Indiana State Department of Health

Refugee Report

Federal Fiscal Year 2014

December 2014

Syrian-Kurdish refugee children sit in a concrete block at the Quru Gusik refugee camp, near Arbil, Iraq, *Safin Hamed/AFP/Getty Images.* (*Photo from* ***http://america.aljazeera.com/articles/2013/9/3/syrian-refugee-numbersswellto2million.html***)

Background

Each year, refugees fleeing persecution and war from all over the world are resettled in the United States. Many of these refugees come to Indiana to build new lives for themselves and their families. Between the mid 1970's and 2007, 200 to 500 refugees were resettled in Indiana each year. In 2007, refugee arrivals dramatically increased, causing the total number of arrivals to increase to approximately 1500. Indiana's primary refugee arrival numbers have been comparable each year since. Primary refugees arrive directly to Indiana from another country.

The sudden increase in arrival numbers that began in 2007 quickly overstretched the refugee service infrastructure in place at that time. In response to the overwhelming burden placed on Indiana's refugee resettlement agencies and healthcare providers, the Indiana State Department of Health (ISDH) hired a State Refugee Health Coordinator. Next, they established an ongoing Memorandum of Understanding (MOU) between the Indiana Family and Social Service Administration, the state agency that houses the State Refugee Coordinator and is responsible for Indiana's Refugee Resettlement Program under 45 CFR (Code of Federal Regulations) 400.5. Through the MOU, ISDH is designated as the state government agency responsible for the Indiana Refugee Health Program, as evidenced by the Indiana Refugee Resettlement State Plan. It is the responsibility of the ISDH to provide oversight and coordination of public and private resettlement resources and health services to refugees in Indiana. This oversight ensures coordination among refugee service providers and cooperation at the state level for broad-reaching health services for refugees.

Karen Human Rights Group. Karen refugees from Burma cross the border into Thailand to escape a Burmese Army offensive. (Photo from: http://www.karen.org.au/refugees.htm)

The mission of the ISDH's Refugee Health Program is to support the resettlement of refugees by providing access and resources for an initial health screening upon arrival to the United States, by identifying emerging health issues in refugee populations and to provide ongoing support through relationships with community, state and federal partners. The vision of the program is that every refugee in Indiana receives an initial health screening within 90 days of U.S. arrival and be referred to a medical home.

The ISDH Refugee Health Program works in collaboration with national, state and local agencies, voluntary resettlement agencies and many other organizations to help provide comprehensive health and mental wellness care to Indiana's refugee communities.

A Somali refugee mother and children in Kakuma Camp, Kenya, hope for a better life. Annie Griffiths/Ripple Effect Images . *(Photo from: http://www.cwsglobal.org/what-we-do/refugees/)*

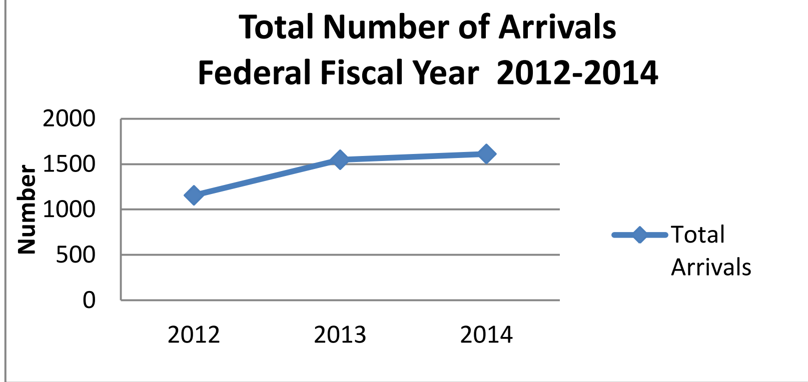
Primary refugees from Burma/Myanmar have accounted for more than 80 percent of Indiana's total annual arrivals since 2007. Not all Burmese refugees share the same language, customs, food and dress. There are many different ethnic groups represented in the newly arriving refugees from Burma. These include, but are not limited to, the Burmese, Chin, Karen, Karenni, Kachin and Rohinga. Of the Indianapolis refugees from Burma/Myanmar, 83 percent are of the Chin ethnicity. Since high numbers of refugees from Burma/Myanmar have been resettled in the state every year since 2007, many refugees from Burma/Myanmar now resettling in the U.S. have family or community ties in Indiana. Due to the large Burmese community in Indiana, it is not uncommon for secondary refugees to make their way to Indiana. A secondary refugee is first resettled in another state and then comes to Indiana. In addition to refugees from Burma/Myanmar, other currently arriving refugees are primarily from Afghanistan, Iraq, Bhutan, Democratic Republic of the Congo, Somalia, Iran, Ethiopia, Cuba, Sudan, Palestine and Eritrea. However, small numbers of refugees are also arriving from Syria, Zimbabwe, China and India.

Syrian refugees gather at the border in Suruc, Turkey, September 2014 (AP). (Photo from: http://www.boston.com/bigpicture/2014/09/syrian_kurdish_refugees_flooding*)*

The majority of the refugees which Indiana expects to receive over the next several years will continue to be from Burma/Myanmar. However, other trouble spots in the world, such as Syria, are producing refugees, some of which will be resettled to the U.S. It is highly likely that Indiana will continue to receive refugees from areas of East Asia, Africa, the Near East and South Asia in the coming years.

Demographic Data

Figure 1.



Newly arriving refugees to Indiana have increased from 1,156 in Federal Fiscal Year (FFY) 2012 to 1,612 in FFY 2014. The federal fiscal year runs from October 1 to September 30. It is anticipated that Indiana will receive approximately the same number of refugees in FFY 2015 and 2016.

While refugees came from 45 different countries in FFY 2014, the majority was born in Burma/Myanmar and came to Indiana from the countries to which they fled to -- Thailand and Malaysia. Refugees with a birth country of Thailand and Malaysia are generally the children of the refugees from Burma/Myanmar who were born in these countries. The countries of birth of the refugees in the past three years and the number of refugees are shown in the table 1 below.

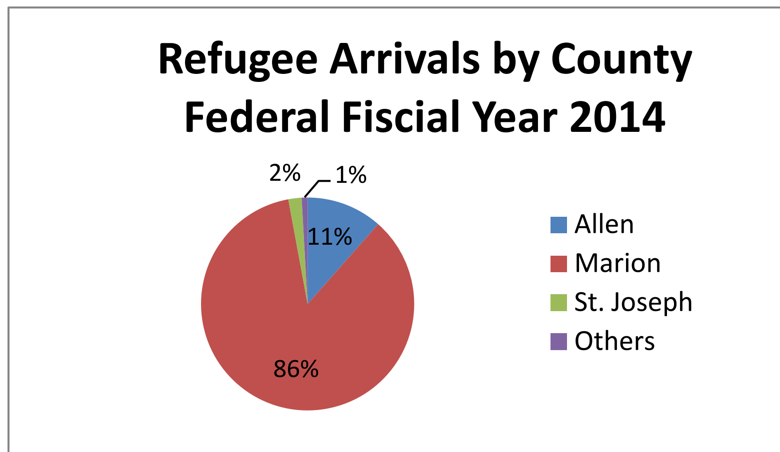
Table 1

Country of Birth	FFY 12	FFY 13	FFY 14	Total
Afghanistan	4		10	14
Bhutan	28	7	16	51
Burma	15	28	53	96
Burundi		1	4	5
Chad	1	1		2
China	7	11	3	21
Congo, Democratic Rep of	9	42	22	73
Cuba	8	9	14	31
Djibouti		2		2
Egypt	1	3	11	15
Eritrea	5	7	8	20
Ethiopia	9	18	14	41
Guinea			1	1
Iceland		1		1
India	3	7	14	24
Indonesia			1	1
Iran	20	2	14	36
Iraq	60	75	116	251
Jordan	5	1	9	15
Kenya	3	2	6	11

Country of Birth	FFY 12	FFY 13	FFY 14	Total
Korea, Demo Peoples Rep	1			1
Kuwait			5	5
Lebanon	2	1		3
Liberia		1	1	2
Libya		4		4
Malawi		1		1
Malaysia	77	169	157	403
Malta			1	1
Moldova	5			5
Myanmar/Burma	706	1111	930	2747
Nepal	17	7	16	40
Pakistan	2	2	3	7
Russia		1		1
Rwanda		14	6	20
Somalia	29	45	34	108
South Africa		1		1
Sudan	19	14	16	49
Syria	4	5	3	12
Thailand	66	78	98	242
Tunisia		2		2
Turkey		2	1	3
Uganda		3		3
United Arab Emirates		2	2	4
Zambia		2		2
Zimbabwe		1	3	4

During FFY 2014, the majority of refugees coming to Indiana were resettled in Marion County.

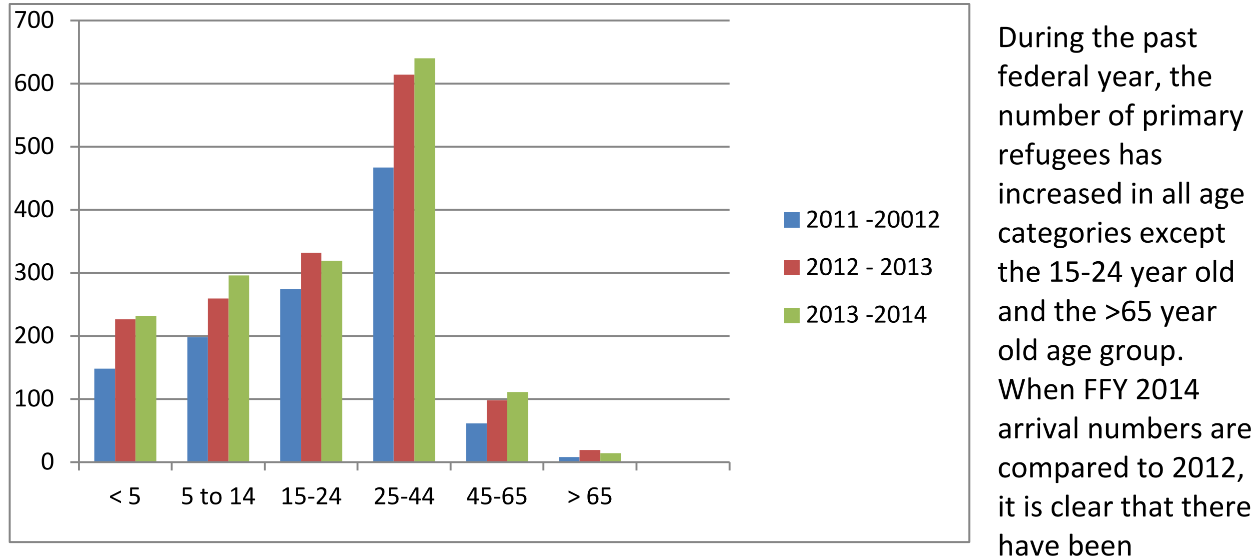
Figure 2



Catholic Charities of the Archdiocese of Indianapolis, Inc. and Exodus Refugee/Immigration, Inc. were the two resettlement agencies welcoming, guiding and supporting them upon arrival. Marion County Public Health Department was the facility providing health screenings to this group. As can be seen in Figure 2, 86 percent of the refugees were resettled to Marion County while 11 percent was resettled to Allen County during FFY 14. Catholic Charities of the Diocese of Fort Wayne – South Bend provided the resettlement services to the refugees

while the Ft Wayne/Allen County Health Department provided the health screenings to refugees resettling in Allen County. A small number of refugees were resettled in St. Joseph County by the Saint Joseph Chapter of the American Red Cross until the end of FFY 2104 when it closed its resettlement activities.

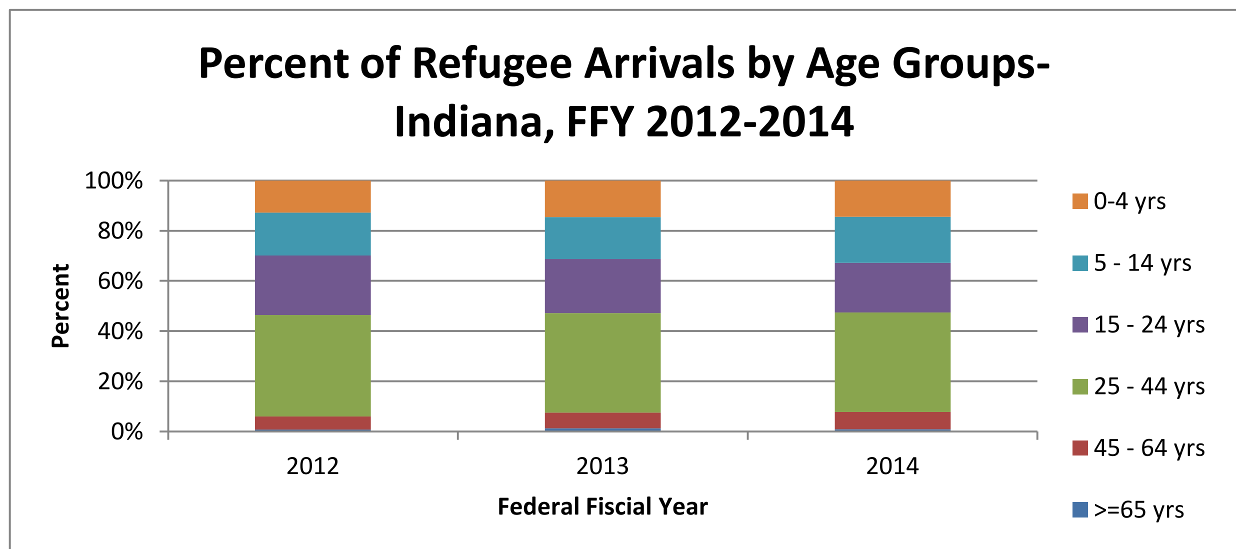
Figure 3. Refugee Arrivals by Age Category and Years



During the past federal year, the number of primary refugees has increased in all age categories except the 15-24 year old and the >65 year old age group. When FFY 2014 arrival numbers are compared to 2012, it is clear that there have been increases in the <5 year olds, the 5-14 year olds, the 25-44 and the 45 -65 year olds age groups.

Figure 4 clearly shows that the 25-44 year old refugees make up almost half of the newly arriving refugees. Not only is this the prime child bearing age, but these are adults who must

Figure 4

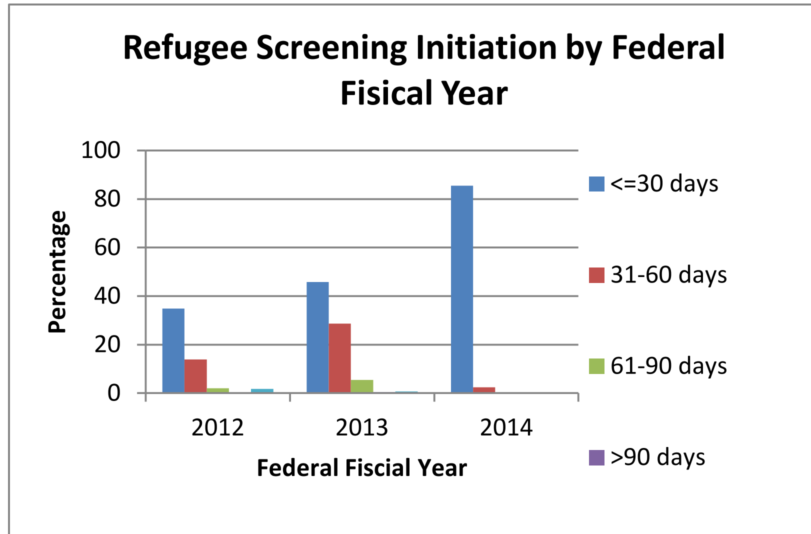


complete their immunizations within one year to be able to apply for change of status from a refugee to a permanent resident.

More male then female refugees arrive each year. This too has been consistent over the past several years. In FFY 2013, there was a slight increase in the male population and a slight decrease in the female population of newly arriving refugees. Otherwise the percentages have remained stable with approximately 60 percent of the refugees being male and 40 percent being female.

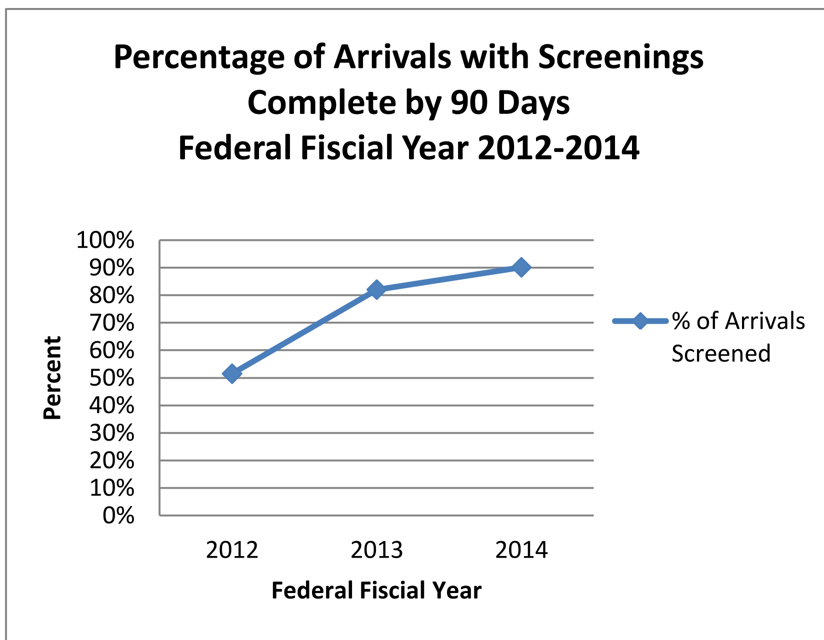
Over the past several years, the refugee resettlement agencies and the local health departments have worked hard to improve the number of primary refugees whose initial screening was initiated within 30 days of arrival. This percentage has gone from less than 40 percent to over 80 percent in the past three years.

Figure 5



Likewise there has been a great increase in the number of refugees who are completing their screening within 90 days. This proportion has gone from 50 percent in 2012 to about 90 percent in 2014 (Figure 6).

Figure 6

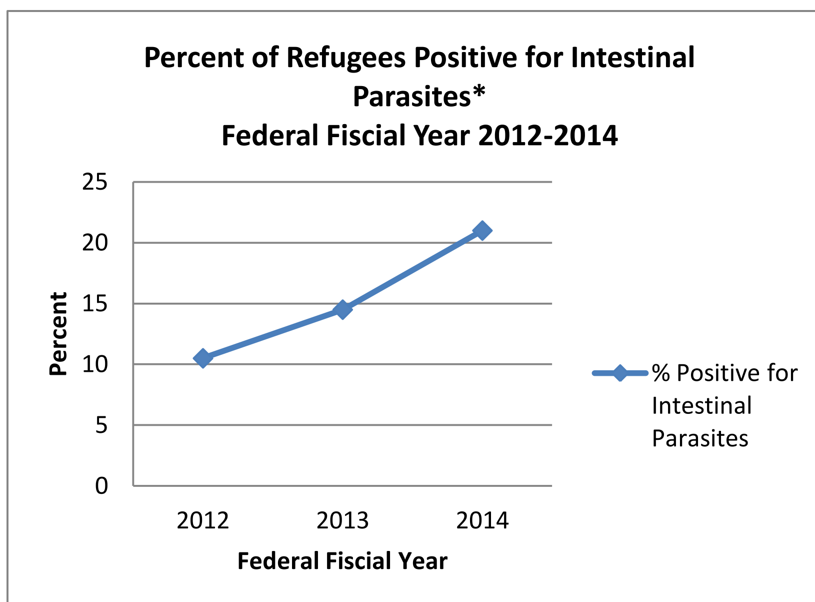


Also, refugees are being enrolled in Medicaid earlier, helping them get established in a primary medical home before their relationship with the resettlement agency wanes. To date, most of our attention has been focused on primary refugees. More attention needs to be given to tracking and providing services to secondary refugees. This is a difficult task as they often do not seek assistance through the resettlement agencies.

Health Issues

Health related issues are just beginning to be tracked so that appropriate interventions can be implemented. Because refugees in the camps in Thailand were given medication for parasites prior to arrival in the U.S., the rate of intestinal parasite infections had decreased. However in the past two years, there has been an increase. This may be due to more refugees being settled from Malaysia where refugees are not in camps, or it may be due to the slight increase in younger refugees. More investigation is needed. It would be expected that children may bring with them more intestinal parasites as they play in the dirt in areas where sanitation is sometimes lacking, which can result in parasites, poor nutritional status and anemia (Generalized Anxiety Disorder {GAD-7} & Patient Health Questionnaire {PHQ-9).

Figure 7



Lead Poisoning is another condition which is seen at higher rates in some refugee children than in their U.S. born peers. In the past, a cosmetic was identified as a possible source of the lead poisoning. This product was removed from the vendor's shelves and information about its dangers was distributed in local languages to the refugees. It appears there may be more cosmetic products or home remedies which contain high lead levels. Investigation is on-going into the source of the lead exposure in both Allen and Marion Counties.

Mental wellbeing is another factor which needs to be assessed in the arriving refugees. Many of these individuals have survived major trauma. The stress of fleeing one's country coupled with the stress of living in a refugee camp and then becoming acclimated to a new culture can be overwhelming. Often the social networks that refugees relied upon to assist with stress reduction are no longer in place in their lives. This places the refugees at a higher risk for conditions such as depression, anxiety and post

http://blog.nohatespeechmovement.org/wp- 1

traumatic stress syndrome. Each year there have been suicides in the refugee community: mostly in males. A retrospective study on depression is currently underway with refugees who were screened with the Generalized Anxiety Disorder (GAD-7) and the Patient Health Questionnaire (PHQ-9) for anxiety and depression in Fort Wayne from 2011 to 2014. The results of this study should be complete in late 2015 and provide valuable evidence-based information on the morbidity trends in depression and anxiety within the refugee population.

In the future, the program hopes to also track and trend more chronic diseases such as obesity, hypertension and diabetes. Acute diseases and maladies such as anemia, poor vision and poor dentition will continue to be tracked and referrals made to appropriate clinicians. Communicable diseases such as tuberculosis infection and disease, sexually transmitted infections, HIV and parasites will continue to be included in the screenings and will continue to be tracked.

For more information about the ISDH Refugee Health Program, visit http://www.in.gov/isdh/24668.htm.