DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
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Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists' (CSTE) position statement 05-EC-01 entitled "Refugee Health Care: Improving overseas and domestic health assessment and management of U.S.-bound refugees."

Enclosed is the Centers for Disease Control and Prevention's response to the CSTE Position Statement.

I appreciate the opportunity to provide a response to CSTE's position statement and applaud your commitment to this important public health issue. We look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

Enclosure

Centers for Disease Control and Prevention (CDC) Comments

CSTE Position Statement #05-EC-01

Title: "Refugee Health Care: Improving overseas and domestic assessment and management of U.S.-bound refugees."

Statement of desired action(s) to be taken:

To reduce health disparities affecting refugees resettled in the U.S. and to prevent the importation of infectious diseases, the following actions should be taken:

1. Implement proven prevention tools, accompanied by access to overseas health services for U.S.-bound refugees. Costs for these services overseas are lower than in the U.S., and performing screening and treatment overseas will prevent importation of infectious diseases.

    a. The highest priority should be given to 1) the initiation of ACIP-recommended vaccinations before resettlement, 2) the expansion of diagnosis and treatment for active tuberculosis to meet U.S. standards, including evaluation for multi-drug-resistant tuberculosis in those with active tuberculosis disease and 3) the provision of directly-observed treatment consistent with W.H.O standards before resettlement.

    b. The second priority should be expansion of the currently limited presumptive treatment program for malaria and intestinal parasites. All U.S.-bound refugees who are at high risk for malaria and intestinal parasites should receive treatment before resettlement.

    c. The third priority should be the enhancement of overseas patient education activities.

2. Enhance the CDC quality assessment program of overseas panel physicians including International Organization of Migration.

    a. Conduct an evaluation of the current CDC quality assessment program.

    b. Set up a formal system to receive ongoing feedback from domestic assessments, in order to identify and remedy gaps in overseas health screening processes.

3. Conduct overseas surveillance for emerging public health threats, such as viral respiratory diseases (e.g., avian influenza H5N1) among U.S.-bound refugee populations.

4. Fully fund the development, implementation and maintenance of the Electronic Disease Notification (EDN) Data System. This is critical for improving the timeliness and completeness of notifications and for allowing evaluation and interventions at the policy and individual refugee level.

5. Provide funds to states to conduct the necessary domestic follow up of refugees including screening, diagnosis, and treatment.

6. Establish a multi-agency working group (possible partners include representatives of the Department of State; Office of Refugee Resettlement, Office of Global Health Affairs, CDC, Department of Health and Human Services; International Organization for Migration; Council of State and Territorial Epidemiologists, Association of State and Territorial Health Officials, National Association of County and City Health Officials, National Tuberculosis Controllers Association and the Association of State Refugee Health Coordinators to:

    a. Define comprehensive recommendations for overseas and domestic health assessments and preventive and therapeutic interventions for refugees.

    b. Improve interdepartmental coordination of overseas and domestic health-care services covered by the Department of State and Department of Health and Human Services, respectively.

    c. Identify areas for policy and regulatory changes to optimize overseas and domestic health assessments.

CDC Comments:
The statement identifies many of the important gaps in refugee health policies and resources.

Worldwide, there are an estimated 12 million refugees. Every year, the United States provides a safe haven and freedom to 50,000-70,000 refugees from around the world who are fleeing severe political, religious, and ethnic persecution. This humanitarian program has been extremely successful in providing opportunities to start a new life through resettlement in the United States. However, most refugees are confronted with important health issues that are not adequately addressed in the current resettlement program. Refugees are resettled in the United States with insufficient access to basic preventive and curative health measures before resettlement. This situation leads to morbidity and mortality among the U.S.-bound refugees, the importation of infectious diseases into the United States, and excess burden on the U.S. healthcare system and receiving U.S. communities. In the last 2 years, CDC has responded to 11 international and domestic outbreaks of infectious diseases among U.S.-bound refugees. CDC is working to move from the reactive to proactive mode to implement overseas and domestic programs that

will address these challenges and fill the gaps. Many healthcare problems in U.S.-bound refugees can be reduced by investing in cost-effective, proven prevention and treatment programs.

CDC is developing a proposal for a basic overseas refugee health program, with the objectives of (1) reducing morbidity and mortality and health disparities among U.S.-bound refugees; (2) ensuring the nation's health security by preventing the importation of disease into the United States; (3) preventing transmission of infectious diseases that may require substantial long-term health care services in the United States: [a] diseases that have chronic complications and [b] perinatally acquired diseases associated with long-term complications (diseases for which there is a limited intervention time period overseas); and (4) promoting successful resettlement and integration in the United States by actively improving the health of U.S.-bound refugees before their arrival in the United States.

To achieve these objectives, the proposed basic refugee health program addresses five major areas: (1) vaccine-preventable diseases; (2) tuberculosis; (3) human immunodeficiency virus (HIV) infection; (4) parasitic (malaria, schistosomiasis, strongyloides, intestinal helminths) and waterborne diseases; and (5) surveillance for emerging infectious diseases. Some of the program's components are routine pre-departure vaccination with ACIP-recommended vaccines; diagnostic testing, including cultures and drug susceptibility testing; directly observed treatment for tuberculosis; use of intrapartum antiretroviral medication to prevent perinatal HIV transmission in U.S.-bound refugee children; presumptive pre-departure treatment for malaria, schistosomiasis, strongyloides, and other intestinal helminths; and the inclusion of refugees in CDC-supported global disease detection surveillance programs.

Our ongoing evaluation of the current CDC Quality Assurance Program for refugee health assessments indicates that additional improvements are needed. The program relies largely on reporting of problems from state and local health departments and U.S. overseas consular posts. CDC has two high priority goals for the Quality Assurance Program. First, we hope to expand resources to allow a complete evaluation of all panel physician sites every four years and, if possible, to review panels in high disease-prevalence areas every two years. This expansion would include physician and laboratory training to improve chest radiograph interpretation and laboratory diagnostic methods for TB disease. The expansion would also increase resources for ensuring that enhanced TB screening components, such as culture and drug susceptibility testing and directly observed treatment programs, are performed properly. One step in this process, the proposed establishment of overseas Division of Global Migration and Quarantine (DGMQ) positions in Eastern Africa and Southeast Asia, has already been initiated. Our second goal is to work more closely with the Department of State to review the qualifications of panel physician applicants before they are hired and to designate diagnostic laboratories, especially in high disease-prevalence areas.

Investments in overseas health services for U.S.-bound refugees will improve U.S. health security and increase the success of the U.S. resettlement program by more rapidly and

enabling the refugees to focus on other challenges of resettlement and integration into their new communities in the United States. These interventions would also greatly reduce the health burden on receiving U.S. communities and domestic public health resources.

Domestically, CDC has four priorities for the refugee health proposal: (1) the development of standardized post-arrival health assessment recommendations for state and local health departments and clinicians; (2) the establishment of a domestic surveillance system for post-arrival health problems after resettlement; (3) the completion and full implementation of the Electronic Disease Notification system to provide notification from CDC to state and local health departments about arriving refugees and their health issues and for CDC to receive feedback from state and local health departments regarding the domestic assessments to identify and remedy gaps in the overseas processing; and (4) the expansion of the Epi-X Refugee Health Forum and other electronic mechanisms to provide more timely and accurate information about health issues among arriving refugees, including outbreaks, data from overseas surveillance systems, and epidemiologic investigations in U.S.-bound refugee populations. These data would be made available to state and local health departments and clinicians and voluntary agencies that provide healthcare services to refugees in the United States. We hope that CSTE will serve as a full partner in these endeavors.

CDC is working to identify resources to fund this proposal and is committed to identifying and filling other gaps in refugee health, along with other stakeholders. CDC is actively collaborating with existing partners at the Bureau of Population and Migration of the Department of State and the Office of Refugee Resettlement and Office of Global Health Affairs of the Department of Health and Human Services; the Association of Refugee Health Coordinators; and state and local health departments, and we are forming new partnerships with clinicians who provide medical care to refugees. CDC is planning to convene a group of partners, including members of CSTE, in the next fiscal year to start the process of strategic planning for refugee health issues and will also continue work with partners to look for additional resources to adequately fund domestic health assessments for U.S.-bound refugees, including screening, diagnosis and treatment.

In summary, CDC is grateful for this resolution, which conveys CSTE's interest and commitment to being a full partner with us in finding solutions to the challenges ahead with respect to refugee health. CDC looks forward to working closely with CSTE toward implementing some of the exciting strategies on the horizon.