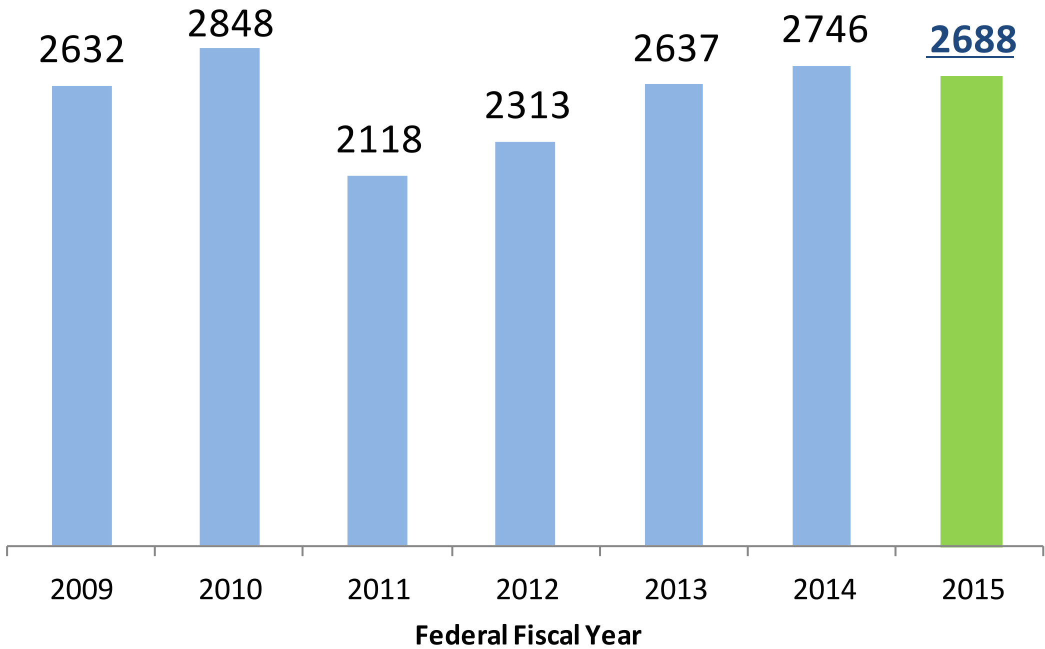
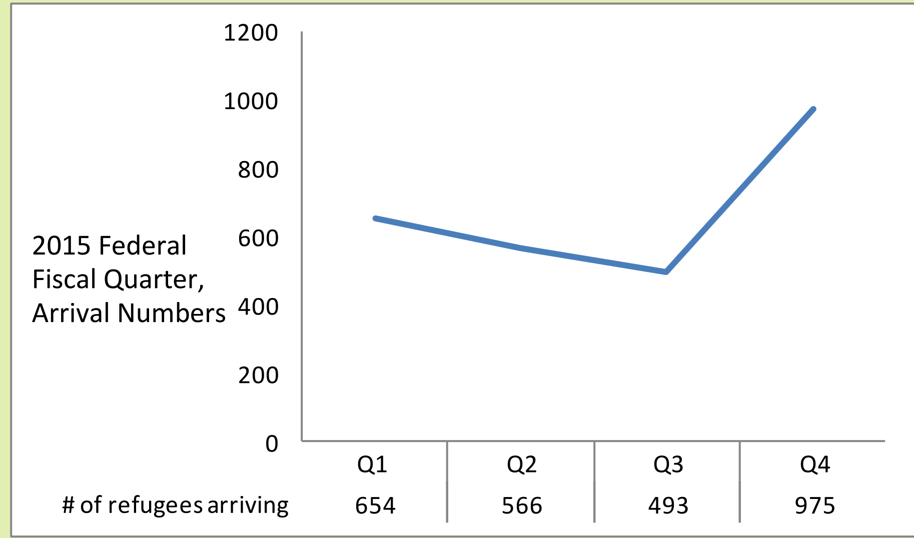
Demographics



Trends in number of total screenings, FFY 2009-2015

The Illinois Refugee Health Program administered **2688** screenings for refugees arriving in the **2015 Federal Fiscal Year**

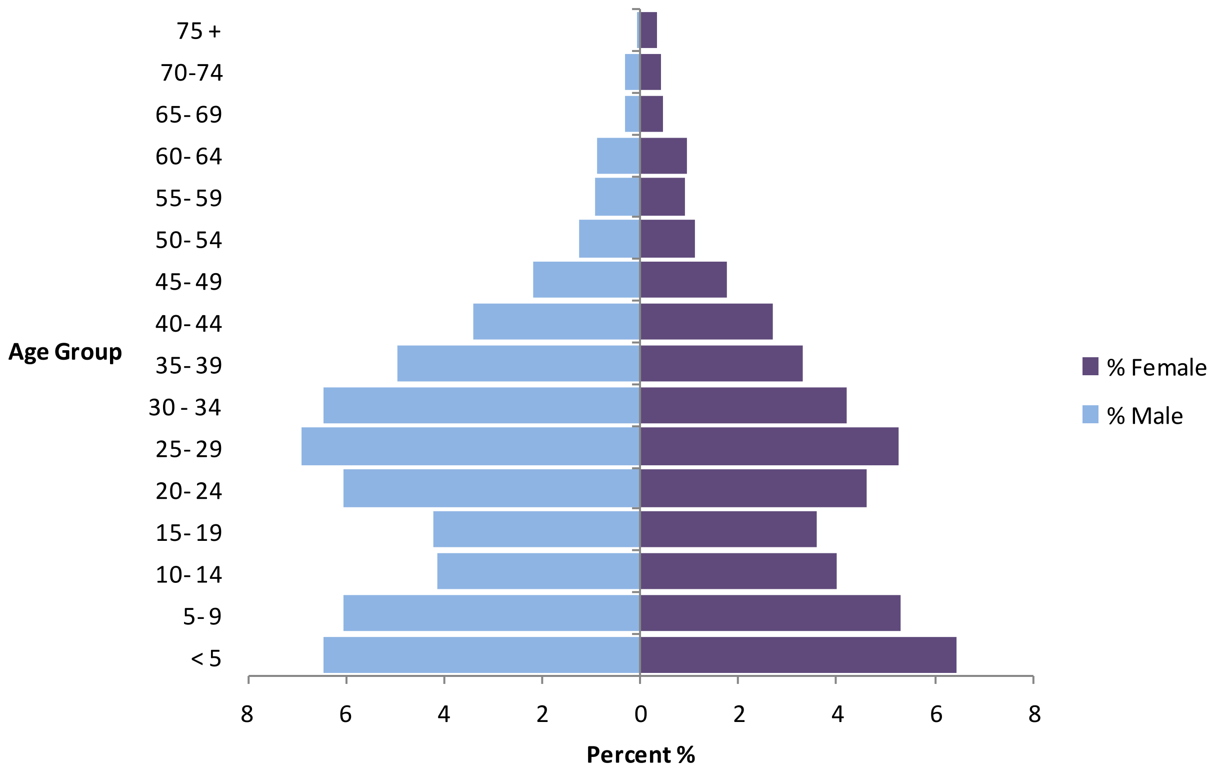


Arrival Dates

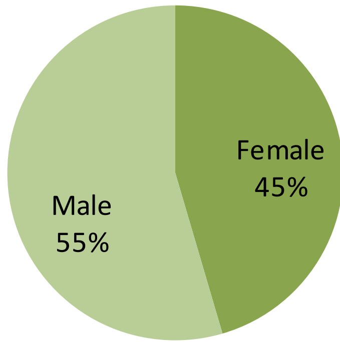
Approximately 36% of the entire year's arrivals occurred in the fourth quarter of the federal fiscal year (7-1-2015 to 9-30-2015). This "surge" of refugees at the end of the fiscal year has occurred in previous screening years.

Population Pyramid N=2688

Age at first clinic date, Gender



Gender, N=2688



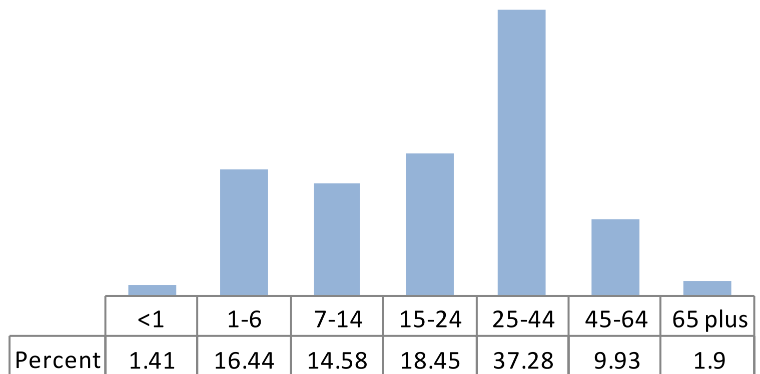
We serve a primarily young population. The average age of an arrival is 24 years

23% of our population

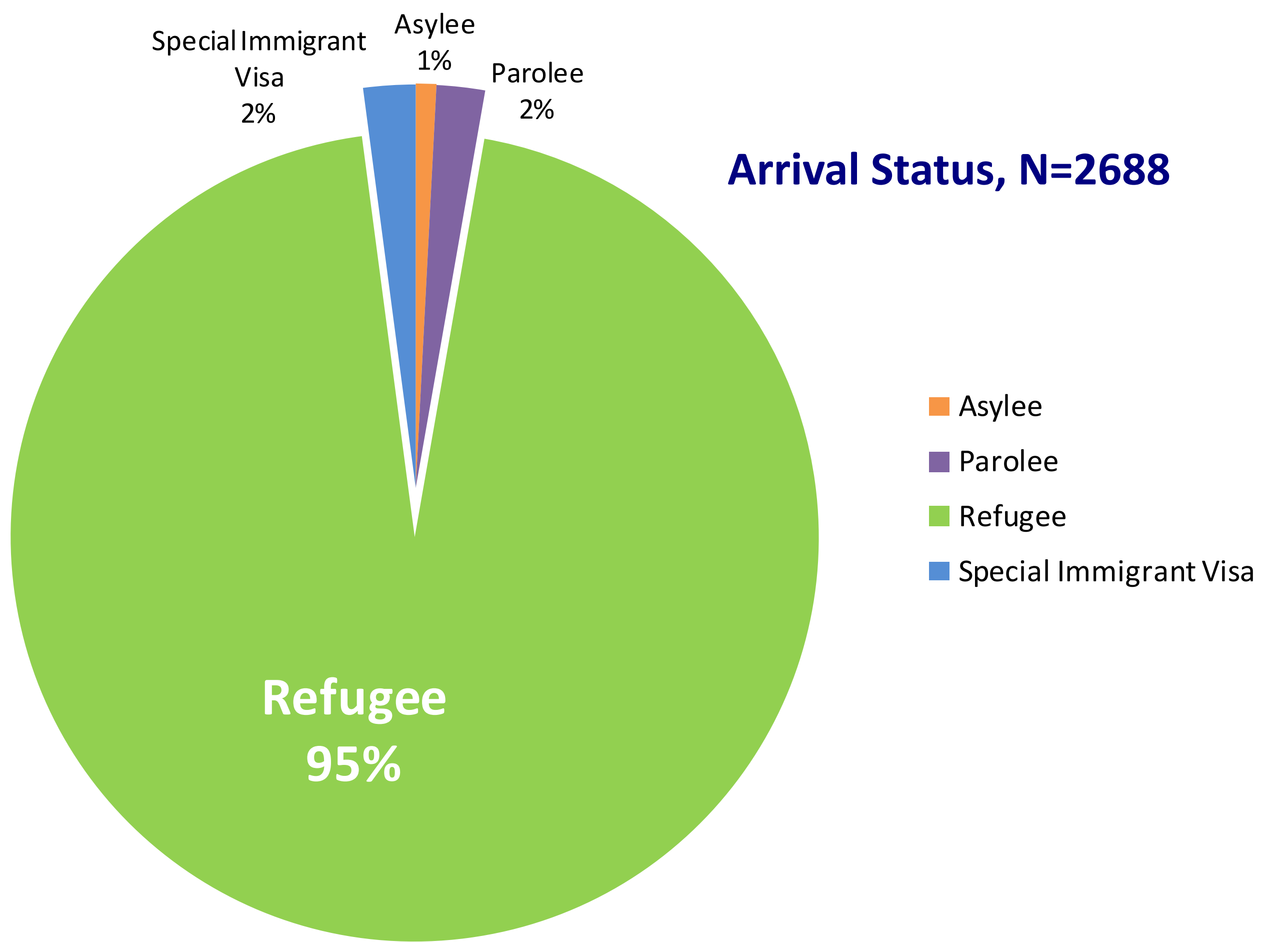
is school aged children (6-18)

The majority of our arrivals fall into the middle, working adulthood age group of 25-44 years of age. This age distribution is consistent with past years' surveillance data trends.

Functional Age Groups Distrubition N=2688



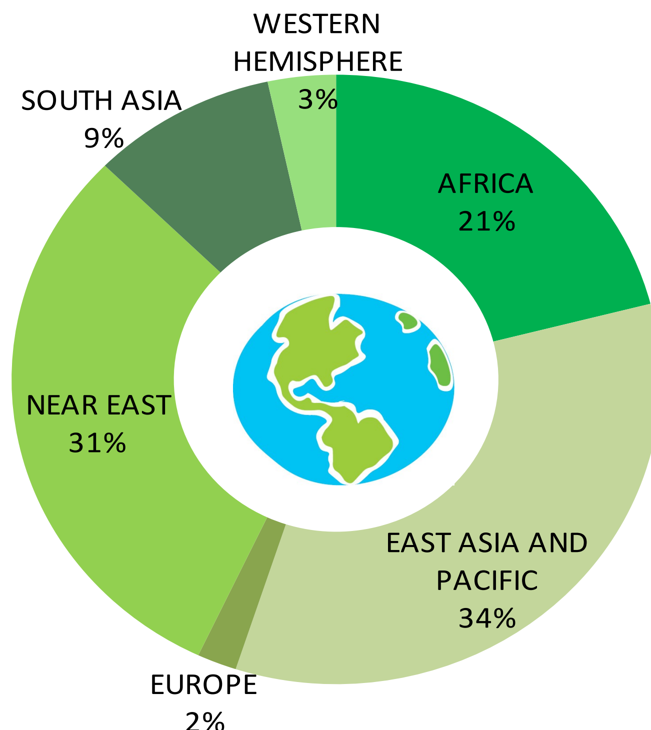
	<1	1-6	7-14	15-24	25-44	45-64	65 plus
Percent	1.41	16.44	14.58	18.45	37.28	9.93	1.9



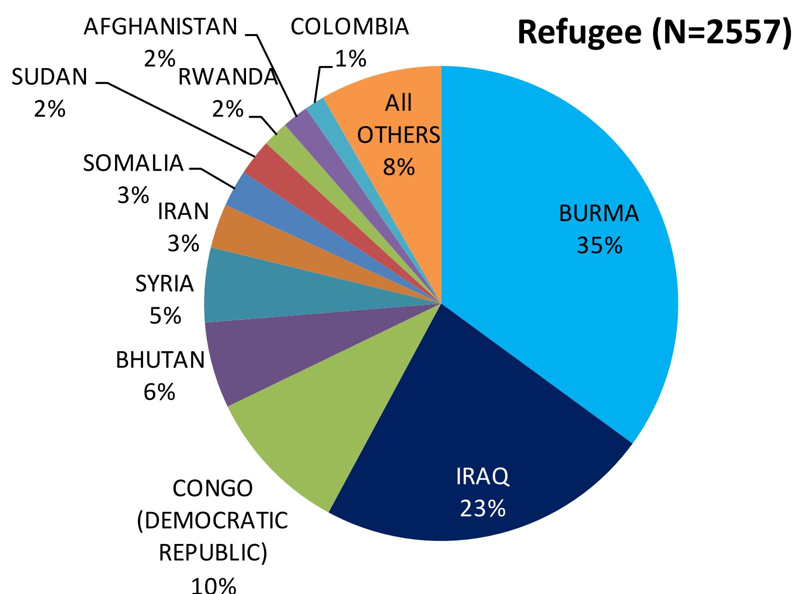
Arrival Status	Frequency
Asylee	22
Parolee	52
Refugee	2557
Special Immigrant Visa	56
Victim of Trafficking	*< 3*

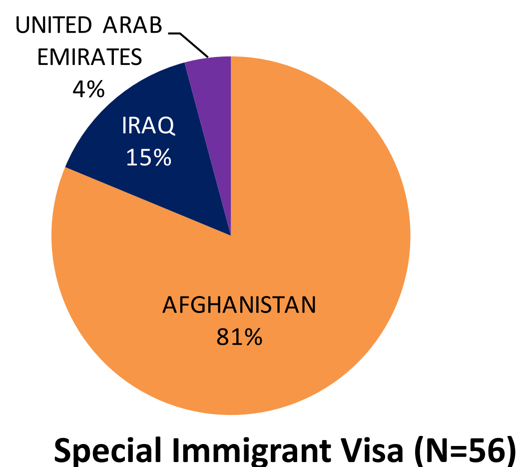
A majority of our screenings continue to be provided to refugees. This year we saw an increase in proportion of refugees and a decrease in the proportions of Special Immigrant Visas. *Screenings given to **2014** arrivals were 87% refugees and 8% SIVs.*

All Arrivals by Department of State Global Regions , N=2688



We screened arrivals from **48** different countries of origin





Special Immigrant Visa (N=56)

Overall trends in 2015 arrivals countries of origin:

The percentage of Burmese refugees is the highest it has been at 35%, surpassing Iraq as the most frequent nationality of our screening population. *In FFY 2014 Burmese refugees were 20% of all arrivals, Iraqis 42%.* The number of refugees arriving from Bhutan continued to decrease (10% in 2014). Refugees from the Congo and Syria also increased this year. *In FFY 2014, Congolese= 5% and Syrian=1% of arrivals screened.*

Screening Timeliness

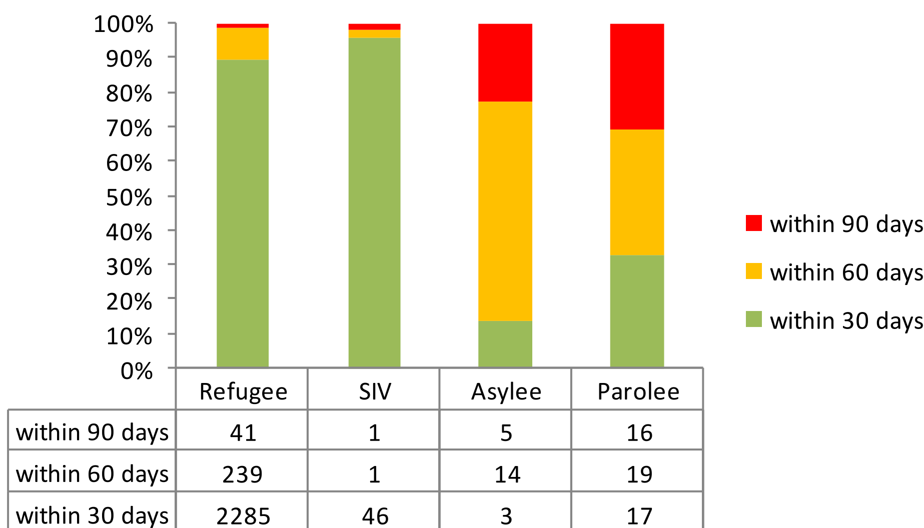
Proportion screened	Frequency	Percent
within 30 days	2352	87.5
within 60 days	273	10.16
within 90 days	63	2.34

The Refugee Health Program of Illinois strives to screen refugees as soon as possible after arrival to the United States -(ideally within 30 days). Arrivals are eligible for screening within the first 90 days of arrival.

87.5% of all screenings occurred within 30 days of U.S. arrival

We have improved dramatically since FFY 2013, where only 48% of arrivals were seen within the first 30 days.

Screening Timeliness by Arrival Status



	Refugee	SIV	Asylee	Parolee
within 90 days	41	1	5	16
within 60 days	239	1	14	19
within 30 days	2285	46	3	17

The median number of days between U.S. arrival and first clinic visit was 18 days

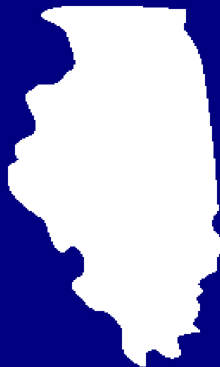
89% of refugee visa screenings occurred within 30 days of U.S. arrival. Due to a variety of logistical reasons, Parolees and Asylees screenings often occur later within the 90 day time frame.

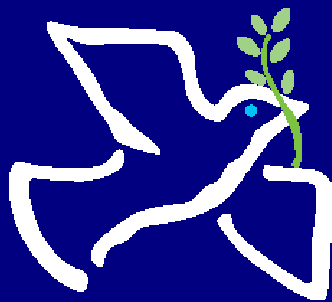
Screening Provider Locations

Clinic Surveillance	Jurisdiction	Frequency	% of total	% of clients screened within 30 days	Median days between arrival and first clinic date	Map Key
ACCESS COMMUNITY HEALTH NETWORK *	DuPage	217	8.07	78.3	20	
AUNT MARTHAS YOUTH SERVICE CENTER	Kane	178	6.62	98.3	7	
DUPAGE COUNTY HEALTH DEPARTMENT *	DuPage	135	5.02	80.7	14	
MT. SINAI COMMUNITY FOUNDATION-TOUHY CLINIC	Cook	1638	60.94	96.2	16	
ROCK ISLAND COUNTY HEALTH DEPARTMENT	Rock Island	219	8.15	56.2	28	
WINNEBAGO COUNTY HEALTH DEPARTMENT	Winnebago	301	11.2	66.1	21	

* Reflects an incomplete year of data. On 7/1/15, screenings were transferred from Access to DuPage County Health Department.

Initial Health Screening Results





Tuberculosis

The International Organization for Migration (IOM) conducts an overseas medical examination for all refugees. The guidelines for screening are provided by the CDC's Division of Global Migration and Quarantine. The overseas exam involves a history and physical, and screening for conditions of public health significance, including tuberculosis (TB). If active, infectious TB is identified, treatment is required prior to being cleared for travel. In other situations, they may receive one of the overseas TB Classifications, defined below.

Class B1 TB: TB disease, pulmonary or extra-pulmonary, active, non-infectious

Class B2 TB: Pulmonary TB, Inactive *(1991 guidelines);* Latent TB Infection (LTBI) needing evaluation *(2007 guidelines)*

Class B3 TB: Contact of an active TB case

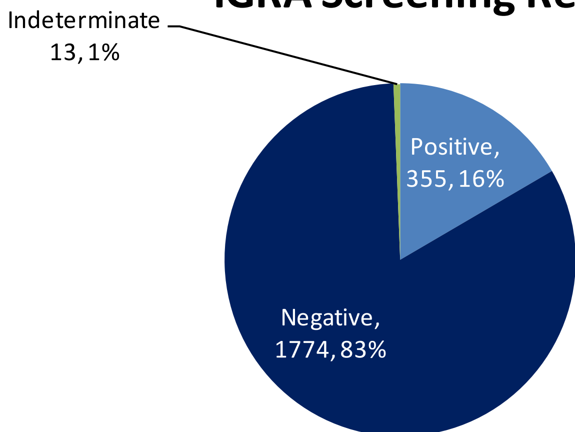
Class B Condition	Frequency
TB B1	110
TB B2	31
Class B- Non TB	563
Any Class B condition in EDN	704

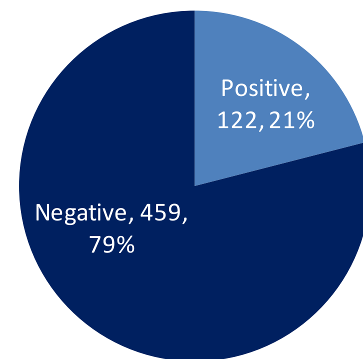
141 refugees arrived to Illinois with a TB class

The goal of the **domestic evaluation for TB** is to identify individuals with latent TB infection (LTBI) or TB disease. Refugees should be screened for TB using the Mantoux tuberculin skin test (TST) or an interferon-gamma release assay (IGRA) for *Mycobacterium tuberculosis.*

In otherwise healthy refugees, ≥10 mm induration is considered positive (≥5 mm in persons with HIV infection). A chest radiograph should be performed to assess for active TB disease for all refugees with a positive TST or IGRA, previous history of TB disease, class A or B TB designation, or symptoms consistent with TB regardless of TST or IGRA result.

98.5% of all arrivals were screened for Tuberculosis Infection





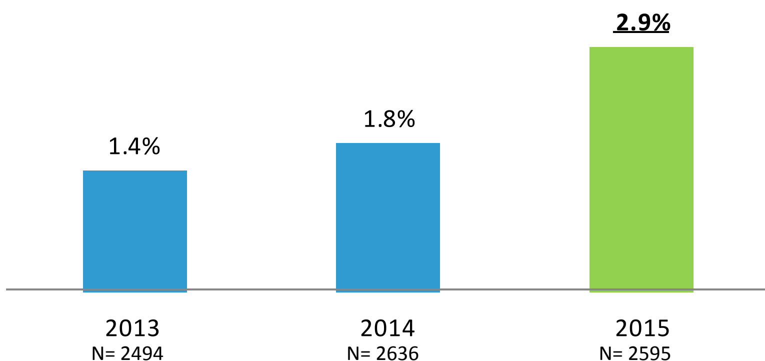
18.6% of arrivals had a positive screening result

Hepatitis B

Chronic hepatitis B virus (HBV) infection, defined as hepatitis B surface antigen (HBsAg) positivity for at least six months, is a major cause of morbidity and mortality worldwide. All individuals who were born or lived in countries where the rate of chronic hepatitis B virus infection is greater than two percent (this includes many countries that refugees come from) should be tested for HBV infection. HBsAg-positive persons should receive appropriate consoling and be evaluated for treatment.

97.9% of all arrivals were screened for Hepatitis B

% HBsAG Positive among those screened by arrival year

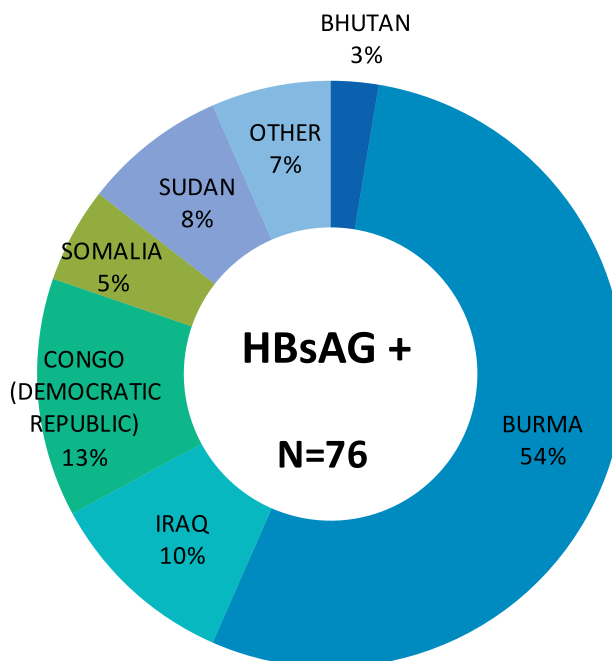


N= total number screened with result data entered

Approximately **3%** of 2015 arrivals screened **positive** for hepatitis B surface antigen, an increase from previous years.

The majority (54%) of positive Hepatitis B screening results came from Burmese arrivals.

For more data on regional specific Hep B prevalence see DOS region charts on page 18

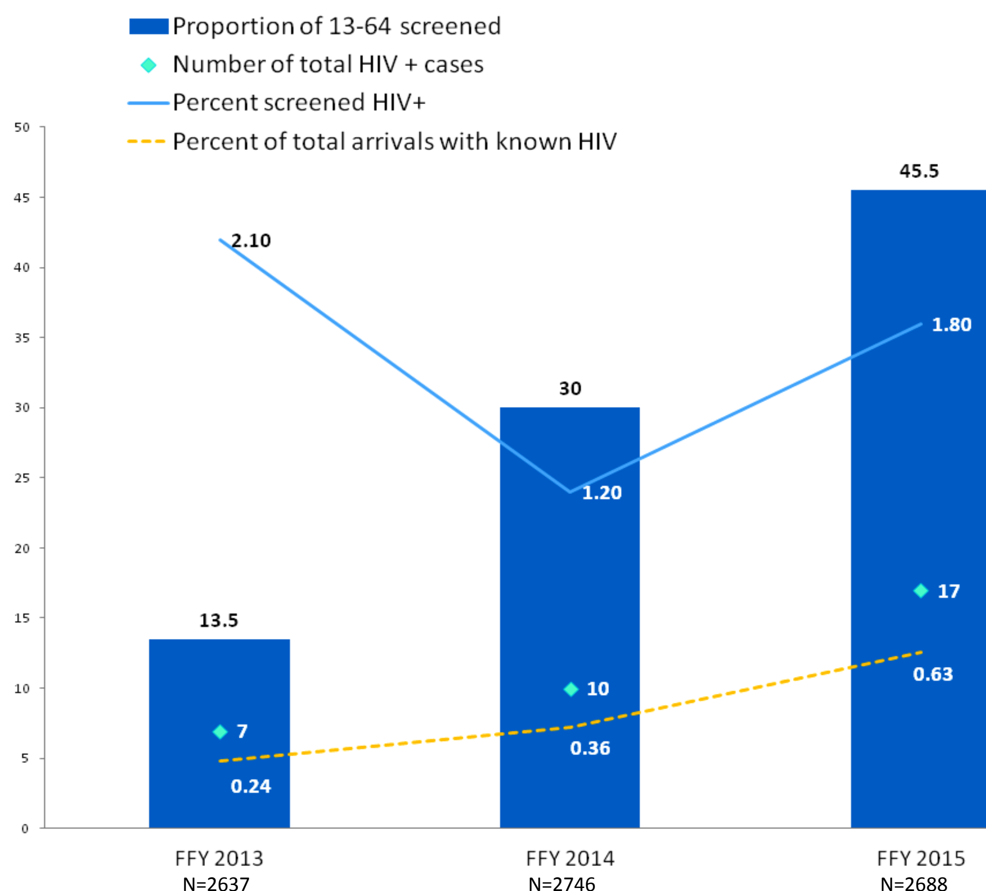


Distribution of country of origin among the HBsAG positive cases

Sexually Transmitted Infections

Human Immunodeficiency Virus (HIV)

HIV was removed from the list of inadmissible conditions in January 2010, and refugees are no longer routinely tested for HIV prior to departure to the United States. Current CDC guidelines recommend HIV screening in health-care settings for all persons 13-64 years of age. Universal screening of all refugees on arrival, including those ≤12 and > 64 years is also encouraged. If HIV infection was indentified overseas, domestic confirmatory testing is recommended.



45.5% of arrivals aged 13-64 were screened for HIV

Our clinics have improved with more consistent HIV screening since 2013. *In 2013, the higher percentage of positive screenings is inflated due to the small proportion of individuals screened, all 7 of the cases were known to providers prior to testing.*

As less than half of all refugees were screened for HIV, we cannot accurately report the true prevalence among all arrivals. The percentage of all ages arrivals with a known HIV infection (including both infections identified during domestic screening and overseas) has steadily increased since 2013. **0.63% of all arrivals this year were HIV positive.**

Syphilis

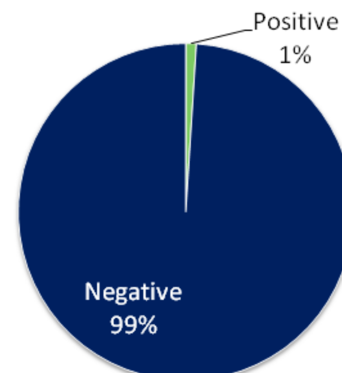
55.3% of arrivals over age 15 were screened for Syphilis

Syphilis screening using Venereal Disease Research Laboratory (VDRL) or rapid plasma reagin (RPR) or an equivalent test is recommended for all persons ≥15 years of age, regardless of the overseas results.

1% of arrivals screened tested positive for Syphilis (screening and confirmatory testing positive). *This proportion is consistent with past years' surveillance data.*

20% of those testing positive for Syphilis were also infected with HIV

Syphilis screening results N=1004



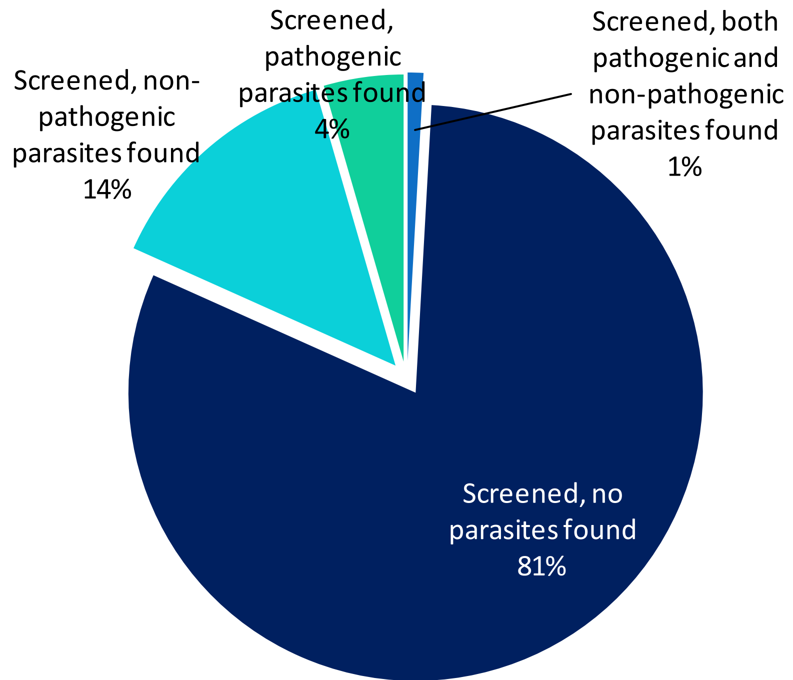
Parasitic Infections

Intestinal Parasites

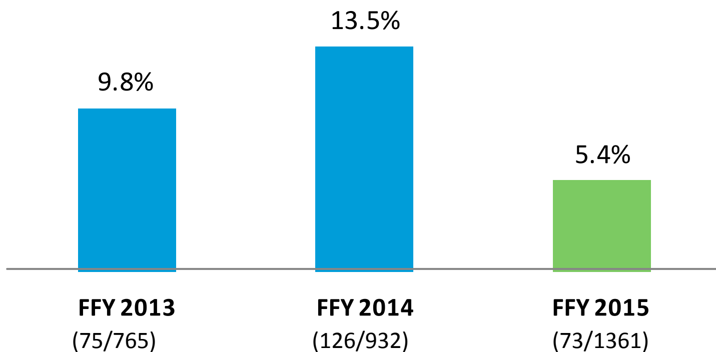
Many refugees may be at increased risk for parasitic infection. Some refugee populations receive pre-departure presumptive treatment for soil transmitted helminth infections, specifically Strongyloides and Schistosoma spp. An algorithm for domestic screening and presumptive treatment was developed by CDC based on current programming and risk factors, and can be accessed through the CDC domestic guideline site. Those guidelines were not fully instituted in Illinois in FFY2015 due to funding restrictions. Screening results for intestinal parasite are from stool ova and parasite (O&P) examinations.

- 12% of arrivals had documentation of overseas parasite treatment
- O&P tests were ordered for 67.8 % of arrivals
- 75% of those tests had valid results entered

5% of arrivals screened with O&P results had pathogenic parasites detected



Intestinal Parasite O&P Screening Results, N=1361



The proportion of O&P results detecting pathogenic parasites has decreased in FFY 2015.

Note: In previous surveillance years, a larger proportion of parasite results were left as "Pending." Providers may have disproportionately updated records with positive results, causing past data to overestimate the true prevalence of positive screenings.

The most common parasite species detected were Giarda (42 cases) and Entamoeba histolytica (19 cases)

Malaria Parasite: 280 arrivals were screened for Malarial infection. 0 results were positive .

Lead Levels – Children

Refugee children arriving in the U.S. in recent years have had higher rates of elevated blood lead level (BLL) on average compared to children born in the U.S. In areas of the world where many refugees originate, potential lead exposures include lead containing gasoline combustion, industrial emissions, ammunition manufacturing and use, burning of fossil fuels and waste, and lead-containing traditional remedies, foods, ceramics, and utensils. CDC recommends children aged 6 months to 16 years receive a blood lead level test as part of their initial health screening

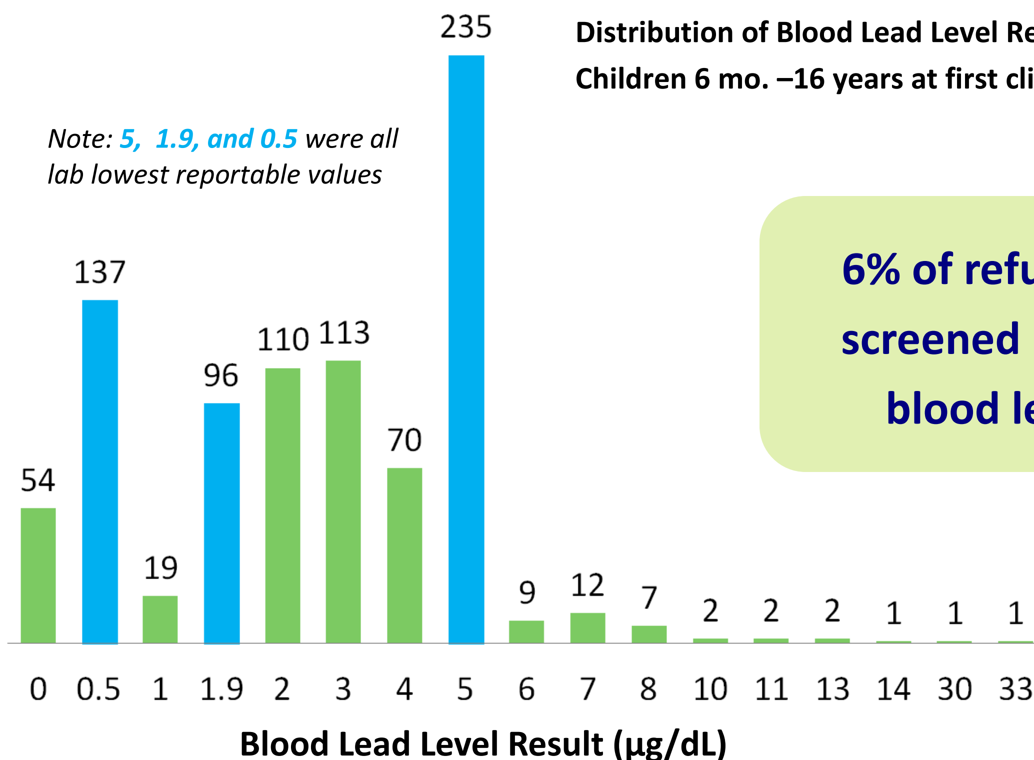
An elevated level of lead is defined by a BLL ≥5µg/dL

99% of children aged 6 months to 16 years had lead screenings performed

92% had results returned with accurate data(871/948)

*Mt. Sinai's lab limit of detection prior to 4/2/2015 was 5. Levels returned before that time need to equal or exceed 6 to be considered elevated. Post 4/2/2015, the lowest reportable level decreased to 1.9, so all levels 5 and above were considered elevated– consistent with other clinics and CDC recommendations.

Distribution of Blood Lead Level Results, Children 6 mo. –16 years at first clinic date N=871



6% of refugee children screened had elevated blood lead levels*

Nutrition

Undernutrition is a condition associated with development and cognitive delays, while overweight and obesity are associated with chronic medical conditions. While undernutrition is often associated with refugee status, there is increasing concern about overweight and obesity among newly arriving refugees. Height and weight measurements are recorded from the initial health assessment and anthropometric indices were used to characterize nutrition status in newly arrived refugees

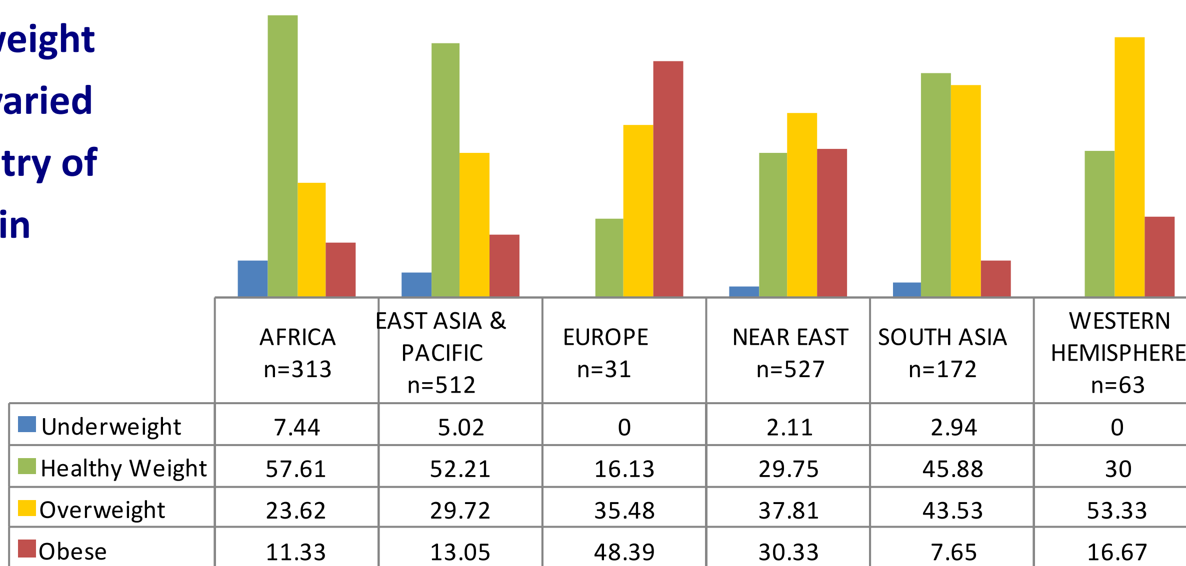
Age	Underweight N (%)	Healthy Weight N (%)	Overweight N (%)	Obese N (%)
2-4	35 23.80%	92 62.59%	6 4.08%	14 9.52%
5-19	68 10.35%	447 68%	68 10.35%	74 11.30%
19 +	64 4.02%	694 43.70%	535 33.70%	296 18.60%

Table of all 2015 arrivals, nutrition status by age group N=2393

Pregnant women and records with missing or biologically implausible values for height and weight were excluded.

Adult Refugees, Weight Status by Region, (%)

Obesity and Underweight status varied by country of origin



	AFRICA n=313	EAST ASIA & PACIFIC n=512	EUROPE n=31	NEAR EAST n=527	SOUTH ASIA n=172	WESTERN HEMISPHERE n=63
Underweight	7.44	5.02	0	2.11	2.94	0
Healthy Weight	57.61	52.21	16.13	29.75	45.88	30
Overweight	23.62	29.72	35.48	37.81	43.53	53.33
Obese	11.33	13.05	48.39	30.33	7.65	16.67

Department of State Region, Country of Origin

Children, *arrival age 2-18*

BMI-for-age Percentile Ranking	Weight Status
Less than 5th percentile	Underweight
5th percentile to less than 85th percentile	Healthy weight
85th percentile to less than 95th percentile	Overweight
Equal to or greater than the 95th percentile	Obese

For children, bmi-for-age and weight-for-age z-scores and percentiles were calculated using CDC growth charts for children 2-19 years of age as indices

Adults, *arrival age 19+*

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Healthy weight
25.0 – 29.9	Overweight
30.0 and Above	Obese

Language & Referrals

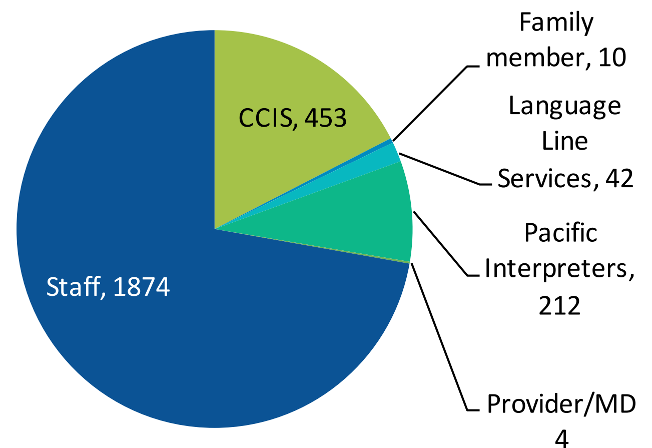
The clinic providing the health screening should ensure there is a medically trained interpreter available during the health assessment. Interpretation is provided telephonically if an in-person interpreter is not available.

98% of screenings required interpretation services

Top languages spoken N=2613

Language	Frequency	%
Arabic	833	31.9%
Burmese	725	27.7%
Swahili/Kiswahili	214	8.2%
Farsi	125	4.8%
Chin	97	3.7%
Spanish	91	3.5%
Karen	78	3.0%
Somali	68	2.6%
French	61	2.3%
Other *	321	12.3%

*includes 25 languages



Type of Interpretation Service used, frequencies, N=2596

As a part of the initial screening, arrivals should be linked to a primary care physician and referred for follow-up care for any pending health issues.

87.4% of all arrivals had a referral to primary care

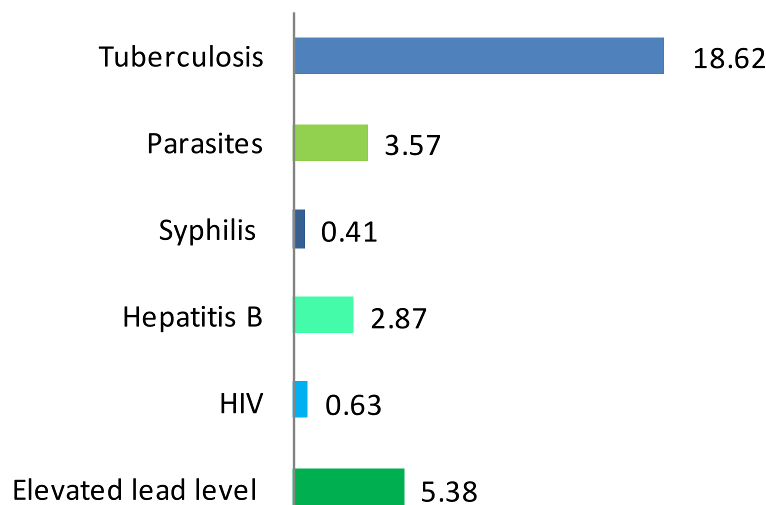
- 457 refugees were referred to public health TB programs
- 47 refugees were referred to infectious disease specialists for follow up unrelated to TB

Specialist Referrals	N	% of all arrivals referred
Dental	583	21.7%
Mental Health	24	0.9%
Nutritionist	101	3.8%
TB Program	457	17.0%
Optometry	280	10.4%
Ob/Gyn	91	3.4%
Infectious Disease	47	1.7%
Gastrointestinal	22	0.8%

Regional Health Profiles

Refugees arrive from all across the globe and have lived in a variety of environments. Arrivals coming from certain regions have different health screening outcomes than arrivals from other regions. The following graphs showcase the diversity of this unique population.

All Regions total arrivals N=2688



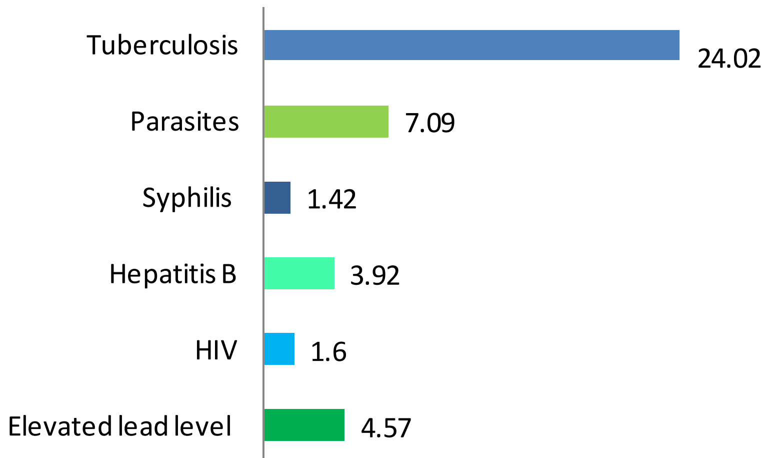
Use this **total arrivals all regions graph** as a reference when comparing the regional specific graphs

Elevated lead level is measured for children only (6 mo.-16 years).

Bar graphs are percent (%) positive of **total arrivals** in each region (example: % HIV positive among all Africans arriving in FFY 2015, not % who screened positive among only those screened)

Note: Specific profiles for Europe and Western Hemisphere Department of State Regions were omitted due to small sample sizes which could jeopardize data confidentiality

Africa

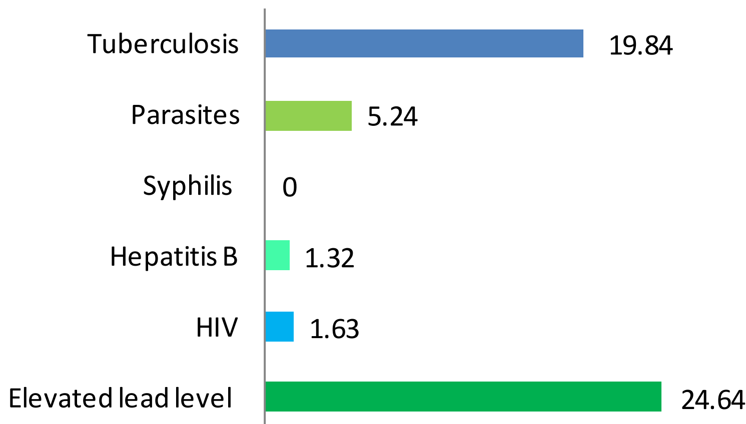


The top 3 most common countries of origin in the Africa Department of State region:

Total refugees screened from African region=564

1. **Democratic Republic of the Congo**
2. **Somalia**
3. **Sudan**

South Asia

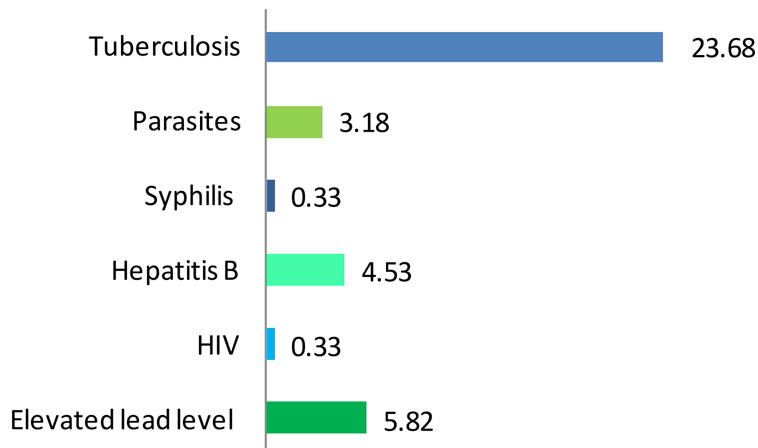


The top 3 most common countries of origin in the South Asia Department of State region:

Total refugees screened from South Asia region=248

1. **Bhutan**
2. **Afghanistan**
3. **Pakistan**

East Asia & Pacific

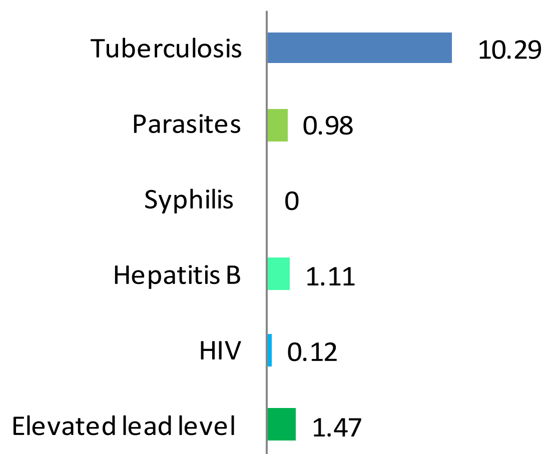


The #1 of origin in the East Asia & Pacific Department of State region:

1. **Burma/ Myanmar**

Total refugees screened from East Asia region=913

Near East



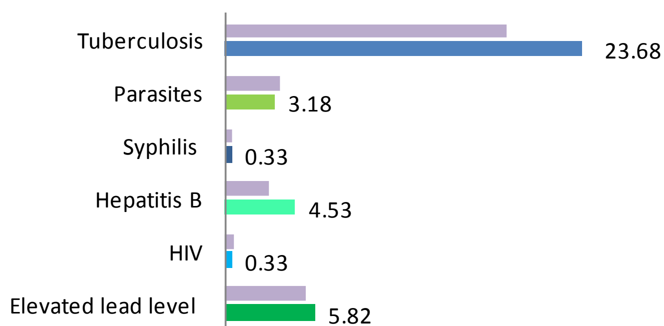
The top 3 most common countries of origin in the Near East Department of State region:

Total refugees screened from Near East region=816

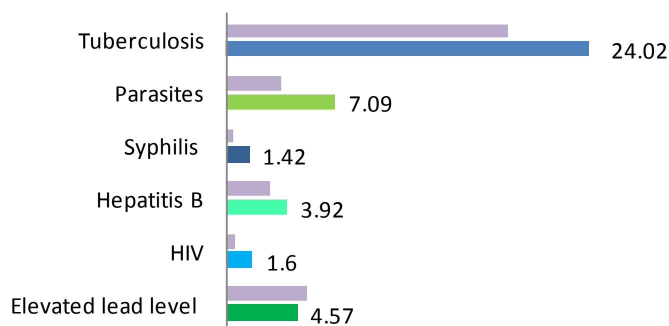
1. **Iraq**
2. **Syria**
3. **Iran**

Overview

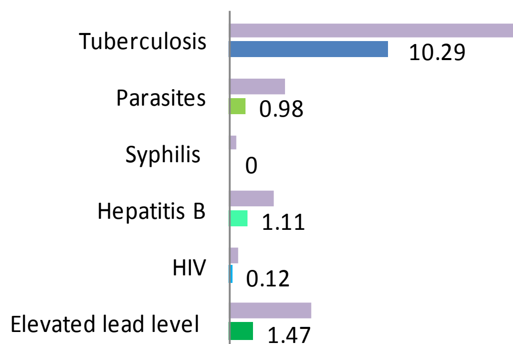
East Asia & Pacific



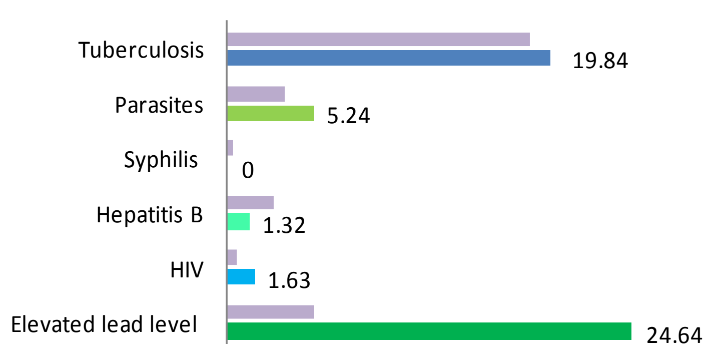
Africa



Near East



South Asia



Percent positive of selected indicators among all arrival by regions, purple bars reflect total Illinois arrival population (all regions).

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