

The New Face of Refugee Resettlement in Wisconsin: What It Means for Physicians and Policy Makers

Jim Sanders, MD, MPH

ABSTRACT

Background: Historically, Wisconsin has received refugees from 3 large geographic areas: Southeast Asia, the Former Soviet Union, and the former Republic of Yugoslavia. However, recent trends demonstrate a dramatic increase in the number of countries from which current refugees originate. Further, state migration patterns show that most counties in Wisconsin have sizable per capita refugee populations and can expect more.

Objective: This paper describes past and current refugee resettlement trends and their ramifications on health care delivery, health policy, and social development in Wisconsin.

Methods: Statistical data on national, regional, and state refugee resettlement trends was obtained from the US Department of Health and Human Services' Office of Refugee Resettlement and the Wisconsin Department of Workforce Development. Additional data was obtained from Milwaukee-based refugee service agencies. Further, discussions were held with health officials in Barron County and around the Midwest.

Findings: Beginning in the 1980s, with the influx of Laotian Hmong refugees, and continuing through the late 1990s with the end of the Balkan Wars, Wisconsin has provided safe refuge for thousands of refugees.

Over the last 5 years the diversity of refugees being resettled in Wisconsin has accelerated to include an array of countries. This phenomenon has led to an increase in the range of health behaviors and health needs characteristic of these populations. The new face of refugee immigration has profound implications on Wisconsin's health

landscape, not only in terms of clinical disease, but also in health policy, planning, and social development.

INTRODUCTION

The number of refugees accepted for resettlement into the United States increased by 50% during the 25-year period between 1975-2000.¹ Many of the refugees who seek resettlement in the United States come from regions of the world that have been subjected to enormous civil stresses (i.e., brutal dictatorships, civil wars, the military abuse of civilian populations, ethnic cleansing, etc.).

Accordingly, the pattern of refugee resettlement in Wisconsin can be traced back to the geo-political changes in the home countries from which the refugees originate. In the early to mid 1980s, after the fall of Laos, there was an influx of Southeast Asian migration into Wisconsin. This changed with the fall of the Berlin Wall, and by the early to mid-1990s the refugees were predominantly from the former Soviet Union. Then, after the collapse of the former Republic of Yugoslavia, Wisconsin received a large wave of people with Slavic and Illyrian ancestry. This last large migration peaked around the end of 1999.

With the turn of the century came a subtle but powerful change in the trend of refugee resettlement into Wisconsin. This change, which has developed over the last 5 years, appears to be accelerating. Up until the late 1990s, well over 70% of Wisconsin's annual refugee resettlement originated from only 3 regions: Southeast Asia, the former Soviet Union, and the former Republic of Yugoslavia. In 1999 refugees resettling in Wisconsin were from only 6 different countries. By stark contrast, by 2003 resettled refugees came from 15 different countries, representing almost a 3-fold increase in just 5 years (Table 1). In the first 5 months of 2004, 70% of resettled refugees originated from several sub-Saharan African countries (Figures 1 and 2).²

In order to assist in health care provision, policy, and planning, this study was undertaken to better un-

Doctor Sanders is an assistant professor at the Medical College of Wisconsin in the Department of Family and Community Medicine. Please address correspondence to: Jim Sanders, MD, MPH, Columbia/St Mary's Family Medicine Residency, 1121 E North Ave, Milwaukee, WI 53212; phone 414.267.6540; fax 414.267.3892; e-mail jsanders@mcw.edu.

derstand the ways in which refugees are migrating and being resettled into Wisconsin as well as the effects this has on health and social services.

METHODS

The author solicited data from the Wisconsin Department of Workforce Development (WDWD), the US Department of Health and Human Services, Administration for Children and Families, and the Office of Refugee Resettlement (ORR). Additional qualitative data were gathered and analyzed from direct meetings, phone conversations, and e-mail exchanges with officers from the immigration integration section of the Wisconsin State Bureau of Refugee, Migrant and Labor Services; the US Office of Refugee Resettlement in Chicago, Ill and Washington, DC; the Health Officer/Program Manager for the Barron County Department of Public Health; several supervisors from Milwaukee; Wisconsin-based refugee resettlement agencies; and regional torture treatment experts.

Additionally, Web searches using the internet search engine Google were performed with key words "Refugee, Wisconsin, Census, County, Barron."

RESULTS

The counties with the highest number of refugee populations are also the counties with the largest populace, specifically Milwaukee and Dane. Yet when these 2 counties are ranked according to refugees per capita, Milwaukee and Dane counties have half the concentrations of refugees as Marathon and Sheboygan counties, which have smaller populations.^{2,3} This demonstrates that refugee resettlement is not limited to the southeast industrial corridor of the state or the urban centers. Instead, refugees have been resettled throughout Wisconsin and at least 74% of Wisconsin counties report refugees within their populations (Figure 3).²

CASE EXAMPLE: BARRON COUNTY

Barron County, in northwest-central Wisconsin, exemplifies the broad reach of the resettlement trend. In 2003, Barron ranked first among Wisconsin counties for the number of refugees relocating to the county after having been first resettled in another locale (defined as "secondary migration").³ One hundred and twenty refugees moved to Barron, all sharing the same ethnicity: Somali. According to the 2000 US Census, Barron County was home to 44,963 people, 97.7% of whom were white, 0.1% of who were black.³ By 2004, Somalis accounted for 13% of Barron's population.⁴ One might easily imagine the dramatic changes that occurred with such a rapid demographic shift.

Table 1. Primary Refugee Migration to Wisconsin 2003: Places of Origin

- Middle East: Iran, Iraq.
- Africa: Congo – DRC, Ethiopia, Liberia, Nigeria, Rwanda, Sierra Leone, Somalia, Sudan.
- Central Asia: Azerbaijan, Belarus, Kazakhstan, Latvia, Moldavia, Russia, Ukraine, Uzbekistan.
- Other European: Albania, Czech Republic, Hungary, Poland, Romania, Bosnia, Croatia, Serbia, Kosovo, Macedonia.

Source: Wisconsin Department of Workforce Development.

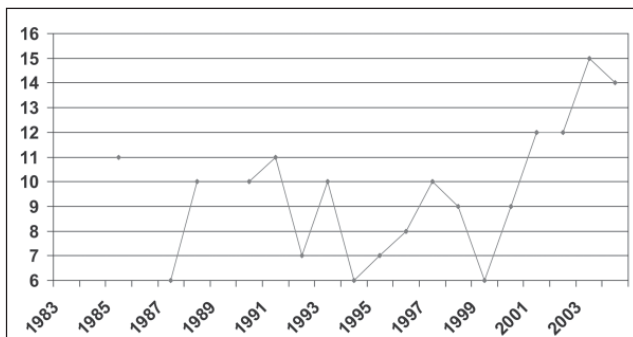


Figure 1. Number of countries of origin all refugees entering Wisconsin 1983-2004. Source: Wisconsin Department of Workforce Development statistics.

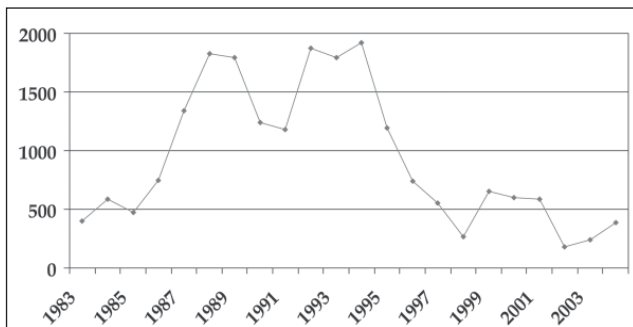
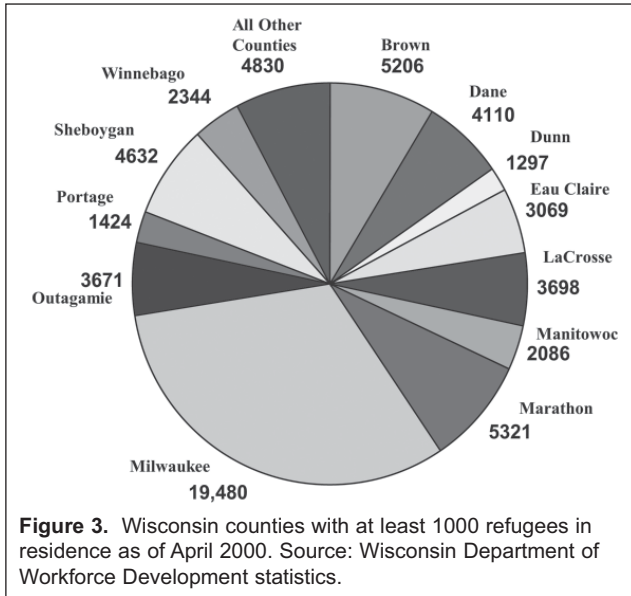


Figure 2. Refugee arrivals by year 1983 – 2004. Source: Wisconsin Department of Workforce Development statistics.

The primary reason for this demographic change has been economic: Barron is home to a meat processing plant where many Somalis readily find work. While employment might have drawn Somali men to Barron, other social features, such as easier high school graduation requirements and simpler local transportation needs, attracted their families and caused them to stay. So compelling are the opportunities in Barron that Somali refugees have moved there from 17 other US states.²

Naturally, such drastic social transformation is accompanied by some significant stress points: specifically the



shifting of health priorities and resources to reflect the new realities of the community's needs. Consequently, over the recent past, the Barron County Public Health Department has been faced with increased numbers of latent tuberculosis and an increasing demand for prenatal services and Women, Infants and Children program nutrition services. In addition, some long-time Barron residents have had a difficult time adjusting to the newcomers. This has led to cultural misunderstandings, the use of racial epithets directed at the refugees, and outright hostilities in the form of property destruction. Accordingly, in addition to addressing purely clinical health-related problems, Barron County has made efforts to address the clinical health needs and to improve social harmony through public education and forums for cultural interchange.^{4,5}

Other towns in Wisconsin have also been forced to adapt to new and changing cultures. In the first few months of 2004 alone, almost 75% of Wisconsin's refugees originated from Sub-Saharan African countries. Furthermore, in 2005 Wisconsin will see the largest influx of refugees in the state's history: over 3000 Laotian Hmong are scheduled to be resettled around the state. This will mean that even counties with relatively small populations such as Outagamie and Eau Claire may expect to host resettled refugees.⁴

DISCUSSION

Issues of Access

Once a person has received an official US State Department designation as a refugee certain benefits and considerations are extended to him/her and his/her immediate dependents. One typical benefit conferred to

refugees after being resettled is state-offered Medicaid health insurance. In Wisconsin, refugees lose this health benefit after 8 months and must find commercially available health insurance or roll over to another state-sponsored health plan, should they so qualify. In practical terms this usually means that refugees are uninsured or underinsured during some point in the first years of their transition within Wisconsin, leaving them without access to good quality health care.

Through this research it has become evident that lack of health insurance is not the only reason refugees are unable to access good quality medical care. Cultural barriers often create distances between patients and their physicians despite the best of intentions on both sides. The Hmong experience in Wisconsin is a good example of this type of cultural disconnect. It is fairly well understood that the Hmong who resettled here during the 1980s had no existing Hmong communities to help navigate the course toward assimilation. Likewise, the medical establishment in place at the time had no prior experience to draw on in order to respond appropriately to the new set of cultural health beliefs and attitudes. Additionally, because the Hmong immigration was so extensive and would eventually reach into so many different parts of the state, it took years before cultural competencies reached a critical mass of penetration. These misunderstandings and episodes of confusion have been well documented in the medical literature.^{6,7}

Human Relations

The primary and secondary resettlement of refugees around the smaller counties of Wisconsin means that many communities are likely to be subject to rapid changes. The transformation of Barron, Wis, exemplifies how the demographics of smaller communities can be changed virtually overnight by refugee migration. A conversation with the health officer in Barron disclosed the continuing confusion and misunderstanding between existing communities and members of the refugee communities. Indeed, racism may well be the largest "health" issue that the Barron community has had to struggle with. Several broad-based initiatives have been implemented in an effort to bring social harmony to all residents of Barron County. A "diversity council" of long-time Barron residents and Somalis has begun to discuss some of these larger issues of social well-being. Additionally, an "international center" has been created and offers English as a Second Language instruction and internet/computer services. Further, the local high school has begun offering soccer as a team sport, and the success of the largely Somali team has helped long-

time residents of Barron better understand their new Somali neighbors.⁸

Torture Survivors

Even without the hostilities associated with attempts to assimilate within an unwelcoming environment there is often a good deal of emotional stress that goes along with having had to flee one's country of origin in the first place. And depending on the underlying nature of the homeland's political situation, it would not be unusual to find a high prevalence of survivors of torture within a given refugee population. The morbidity associated with torture survivorship is as underdiagnosed as it is undertreated.⁹⁻¹²

The US ORR estimates the number of such survivors in the United States to be in excess of 500,000.^{12,13} Identification of this suffering is important from a medical perspective for several reasons. First, the primary care physician is in a unique position to diagnose Post Traumatic Stress Disorder and institute treatment measures. Second, survivors of torture often have somatic symptoms that might be more easily and quickly understood if the physician is aware of a history of torture. And third, if there is unresolved physical or emotional anguish the important process of assimilation into their newly adopted country may be complicated or delayed. Although primary care physicians are most likely to care for torture survivors longitudinally, all physicians must be aware of the increased likelihood of a history of torture-related trauma in patients arriving from countries with oppressive or turbulent regimes.

Resources

All refugees coming to the United States are issued US Department of State Medical Examination forms as part of their application for immigration. Additionally, many refugees also carry health forms issued by the International Organization for Migration. These forms contain information the primary doctor will find most useful: purified protein derivative (PPD) status, chest x-ray results, HIV status, pertinent health histories, and vaccination status.

The Data

The WDWD keeps statistics on refugee migration to Wisconsin. This data is obtained from a number of different sources including the federal ORR and local volunteer organizations and agencies involved with resettlement; therefore it may lack precision. For example, the data collection protocol uses categories that may not distinguish political distinctions. Therefore, groups that share the same language are counted together despite the fact that they might have originated from different

countries and consider themselves to be from distinct cultural groups. Thus, Croats, Serbs, and Bosnians are counted as 1 group because they all speak the same language: Serbo-Croatian. The Wisconsin refugee population categories are likely skewed as a consequence of such general classifications. Some WDWD data sets count refugees "regardless of state or date of arrival or immigrant/citizenship status—(and) may include US-born children"² leading to the possibility of an over-inclusive labeling of individuals as refugees. Some groups of refugees such as the Hmong tend to have larger families than other groups, compounding the problem of over-inclusiveness. This method of refugee classification does not aid accurate determination of health and social needs, as the generation born in the United States is likely to have different concerns than their parents who arrived 20 years earlier.

Finally, it is also difficult to count refugees' secondary migration from other states to Wisconsin since there is no requirement of notification of relocation. It is reasonable to assume that there is some degree of imprecision with respects to these incoming and outgoing secondary migration numbers.

Implications

Wisconsin will soon face 2 important refugee resettlement situations. The first involves about 250 Somali Bantu refugees who have been languishing in refugee camps in Tanzania for over a decade. This group of Somalis is ethnically distinct from other Somali migrants and will have no similar existing community to join. This migration, small as it might be, will challenge existing social and health services partly because it is a small group that will have a more difficult time achieving recognition within the health care system. Larger groups, such as the Hmong or Serbians, can command more accommodation for their particular needs simply because of their sheer numbers. Medical clinics that profitably employ personnel from a large refugee community to assist with that group's language and cultural needs may find it difficult to justify the cost of such specialized staff for a small patient population such as the Somali Bantu.

The second resettlement situation is the more than 3600 ethnic Hmong who will be resettled to Wisconsin in 2005. It will be the largest single influx of refugees in the state's history. Less than a third of these newly arriving Hmong will be resettled in the Milwaukee area. The rest will be resettled around the state in smaller communities. Consequently, many health clinics are likely to have newly arrived Hmong refugees as patients in the not-too-distant future. Unlike the Somali Bantu's

anticipated problem of access, the challenge we face in receiving this huge wave of Hmong refugees will be the health systems' capacity to respond to their needs with sufficient services.

These 2 distinctly different refugee groups share a common health issue that is likely to go underaddressed: the predictable high prevalence of mental duress due to their long stay in holding camps prior to arrival in the United States.

RECOMMENDATIONS

The issue of immigration is often distant from the concerns of health officials and health planning. However, as anecdotal evidence from Wisconsin's experience with resettling refugees over the last 2 decades has demonstrated, significant health concerns arise when refugees are newly resettled into an area either for the first time, such as the initial Hmong refugees, or in numbers large enough to displace a local sense of order, such as the Somali in Barron, Wis.

As patterns of political and social struggles change in the world, so too will the patterns of refugee resettlement in Wisconsin. As a result of the increasing variety of ethnic and racial groups coming to Wisconsin, there is potential for dramatic impact on our state's health, in both positive and negative ways. Even with the casual inquiry that this research has undertaken, it is obvious that the breadth of health issues involved is sweeping, ranging from the clinical (such as tuberculosis) to the social (such as racism).

Physicians and health policy planners need to anticipate the ramifications of current immigration patterns and help local, county, and state planners lay the groundwork for the successful, healthy integration of refugee peoples into our state. Closer collaboration between the WDWD, refugee resettlement agencies, and county health officials might be a sensible place to start.

Editor's Note: This article was accepted for publication in the spring of 2005. No further updates on the 2005 resettlements are available at this time.

REFERENCES

1. US Dept. of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement (ORR), Annual Report 2000.
2. Wisconsin Department of Workforce Development statistics.
3. ePodunk. Available at: <http://www.epodunk.com/top10/countyPop/coPop50.html>. Accessed April 20, 2006.
4. Johnson M. Two cultures learn to value differences. *Milwaukee Journal Sentinel*, July, 24, 2004:1, 28A.
5. Kutz B. Center helps newcomers with jobs, language skills. *Superior Catholic Herald*. April 11, 2002. Available at: www.catholicherald.org/archives/articles/index2002A.html. Accessed April 20, 2006.
6. Fadiman A. *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus, Giroux; 1997.
7. Culhane-Pera K, Vawter D, Xiong P, et al. *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers*. Nashville: Vanderbilt University Press; 2003.
8. Personal communication: Hilde Perala, Health Officer/ Program Manager, Barron County Dept. of Public Health. May 20, 2004.
9. Forrest DM. Examination for the late physical after effects of torture. *J Clin Forensic Med*. 1999;(6):4-13.
10. Basoglu M. Prevention of torture and care of survivors – an integrated approach. *JAMA*. 1993;270:606-611.
11. Weinstein H, Dansky L, Iacopino V. Torture and war trauma survivors in primary care practice. *West J Med*. 1996;165:112-118.
12. Randall GR, Lutz EL. *Serving Survivors of Torture: A Practical Manual for Health Professionals and Other Service Providers*. Washington, DC: American Association for the Advancement of Science; 1991.
13. Personal written communication with Mary Fabri, Director, Marjorie Kovler Center for the Treatment of Survivors of Torture, Heartland Alliance, Chicago, Illinois. March 19, 2005.

Wisconsin Medical Journal

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the *Wisconsin Medical Journal* at 866.442.3800 or e-mail wmj@wismed.org.

© 2006 Wisconsin Medical Society