

# Refugee Health Quarterly

A Refugee Health update from the Minnesota Department of Health



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## Greetings from the Refugee and International Health Program

Can you believe it's April? RIHP and our partners have made exciting progress since our last quarterly. Many of our Center of Excellence in Refugee Health projects are in full gear. Partner clinicians in Philadelphia, Minnesota and Colorado have been busy reviewing the existing CDC refugee screening guidelines to recommend updates and revisions. Our teams are also writing new clinical guidelines in women's health, pediatrics and preventive health. To inform this work, we're preparing to disseminate a survey to assess healthcare providers' needs related to refugee health clinical guidance. In May, we'll reach out to Refugee Health Coordinators and clinicians around the U.S. to gather the information.

This issue includes an update on the Malaria Project, led by the University of Minnesota in partnership with MDH, Hennepin County Medical Center, the Uniformed Services University of Maryland, Albert Einstein University (the Bronx, New York), and HealthPartners.

A new student worker, Fathi Ahmed, joined the RIHP in March. She's a student at St. Kate's University in St. Paul, majoring in public health. Fathi will assist with various projects in Refugee and International Health as well as in the MDH Immunization Program.

We hope you enjoy reading this edition of our newsletter. Happy spring!

## LPH/VOLAG Spotlight: Remote Placement Program

One of the most important considerations in the placement of arriving refugees is closeness to a U.S. tie. Usually family members, U.S. ties offer support and guidance as refugees adjust to life in the U.S., a helpful addition to the resources provided by resettlement agencies. A challenge is that many U.S. ties live more than 100 miles from the nearest resettlement office. Services are limited outside the 100-mile service area. The Remote Placement Program (RPP) is a new pilot program through the United States Conference of Catholic Bishops/Migration and Refugee Services (the national affiliate of Catholic Charities) that seeks to address this gap.

Through the RPP, a remote placement site can assist in resettling up to 35 refugees per fiscal year. The site is bound by the same expectations as established refugee resettlement agencies. These responsibilities include airport pickup; housing placement; orientation to the U.S.; and assistance with employment, social security registration, and accessing programs such as English classes. Agencies also collaborate with the local public health office to ensure access to health care and a refugee health screening.

The first remote placement pilot site in Minnesota is in Marshall, at [Western Community Action](http://www.wcainc.org/) (WCA, <http://www.wcainc.org/>), a nonprofit organization that has been serving the area since 1965. WCA has worked with refugees and immigrants for many years. When

WCA was approached about participation in this pilot, it was a natural fit, says WCA Development Director Allan Bakke. "The motivation was to help refugees and immigrants move through self-sufficiency to thriving," Bakke explains.

WCA has resettled one family of three individuals so far. By the end of May 2016, they expect to receive 19 more people, including a family of 13. Housing is one of the biggest challenges for WCA. Refugee arrival dates are often in flux, making it difficult to set a start date for a lease. WCA has several local partners to address housing needs, including some local employers.

Bakke shared a personal story as one example of what inspires him in this work: "My spouse and I had gone with the anchor family to pick up the arriving family at the airport. It was so inspirational and interesting to be with the anchor family, who hadn't seen the sister in a dozen years. Emotions aren't always 'large' or meant to be seen across a room depending on the culture, but you could see faces just get big and smile as eyes light up, the embrace with the heads close together. Being a witness to that was phenomenal."

WCA has already seen the impact of immigration in the area. Some of the earlier arrivals are opening businesses, expanding the region's culinary options. For long-standing businesses and industries, immigration, including refugee resettlement, brings a needed workforce to the community.

Bakke explains the influence of working with refugees and immigrants on WCA: "We are learning more as an agency (and other agencies as well), how we can become more effective and do things that people really need, by them telling us what that is instead of what we think they need. The best part is getting to know them and hearing their story, seeing their hope and getting to be a part of helping that hope come true."



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## Provider Update: Skin Disease in Refugees

By guest author **Alexia Knapp, MD, HealthPartners Global Dermatology Clinic, St. Paul, MN.** She can be reached at [alexia.p.knapp@healthpartners.com](mailto:alexia.p.knapp@healthpartners.com).

Although skin diseases are rarely life-threatening, they can cause significant morbidity and have a negative impact on quality of life. There is a high burden of skin disease in low- and middle-income countries, mostly from infectious causes, and many refugees resettling in our community have had little or no prior access to dermatologic care.

Common skin diseases, such as eczema, psoriasis, and lichen planus, may cause significant itching. In some cases the itch is debilitating, causing difficulty sleeping and concentrating and therefore decreasing quality of life and productivity. Patients may also scratch at their skin to the point of bleeding, leading to secondary bacterial infection and scarring. Some itchy skin disorders are contagious, spreading the misery to the whole family.

Patients may also experience disfigurement as a result of their skin condition. This may present as scarring or changes in the pigmentation, or color, of their skin. Patients may experience embarrassment or social stigma, including in severe circumstances rejection from a spouse.

Skin diseases that may be endemic in a refugee's country of origin but are not commonly seen in United States may have delayed diagnosis or inappropriate management. For example, mycetoma, a chronic debilitating skin infection due to fungus or bacteria, is seen in refugees from East Africa, including Sudan, and requires complex treatment with medications and/or surgery. Hansen's disease (leprosy) is present worldwide, and it can take years for patients to show symptoms; relapses can occur years after treatment. Cutaneous leishmaniasis, of which there was a recent outbreak in Syrian refugees, can take months to develop.

Seemingly harmless cosmetic products used in some refugee communities may have significant medical consequences, such as skin lightening creams that contain high levels of mercury, leading to toxicity. Potent corticosteroid creams brought from overseas may be inappropriately used by patients attempting to self-treat, leading to disfiguring acne, pigment changes, and stretch marks. Commonly applied henna tattoos may be adulterated with a black dye, which in some people causes a blistering rash that heals with scarring and/or changes in the color of the skin.

Refugees accustomed to warm climates may find it challenging to adapt to our harsh cold Minnesota winters. As a result, they may develop dermatitis, an itchy rash, from frequent hot showers. Education about skin care, such as limiting showers to 5 minutes with warm water, using mild cleansers, and applying a thick fragrance-free moisturizer right after the shower, can help prevent this bothersome condition.

For most skin diseases, there are good, cost-effective treatments available that can alleviate suffering and minimize disfigurement. Providers caring for refugees should:

1. Include questions about skin lesions or rashes on intake forms or on review of systems. Patients may not mention skin concerns unless specifically asked. It is also important to know about prior skin disorders, such as Hansen's disease, which may relapse after treatment.
2. Establish a relationship with a dermatologist interested in refugee health. Many skin conditions are chronic and need ongoing management and coordination with other specialties, such as infectious diseases, rheumatology, and oncology.



*April diverse media ad translated into Somali. The ad highlights the importance of protecting babies through immunization.*

Waxaad awood u leedahay  
inaad ilmahaaga ka  
ilaaliso cudurrada aadka u  
bukaysiin kara.

**Jeclow iyaga.**  
**Ilaali iyaga.**  
**Tallaal iyaga.**

Wixii macluumaad dheeraad ah, booqo  
<http://www.health.state.mn.us/immunize>

## Refugee Health Data: TB Continues to Affect Refugee Communities

Tuberculosis (TB) has surpassed HIV as the leading cause of death from infectious disease worldwide. Data from 2015 show that the number of TB cases has increased (by 1.7 percent) nationally for the first time in 23 years, with a total of 9,563 TB cases reported. Incidence held steady at 3 cases per 100,000 people. Eliminating TB in the U.S. will require increased attention to the diagnosis and treatment of latent TB infection (LTBI).

Minnesota had 150 cases of TB in 2015, compared to 147 cases in 2014 (a 2 percent increase). The most common risk factor for TB cases in Minnesota is being from a country where TB is common (see Figure 1). TB screening is offered to all refugees during the domestic refugee

health exam. In 2014, 22 percent of refugees screened tested positive for LTBI. Minnesota's LTBI treatment completion rate for refugees who start treatment is one of the highest in the nation at 86 percent in 2013.

It takes the continued collaboration of all partners in refugee health to address barriers to screening and treatment. The MDH TB Program and its partners are working on increasing awareness of the need for TB screening and treatment in affected communities, including through targeted ads. For more information, please email [Health.TBProgram@state.mn.us](mailto:Health.TBProgram@state.mn.us).

An estimated 1 out of 3 people in the world are infected with tuberculosis.

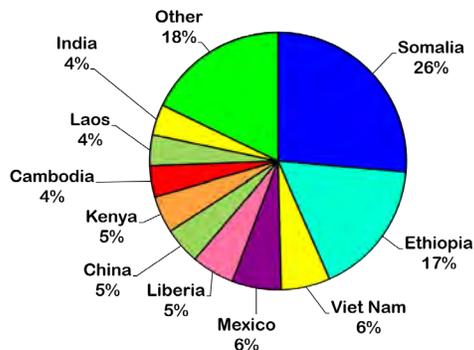
TB is preventable and curable.



Talk to your doctor to get tested for TB.

**MDH** Minnesota Department of Health  
[www.health.state.mn.us/tb](http://www.health.state.mn.us/tb)

**Figure 1: Foreign-Born Tuberculosis Cases by Country of Birth, Minnesota, 2015**



## Community Spotlight: Malaria Project

The RIHP work on the CDC-funded multi-site Malaria Project is underway. Community Advisory Boards (CABs) have been formed to guide the work at both the MN and New York sites. The MN CAB consists of eight highly accomplished community leaders who were born in West Africa and have a variety of health backgrounds. They have agreed to lend their expertise to assist project staff in trying to reduce the number of malaria cases seen among community members visiting friends and relatives back in West Africa, called VFR travelers.

The CABs will meet monthly to provide guidance on the project, starting with what questions to ask and how to ask them, through focus groups, surveys, and assessing community barriers and assets. They will also be very involved in the analysis and interpretation of the findings, as well as helping to create solutions and interventions to implement in community, health care, and travel settings. Lastly, the CABs will advise on the best means of messaging to their communities. Danushka Wanduragala of RIHP coordinates the Malaria Project and works closely with the MN CAB.

The majority of our work so far has been preparing to engage key communities to identify the barriers to malaria prevention in VFR travelers. The team has also been working with community leaders, surveillance

workers, and travel doctors to develop an interview form to be used with people who have contracted malaria while visiting friends and relatives. The interviews will begin this month and are aimed at exploring beliefs, behaviors, and barriers related to malaria prevention. In the next several months, MN and New York sites will hold a series of focus groups in the Minneapolis area and in the Bronx. Each site will focus on the West African communities in their respective areas.



*The MN CAB, from left to right: Wilhemina Holder, Joyce Onyekaba, Arthur Biah, Clarence Yaskey, Tolulope Ola, David Wilson, Ama Akapo, and Baninla Ladze*