Health Status of **Omaha Refugee**

2021

Department of Health & Human Services
Division of Public Health
Office of Health Disparities and Human Services

NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Omaha Refugee Health Status Report

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Acknowledgment

The Office of Health Disparities and Health Equity would like to thank the Karen Society of Nebraska and refugee group from Bhutan for their involvement in this project. Further appreciation goes to all of the volunteers who assisted in this project by helping with survey collection and other support work.

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Methodology

Project Development

In an effort to gain a deeper and more comprehensive understanding of the health needs of refugee communities, the Nebraska Office of Health Disparities and Health Equity conducted its first statewide Refugee Needs Assessment Survey in 2017. A qualitative and quantitative mixed methods approach was used in this project. Qualitative research was first conducted through focus groups and task force meetings with refugee communities and partner organizations. These focus groups and task force meetings served to address survey strategies, including training and other logistics issues, and were fundamental to the creation of the statewide quantitative needs assessment.

Based on the Nebraska 2007-2016 Refugee Resettlement data, the needs assessment primarily targeted the top five refugee populations from Burma, Bhutan, Iraq, Somalia, and Sudan. Refugees from Sudan and South Sudan were combined into one category, as many refugees came to Nebraska before South Sudan gained independence in 2011.

Survey Design

Combining the findings of the focus group discussions and task force meetings, the Nebraska Refugee Behavioral Risk Factor Surveillance System Questionnaire was developed, consisting of 123 questions.

Eligibility Questions

At the beginning of the survey, participants were asked three eligibility questions. The first two questions were designed to ensure that each participant was at least 18 years of age and had come to the United States as a refugee. The third question was added to confirm that the participant was not a second-generation refugee or born in the United States.

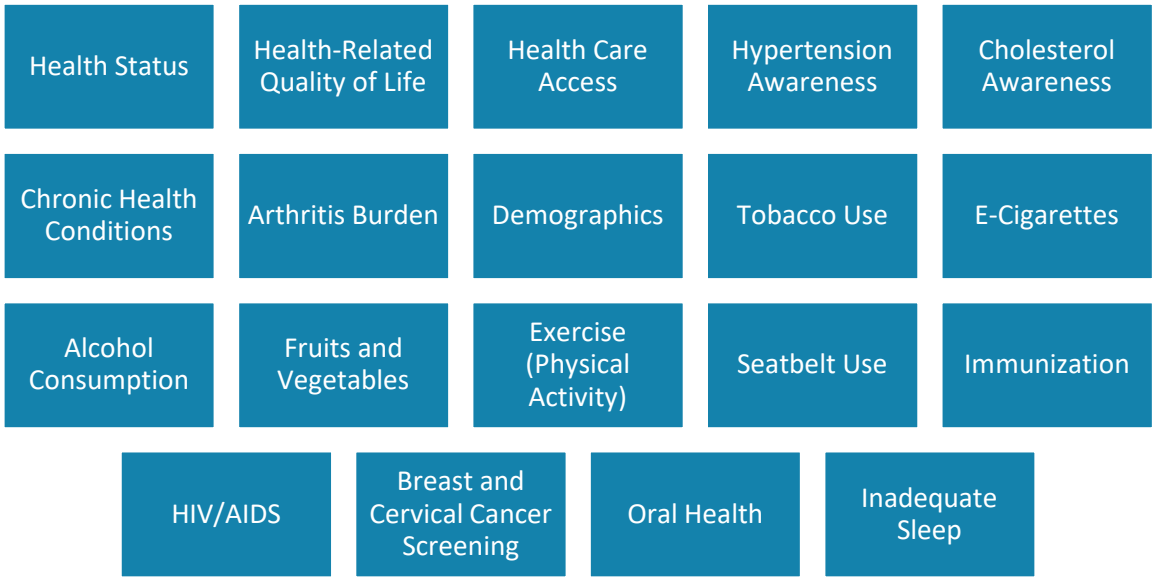
State-Added Questions

The next section included 19 state-added questions. These questions were chosen and composed after discussions between the Office of Health Disparities and Health Equity and partner organizations during focus groups and task force meetings. Many of these questions are refugee-specific demographic questions aimed at gathering detailed information about each participant, such as their home country, native language, and English level. Other questions focused on overall needs and challenges and navigating the health care system.

Core Questions

The majority of the questions in the survey were standardized questions from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS). The Nebraska BRFSS has been conducting surveys annually since 1986 to collect data on the prevalence of major health risk factors among adults residing in the state. This surveillance system is based on a research design developed by the Centers for Disease Control and Prevention (CDC) and used in all 50 states, the District of Columbia, and three of the U.S. territories. Information gathered through the BRFSS can be used to target health education and risk reduction activities to lower rates of premature death and disability. Of the survey questions, 101 questions came from the 2016-2017 CDC BRFSS core questions. These questions were grouped into the 19 sections shown below.

Core Question Sections



Implementation

To implement the needs assessment, OHDHE contracted with several partner organizations, including the Karen Society of Nebraska and the Asian Community and Cultural Center. These organizations assisted in identifying participants and interpreters to conduct the interviews.

Before conducting the interviews, interpreters were trained by OHDHE staff to ensure that the survey was given in a standardized manner. More than 60 interpreters were trained in a series of twenty workshops. The surveys were all completed in face-to-face interviews. Participants were anonymous and informed that their answers would be kept confidential. Participants were also able to skip any questions they did not want to answer and could end the interview at any time.

To ensure the validity and integrity of the data collected, quality control measures were put in place. These measures included selecting at least 5% of participants at random and contacting them by phone or in-person to confirm selected answers. The quality control calls were completed by an interpreter other than the individual who conducted the initial interview with the participant.

More than 2,300 surveys were completed in Omaha, Lincoln, Grand Island, Lexington, and other cities/towns across Nebraska. This report will focus exclusively on the 1132 refugees who reported their current residence as Omaha, Nebraska.

Methodology Limitations and Challenges

Surveying Nebraska's refugee populations presented unique challenges. While using a mixed methods approach and working closely with the refugee communities and interpreters helped to mitigate certain challenges, the employed methodology is still subject to limitations.

The validity of the data is always a primary concern when using questionnaires, as the information collected relies on the honesty of participants. Participants may hesitate to answer sensitive questions truthfully for a variety of reasons. Social desirability bias, or the tendency of participants to answer questions in a manner they may view as socially acceptable, can lead to skewed results. For example, in a culture where alcohol consumption is not accepted, participants may be reluctant to answer alcohol-related questions honestly.

Information also heavily relies on the participant's understanding of the questions. During training, interpreters were instructed to translate the questions as written and to not explain the questions to limit misinterpretation. While questions were written to ensure consistency, misinterpretation may still occur, in part due to cultural and linguistic differences. In addition, even when the questions are interpreted as intended, the participants' answers rely on their ability to accurately recall information.

According to the Centers for Disease Control and Prevention, priority health concerns among many refugee populations include various infectious diseases, such as intestinal parasites and

malaria.[1] These diseases are often treated overseas before the departure of refugees to their host countries. Due to this reason, and the fact that many refugees in Nebraska have already been in the country for numerous years, such diseases were not investigated in this survey.

[1] Centers for Disease Control and Prevention. (2013). Refugee health guidelines. Retrieved from www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html

Demographics

According to the United Nations High Commissioner for Refugees (UNHR), the population of displaced people rose from 33.9 million in 1997 to 65.6 million at the end of 2016. Of this 65.6 million, 40.3 million were internally displaced, 22.5 million were refugees, and 2.8 million were asylum-seekers. While countries such as Turkey, Pakistan, and Lebanon hosted over one million refugees each, only 189,300 refugees were resettled around the world in 2016. The United States was the world's top resettlement country, admitting 96,900 of those refugees.[2]

In fiscal year 2016, Nebraska admitted 1,441 refugees.[3] This was more refugees per capita than any other state, amounting to 76 refugees resettled per 100,000 residents.[4] In the past fifteen years, the top refugee groups arriving in Nebraska have come from Burma, Bhutan, Iraq, Sudan and South Sudan, and Somalia. Nebraska has seen consistent growth among these populations due to continuing conflicts. Sudan, South Sudan, Somalia, and Burma remain on the global list of the top ten major source countries of refugees. Additionally, due to famine and drought, the situation in South Sudan has worsened significantly, causing the refugee population from South Sudan to grow by 85% in 2016.[5]

It is important to remember that the demographic landscape of refugees in Nebraska is constantly changing. Just over 10 years ago, from 2002-2007, the top five refugee populations admitted into Nebraska included refugees from Vietnam and refugees from countries of the former Soviet Union and the former Yugoslavia.[6] More recently, the worldwide increase in refugees has been driven largely by the Syrian conflict. In 2016, Nebraska accepted its first refugees from the conflict and resettled 118 refugees from Syria. Though Syrian refugees are not currently one of the top five arrival groups in Nebraska, there are 5.5 million Syrian refugees worldwide.[7] This rise and fall of conflicts around the world has the potential to reshape resettlement patterns in Nebraska.

This section focuses on the demographics of the top five refugee populations in Omaha, Nebraska as of 2017. The section contains both state-added questions and questions from the demographics section of the 2017 Centers for Disease Control and Preventions (CDC) Behavioral Risk Factor Surveillance System (BRFSS).

[2] United Nations High Commissioner for Refugees. (2017). Global trends: forced displacement in 2016. Geneva: United Nations High Commissioner for Refugees.
[3] Office of Refugee Resettlement. (2016). Refugee arrival data.
[4] US. Census Bureau. (2016). 2016 Population Estimates.
[5] United Nations High Commissioner for Refugees. (2017). Global trends: forced displacement in 2016. Geneva: United Nations High Commissioner for Refugees.
[6] Office of Refugee Resettlement. (2016). Refugee arrival data: 2002-2016.
[7] United Nations High Commissioner for Refugees. (2017). Global trends: forced displacement in 2016. Geneva: United Nations High Commissioner for Refugees.

Omaha's Refugee Population Demographics

Omaha refugees surveyed come from

Burma (Myanmar)	Bhutan	Somalia
47.2%	**32.7%**	**13.0%**

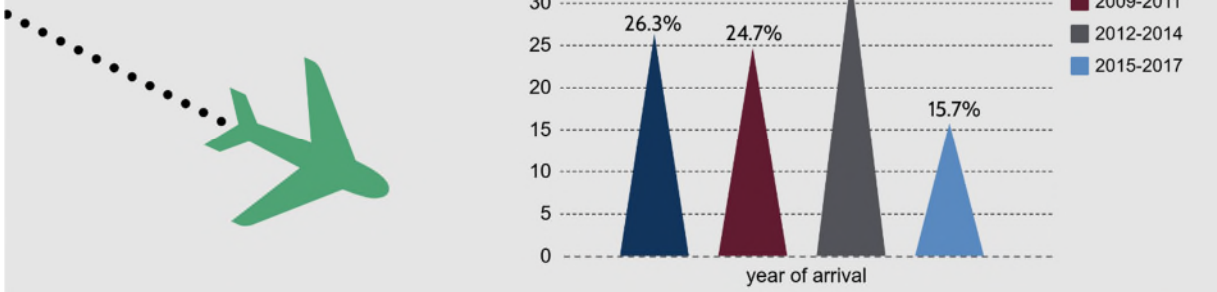
Top Five Languages

- **Karen** | 47.6%
- **Nepali** | 32.9%
- **Somali** | 12.7%
- **Nuer** | 4.2%
- **Dinka** | 0.5%

Age Groups Surveyed

- **48.6%** Ages 18-34
- **32.5%** Ages 35-54
- **19%** Ages 55 and older

Year of Arrival in the U.S.



Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Demographic Overview

The below tables represent the demographic information of Omaha refugees surveyed.

Gender	Total Respondents
Male	516
Female	611
Refused	5
Total	1132

Age Group	Total Respondents
18-24 years old	199
25-34 years old	328
35-44 years old	192
45-54 years old	160
55-64 years old	137
65+ years old	69
Refused	47
Total	1132

Country of Origin	Total Respondents
Burma	534
Bhutan	371
Somalia	146
Sudan/South Sudan	55
Iraq	1
Other	25
Total	1132

Year of Arrival	Total Respondents
2008 & earlier	293
2009-2011	275
2012-2014	370
2015-2017	175
Refused	19
Total	1132

Native Language	Total Respondents
Karen	538
Nepali	373
Somali	143
Nuer	47
Burmese	5
Arabic	4
Dzongkha	3
Other	1
Refused	18
Total	1132

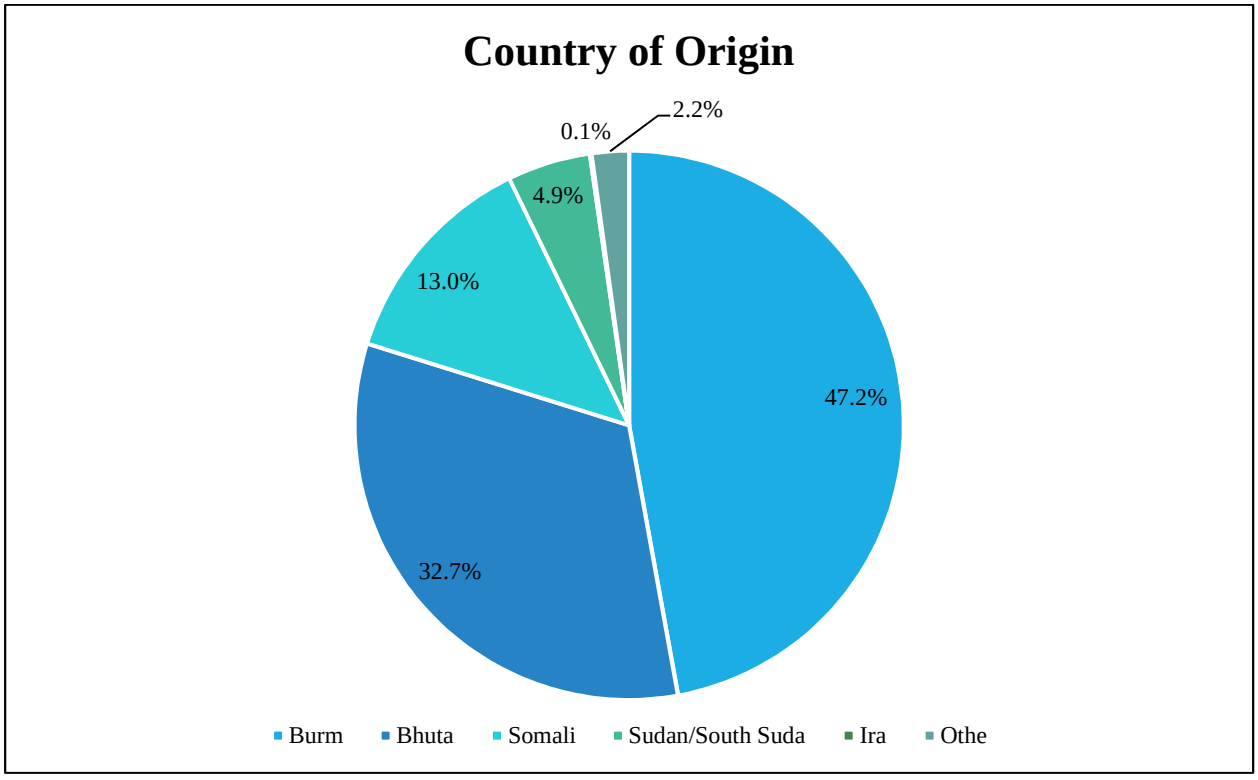
Country of Origin

What is your home country or country of origin?
Bhutan • Burma • Iraq • Somalia • Sudan • Other • Unsure • Refused

The below chart and table represents the country of origin of Omaha refugees surveyed.

Key Findings

- Refugees from Burma represented the largest group of Omaha refugees surveyed at 47.2%.
- Approximately 33% of Omaha refugees were from Bhutan, 13% were from Somalia, and 4.9% were from Sudan or South Sudan.



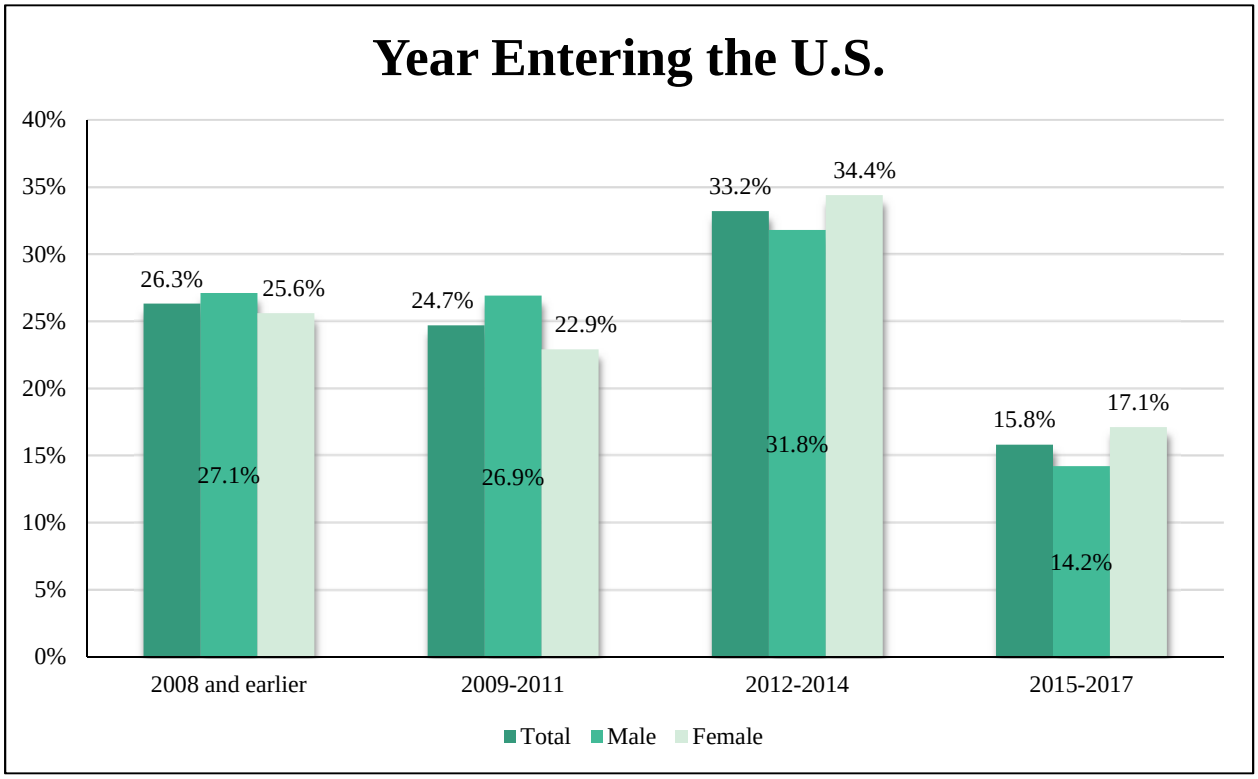
Year of Arrival

In what year did you come to the United States as a refugee?

The below chart represents the year Omaha refugees arrived in the United States.

By Gender

- Approximately one-third of Omaha refugees surveyed arrived in 2012-2014 (33.2%). The next largest group of refugees arrived in 2008 and earlier (26.3%).
- Approximately 25% of Omaha refugees surveyed arrived in 2009-2011 (24.7%) and approximately 16% arrived in 2015-2017 (15.8%).
- While more male refugees reported arriving in 2008 and earlier and 2009-2011, more female refugees reported arriving in 2012-2014 and 2015-2017.

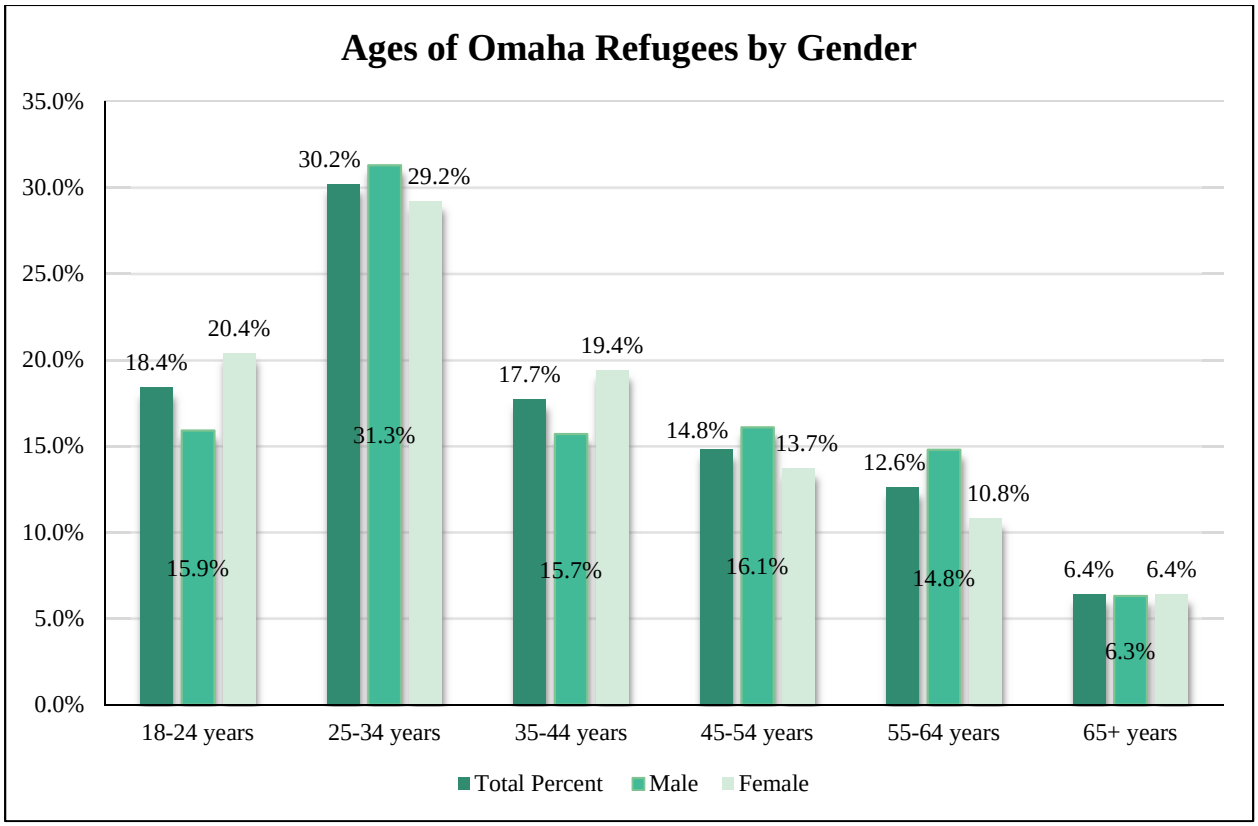


Age Group

The below charts represent the age groups of Omaha refugees surveyed.

By Gender

- Omaha refugees ages 25-34 (30.2%) and ages 18-24 (18.4%) made up the largest age groups of those surveyed. Approximately 18% of refugees surveyed were ages 35-44 (18.4%), followed by ages 45-54 (14.8%) and ages 55-64 (12.6%). The smallest group were ages 65 and older (6.4%).
- There were similar proportions of male and female refugees in all age groups.

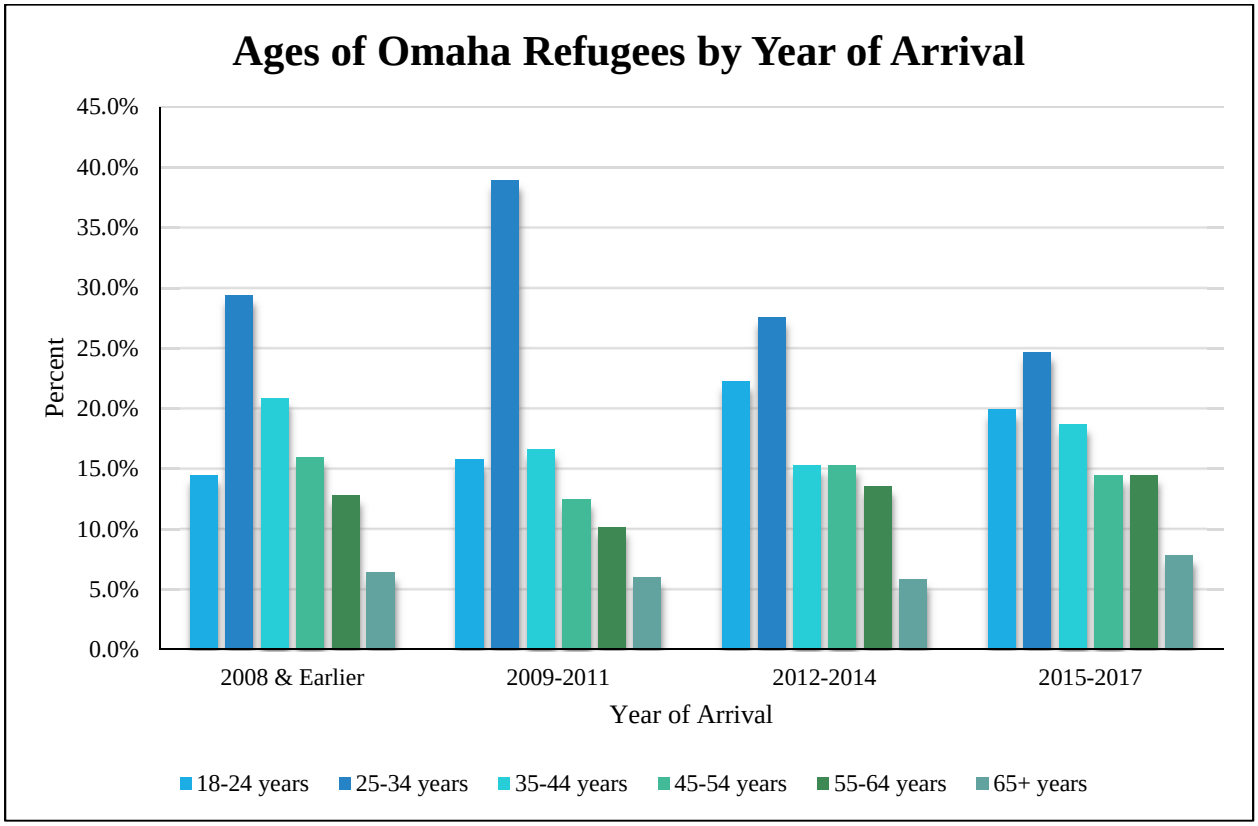


Age Group

The below charts represent the age groups of Omaha refugees surveyed.

By Year of Arrival

- The majority of refugees ages 25-34 arrived in 2009-2011 (38.9%), followed by 2008 & earlier (29.4%), 2012-2014 (27.6%), and 2015-2017 (24.7%).
- Majority of refugees ages 18-24 arrived in 2012-2014 (22.3%) and 2015-2017 (19.9%).
- Refugees, ages 35-44, were more likely to report arriving in 2008 & earlier (20.9%) and 2015-2017 (18.7%).
- Similar proportions of refugees ages 45-65+ were seen across all arrival groups.



Age Group	2008 & Earlier	2009-2011	2012-2014	2015-2017
18-24 years old	14.5%	15.8%	22.3%	19.9%
25-34 years old	29.4%	38.9%	27.6%	24.7%
35-44 years old	20.9%	16.6%	15.3%	18.7%
45-54 years old	16.0%	12.5%	15.3%	14.5%
55-64 years old	12.8%	10.2%	13.6%	14.5%
65+ years old	6.4%	6.0%	5.8%	7.8%

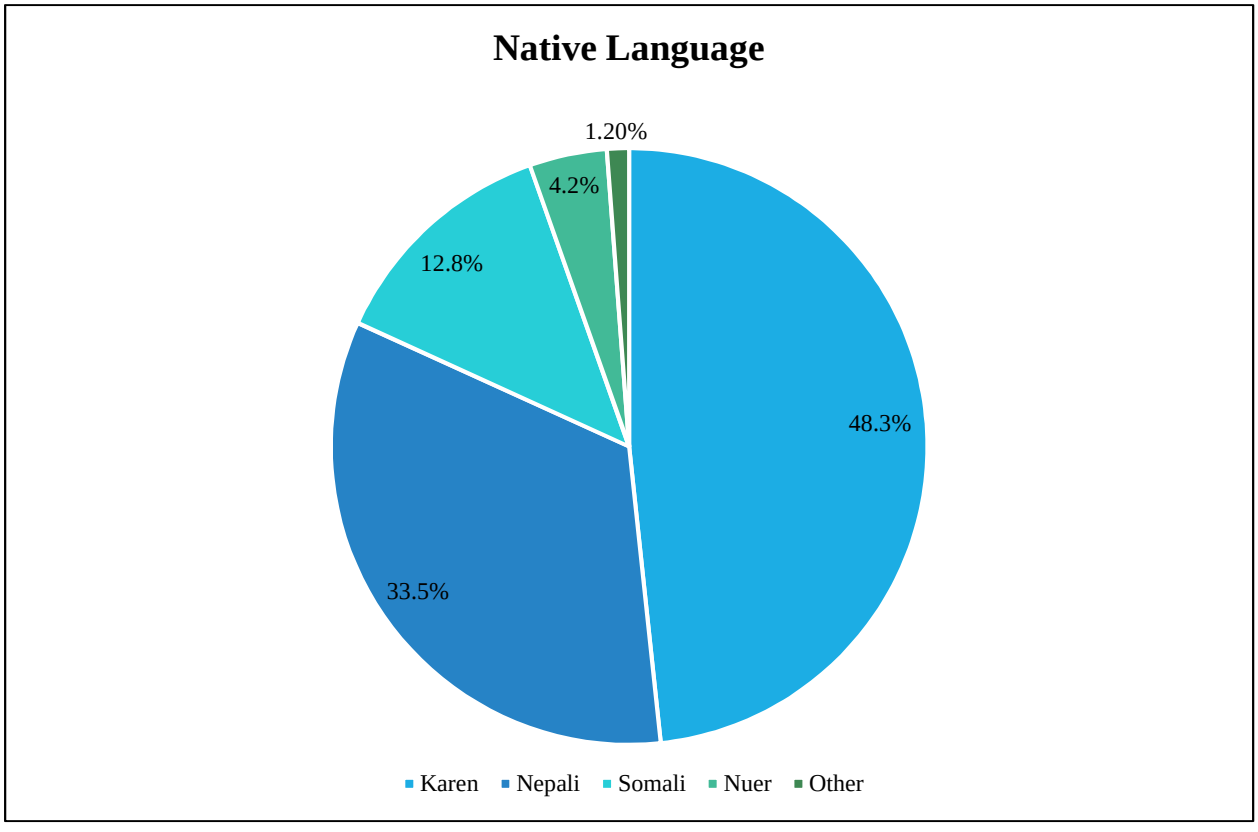
Native Language

What is your native language?
Karen • Burmese • Nepali • Somali • Arabic • Chin • Nuer • Dzongkha • Kurdish • Kurmanji • Other

The below chart represents the native languages reported by Omaha refugees. Native languages that were reported by less than one percent of refugees surveyed are combined in the "other" category.

Key Findings

- Just under one half of Omaha refugees reported Karen (48.3%) as their native language and one third of Omaha refugees reported Nepali (33.5%) as their native language.
- Somali (12.8%) was the third native language likely to be reported by Omaha refugees, followed by Nuer (4.2%).
- Other native languages reported included Burmese, Arabic, and Dzongkhag. The percentages were all less than 1%.



Challenges and Needs

The following section examines the greatest challenges and most urgent needs reported by Omaha refugees surveyed. For both questions, participants could choose more than one response and had the option of writing in any challenge or need not listed. The pre-listed responses to these questions were generated through discussions with refugee communities prior to the creation of this survey. These two questions are listed below.

What are your biggest challenges?

Language Barriers	Mental Health Issues	Discrimination and Oppression
Transportation Issues	Documentation and Bill Pay	Navigating and Understanding U.S. Systems
Access to Health Services	Other	

What are your most urgent needs?

Financial	Social Support	Education	Work
Housing	Food	Healthcare	Legal
Interpretation	Other		

The question regarding biggest challenges focuses on hurdles in everyday life, including language barriers, having access to transportation, and other issues that may prevent refugees from thriving in Nebraska. The second question, which asks specifically about most urgent needs, identifies those areas where refugees feel they need the most immediate support, such as education, employment, or housing.

The responses to these questions, presented in the following pages, are important to understanding the situation of refugees in Nebraska on a broader level. Identifying and examining Nebraska refugees' biggest challenges and most urgent needs will help to ensure that future projects and support intended for the refugee community are relevant and successful. To this end, it is also important to consider the differences in responses dependent upon country of origin or date of entry into the United States. While there are clear trends among the overall refugee population, these variances are integral to understanding specific populations.

Omaha's Refugee Population

Challenges & Needs

Top Five

Most Urgent Needs

Reported by Omaha Refugees

- Health Care | 39.7%
- Education | 25.4%
- Financial Needs | 12.7%
- Interpretation | 12.7%
- Legal support | 8.7%

Top Five

Biggest Challenges

Reported by Omaha Refugees

- Language Barriers | 72.8%
- Navigating & Understanding US Systems | 13.9%
- Access to Health Services | 10.4%
- Documentation & Bill Pay | 10.2%
- Transportation Issues | 8.7%

Spotlight on Health Care and Access to Health Services

- Refugees arriving in 2009-2011 and 2012-2014 were most likely to report access to health services as one of their biggest challenges.
- Similar percentages of female refugees (40.0%) and male refugees (39.3%) reported health care as the most urgent need.

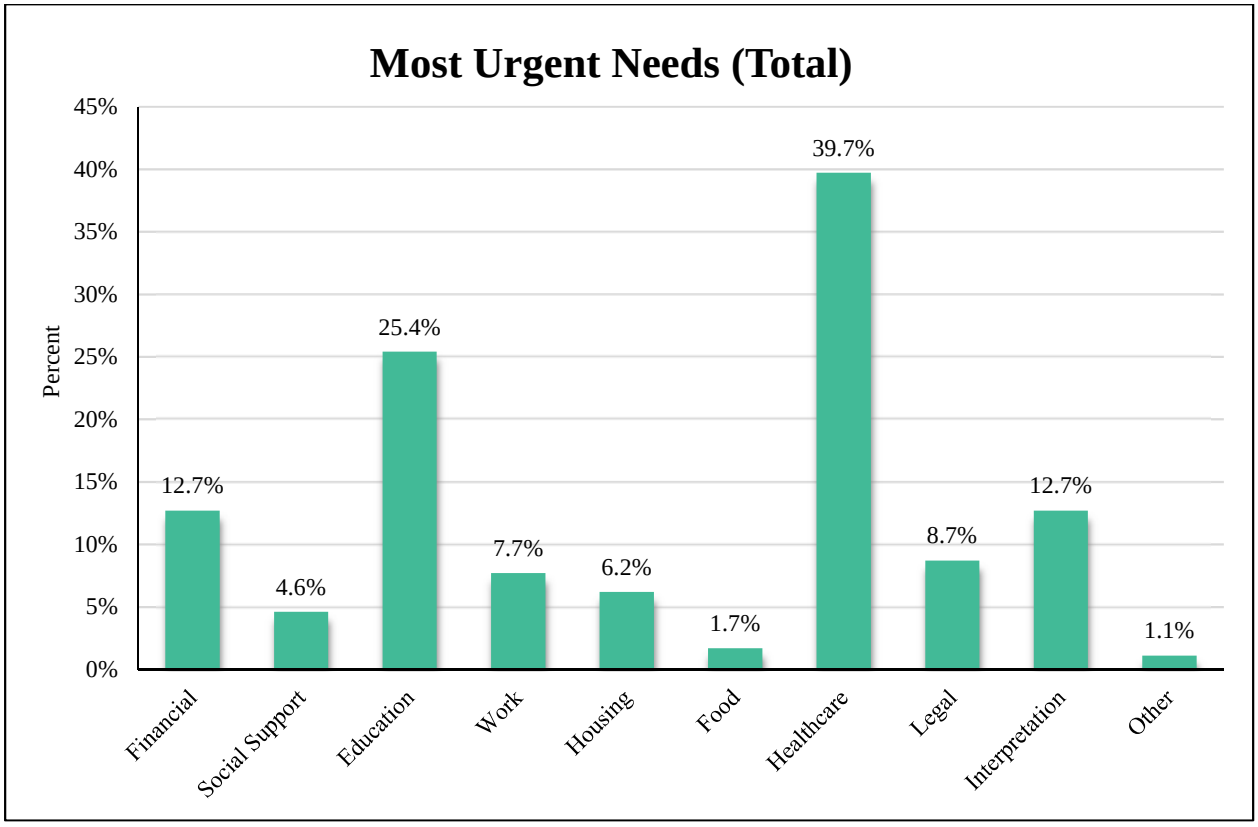
Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Most Urgent Needs

The below chart represents the most urgent needs reported by Omaha refugees surveyed.

Key Findings

- Health care (39.7%) was the most reported urgent need. This was 1.6 times greater than the second most reported urgent need of education. (25.4%).
- Financial (12.7%), interpretation (12.7%) and legal support (8.7%) were also among the top five urgent needs reported by Omaha refugees.
- Approximately 8% Omaha refugees reported work support (7.7 %) as an urgent need and 6% reported housing (6.2%) as an urgent need.
- Social Support (4.6%), food (1.7%) and other (1.1%) were among the least reported urgent needs of Omaha refugees.

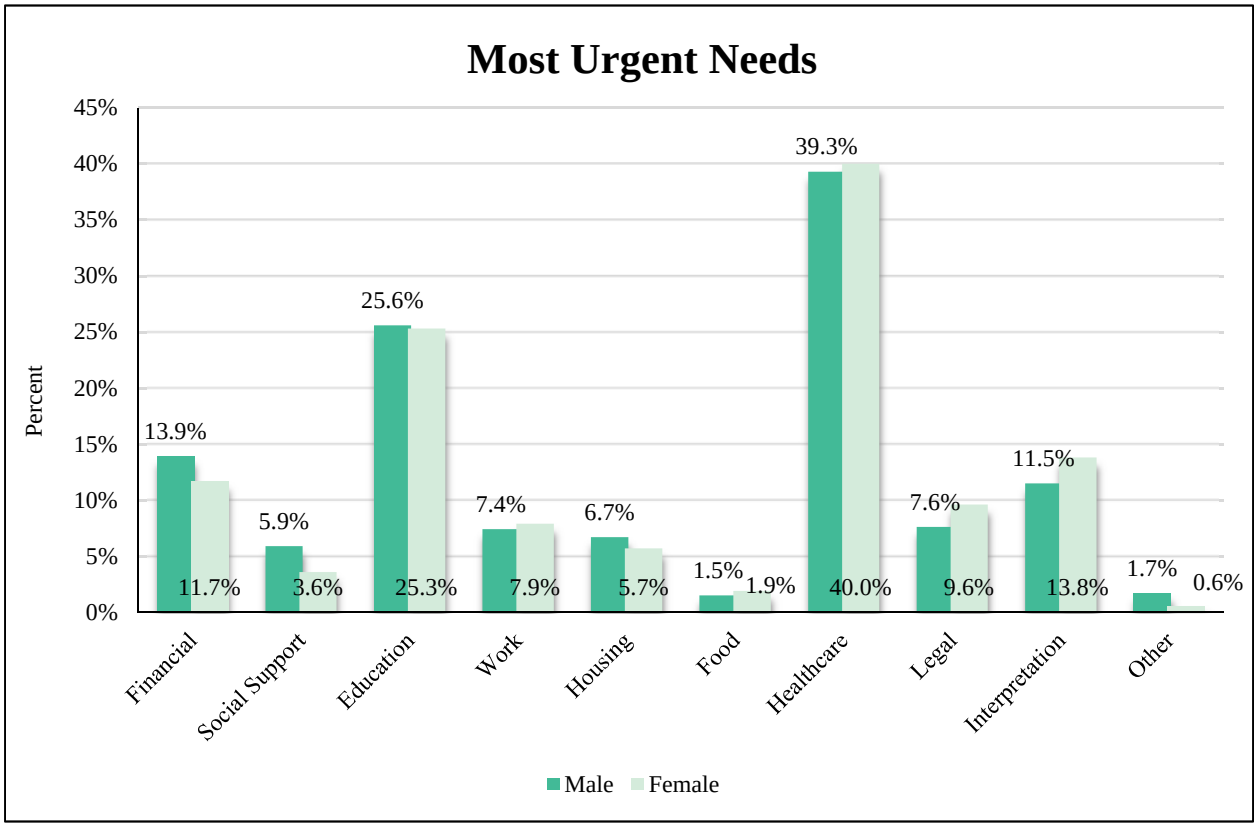


Most Urgent Needs

The below chart represents the most urgent needs of Omaha refugees surveyed.

By Gender

- Both male and female refugees in Omaha reported the same top five urgent needs: health care, education, financial, interpretation, legal support. Health care was the most urgent need for both males (39.3%) and females (40.0%).
- Similar rates were seen across all urgent needs for both male and female refugees.



Most Urgent Needs

The below tables represent the most urgent needs of Omaha refugees surveyed.

By Year of Arrival

- Health care was the most reported urgent need among all Omaha refugee arrival groups, with 33-44% of each population reporting it as such.
- All refugee arrival groups reported education (18.8-33.7%), financial (10.3-15.4%), and work (6.4-10.8%) as the top 5 urgent needs.
- Those arriving in 2008 and earlier (6.2%), 2012-2014 (6.7%), and 2015-2017 (6.5%) reported housing among the top 5 urgent needs.
- For refugees arriving in 2009-2011, social support (8.0%) was the fifth most reported urgent need after healthcare (43.8%), education (18.8%), financial (10.3%), and work (8.0%).
- For refugees arriving in 2015-2017, education was the second most reported urgent need at 25.0%. This percentage was 1.7 times higher than the next urgent need that followed for the population – financial at 14.3%.

2008 & earlier: Top 5 Most Urgent Needs

Rank	Urgent Need	Percent
1	Health Care	33.2 %
2	Education	21.2%
3	Financial	15.4%
4	Work	7.3%
5	Housing	6.2%

2009-2011: Top 5 Most Urgent Needs

Rank	Urgent Need	Percent
1	Health Care	43.8%
2	Education	18.8%
3	Financial	10.3%
4	Work	8.0%
5	Social Support	8.0%

2012-2014: Top 5 Most Urgent Needs

Rank	Urgent Need	Percent
1	Health Care	43.8%
2	Education	33.7%
3	Financial	10.6%
4	Housing	6.7%
5	Work	6.4%

2015-2017: Top 5 Most Urgent Needs

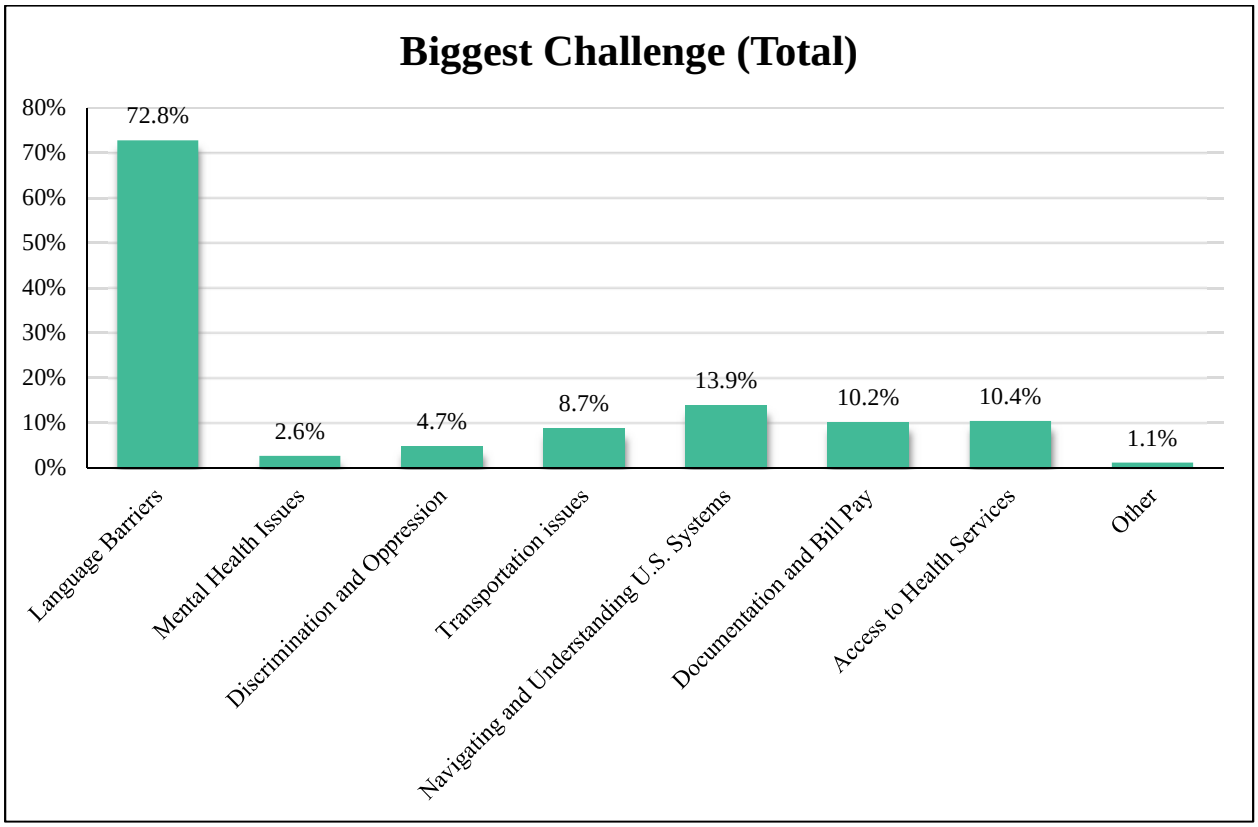
Rank	Urgent Need	Percent
1	Health Care	35.1%
2	Education	25.0%
3	Financial	14.3%
4	Work	10.8%
5	Housing	6.5%

Biggest Challenges

The below chart represents the biggest challenges reported by Omaha refugees surveyed.

Key Findings

- Language barriers (72.8%) were by far the biggest challenge reported by Omaha refugees. This percentage was 5.2 times higher than the second biggest challenge reported, navigating and understanding U.S. systems (13.9%).
- Access to health services (10.4%), documentation and bill pay (10.2%), and transportation issues (8.7%) were also among the biggest challenges most often reported by Omaha refugees.
- Omaha refugees were somewhat less likely to report discrimination and oppression (4.7%) and mental health issues (2.6%) as their biggest challenges.

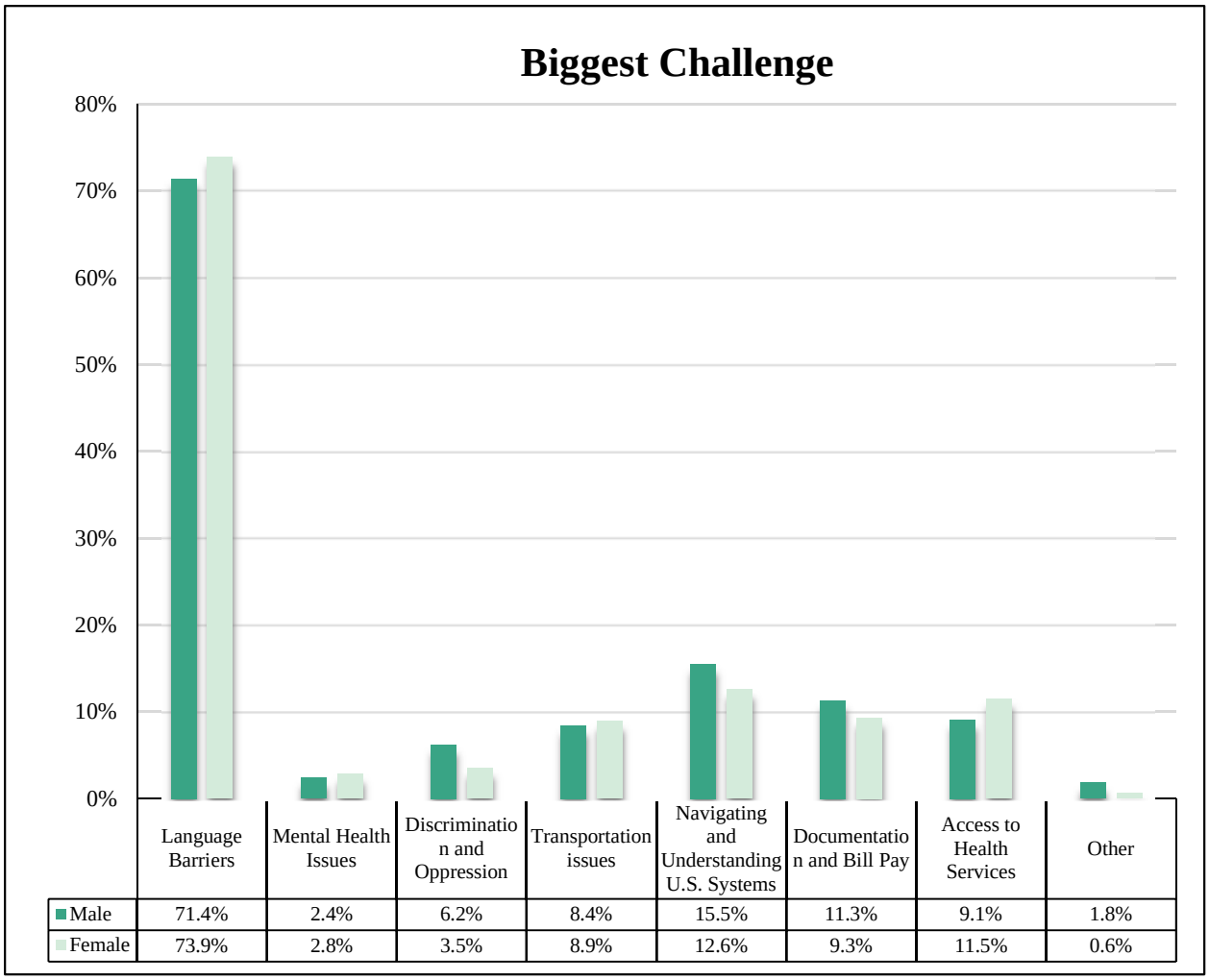


Biggest Challenges

The below chart represents the biggest challenges reported by Omaha refugees surveyed.

By Gender

- In Omaha, female refugees (73.9%) were somewhat more likely than male refugees (71.4%) to report languages barriers as their biggest challenge.
- Male refugees (6.2%) were 1.8 times more likely than female refugees (3.5%) to report discrimination and oppression as one of the biggest challenges.
- Both male and female refugees reported navigating and understanding U.S. systems, documentation and bill pay, access to health care, and transportation issues among their top five biggest challenges.



	Language Barriers	Mental Health Issues	Discrimination and Oppression	Transportation issues	Navigating and Understanding U.S. Systems	Documentation and Bill Pay	Access to Health Services	Other
Male	71.4%	2.4%	6.2%	8.4%	15.5%	11.3%	9.1%	1.8%
Female	73.9%	2.8%	3.5%	8.9%	12.6%	9.3%	11.5%	0.6%

Biggest Challenges

The below chart represents the biggest challenges reported by Omaha refugees surveyed.

By Year of Arrival

- All Omaha refugee arrival groups reported language barriers as their top biggest challenge. The most recently arrived group of refugees (79.3%) reported the highest percentage of those who felt language barriers were their biggest challenge, while those arriving in 2008 and earlier (61.0%) presented the lowest percentage of those reporting the same.
- Navigating and understanding U.S. systems was the second biggest challenge for both 2012-2014 and 2015-2017 arrival groups. Omaha refugees arriving in 2009-2011 reported documentation and bill pay and Omaha refugees arriving in 2008 & earlier reported transportation issues as their second biggest challenge.
- In addition to language barriers, documentation and bill pay, and navigating and understanding U.S. systems were among the top five biggest challenges within every refugee arrival group. Omaha refugees arriving in 2012-2014 and 2015-2017 reported access to health services and transportation issues as two of the top five biggest challenges.

2008 and Earlier: Top Five Biggest Challenges

Rank	Need	Percent
1	Language Barriers	61.0%
2	Transportation Issues	10.4%
3	Navigating & Understanding U.S Systems	10.4%
4	Documentation and Bill Pay	9.2%
5	Discrimination and Oppression	8.8%

2009-2011: Top Five Biggest Challenges

Rank	Need	Percent
1	Language Barriers	75.8%
2	Documentation and Bill Pay	8.8%
3	Navigating & Understanding U.S. Systems	8.8%
4	Access to Health Services	8.4%
5	Mental Health Issues	4.4%

2012-2014: Top Five Biggest Challenges

Rank	Need	Percent
1	Language Barriers	76.3%
2	Navigating & Understanding U.S. Systems	20.1%
3	Access to Health Services	12.9%
4	Transportation Issues	10.2%
5	Documentation and Bill Pay	10.2%

2015-2017: Top Five Biggest Challenges

Rank	Need	Percent
1	Language Barriers	79.3%
2	Navigating & Understanding U.S. Systems	14.8%
3	Access to Health Services	13.6%
4	Documentation and Bill Pay	13.0%
5	Transportation Issues	8.9%

Social Determinants of Health

While health is often influenced by genetics, individual behavior, and social and economic factors. These factors, the social determinants of health, are often created by the conditions in which people live and work and can be divided into five broad categories: economic stability, education, social and community context, health and health care, and neighborhood and built environment. [8] These categories can be measured by various indicators. For instance, economic stability can be measured in part by employment status and income, while education can be measured by indicators such as graduation or enrollment in higher education.

The International Organization for Migration identifies migration as a social determinant of health by acknowledging that "most migrants face a combination of legal, social, cultural, economic, behavioral, and communication barriers which put their physical, mental, and social well-being at risk."[9] These barriers can be even more severe for those migrants, such as refugees, who are forcibly displaced from their homes. Refugees are generally unable to choose their host country and are not adequately prepared for the transition. Additionally, refugees have often been exposed to violence and poverty and many have lived for years in refugee camps before coming to the United States. These factors, along with country of origin, may influence a refugee's health behaviors and beliefs about health.

Upon arrival, some of the most common barriers faced by refugees include individual factors, such as educational attainment, employment status, income level, and language ability. Higher education and income have repeatedly been linked to better health.[10,11] Especially upon arrival, such individual factors can contribute to less desirable living and working conditions. Unsafe housing, poor working conditions, and limited access to resources and healthy foods often contribute to negative health outcomes.

Furthermore, there are social and community influences that can influence health. Many refugees have been separated from their families and are faced with a level of social isolation upon arrival in the United States. While many refugees eventually become part of a local community, lack of culturally and linguistically appropriate services may hinder access to local health care.[12] Identifying and understanding the vulnerabilities regarding the social determinants of health is an important step in promoting positive health outcomes among Nebraska's refugee population.

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[8] Healthy People. (2018). Social determinants of health. Retrieved from: www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

[9] International Organization for Migration. (2018). Social determinants of migrant health. Retrieved from www.iom.int/social-determinants-migrant-health

[10] Hahn, R. A. & Truman, B. I. (2015). Education improves public health and promotes health equity. *International Journal of Health Services, 45*(4), 657-678.

[11] Feinstein, J. S. (1993). The relationship between socioeconomic status and health: A review of the literature. *The Milbank Quarterly, 71*(2), 279-322.

[12] International Organization for Migration. (2018). Social determinants of migrant health. Retrieved from www.iom.int/social-determinants-migrant-health

Omaha Refugee Population

Social Determinants of Health

Education

50.7% Approximately half of Omaha's refugee population has a middle school education or less.

Household Income

7.8% Approximately 8% of Omaha refugees had a household income of less than $15,000 annually.

Unemployed or Unable to Work

21.1% Two of every ten Omaha refugees were unable to work or unemployed.

English Language Ability

81.2% Approximately eight of every ten Omaha refugees surveyed reported speaking a language other than English at home.

67.4% Approximately 68% Omaha refugees reported speaking English not well or not at all.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Educational Attainment

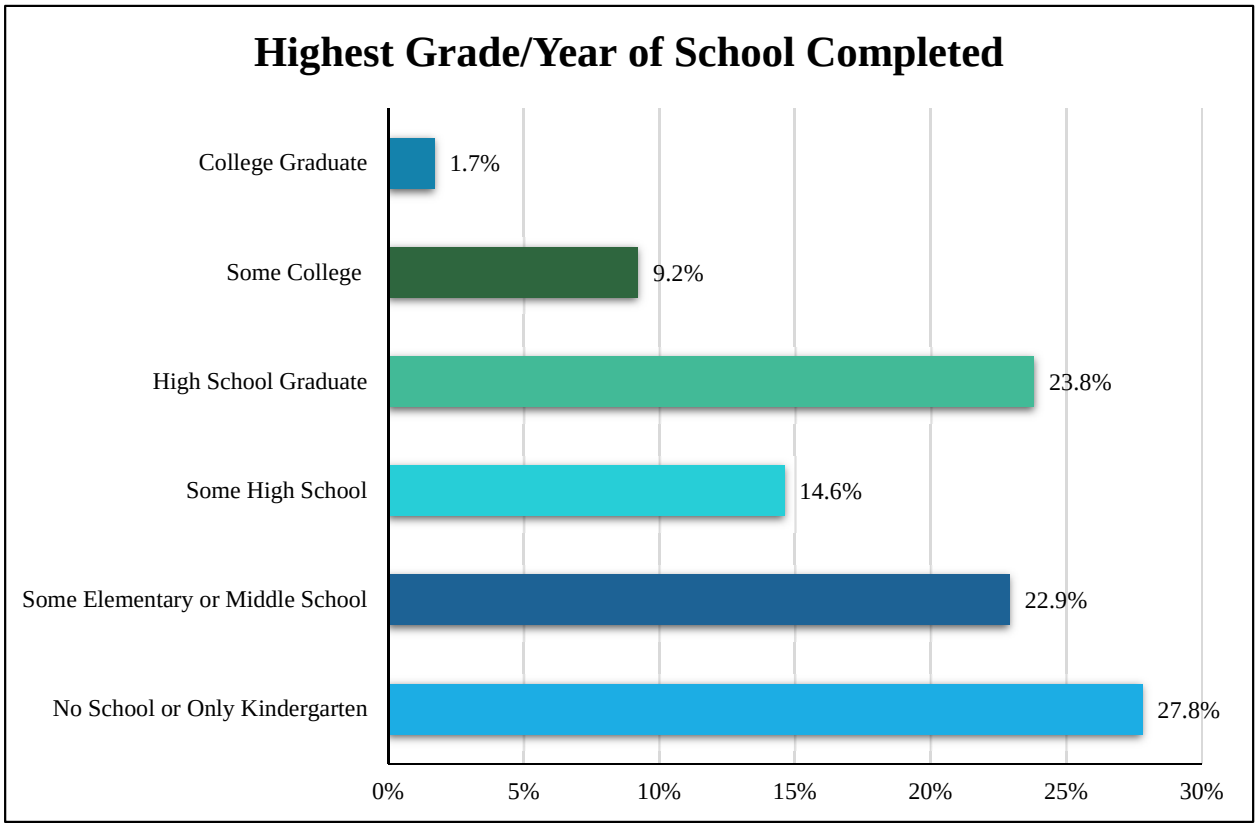
What is the highest grade or year of school you completed?

Education has long been positively associated with health. Individuals with higher educational attainment live longer and are generally healthier than are those with fewer years of schooling.

The below chart represents the highest level of education completed by Omaha refugees surveyed.

Key Findings

- Under one-third of Omaha refugees (27.8%) reported having no education or having only attended kindergarten. An additional 22.9% of Omaha refugees reported having only some elementary or middle school education.
- Only 1.7% of Omaha refugees reported being college graduates.
- Approximately 24% of Omaha refugees reported being high school graduates with no higher education.



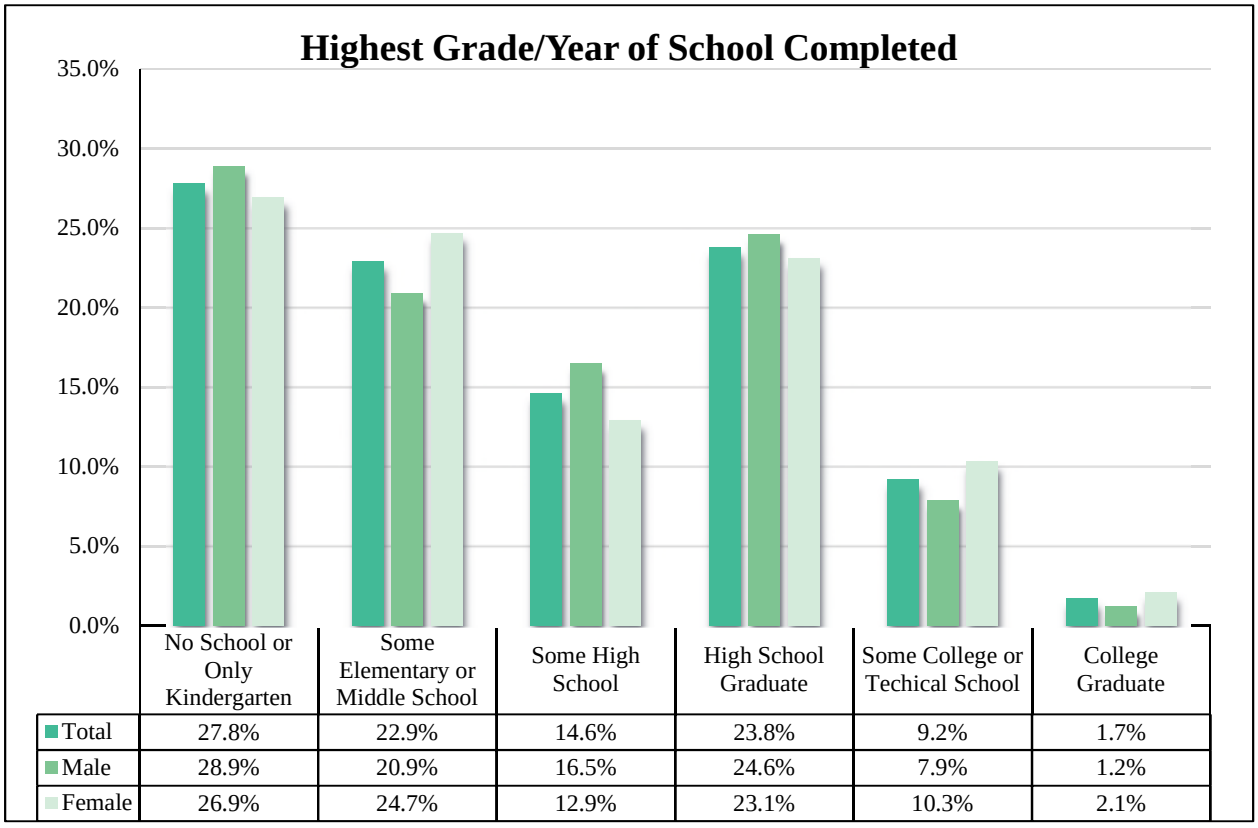
Educational Attainment

What is the highest grade or year of school you completed?

The below chart represents the highest level of education completed by Omaha refugees surveyed.

By Gender

- Female refugees (24.7%) were more likely than male refugees (20.9%) to report some elementary or middle school while male refugees (16.5%) were more likely than females (12.9%) to have some high school.
- Similar high school graduation rates were see for Male refugees (24.6%) and female refugees (23.1 %).
- Male refugees (7.9%) had a lower rate of some college or technical school compared to female refugees (10.3%).
- Female refugees (2.1%) were 1.8 times more likely than male refugees (1.2%) to report being college graduates.



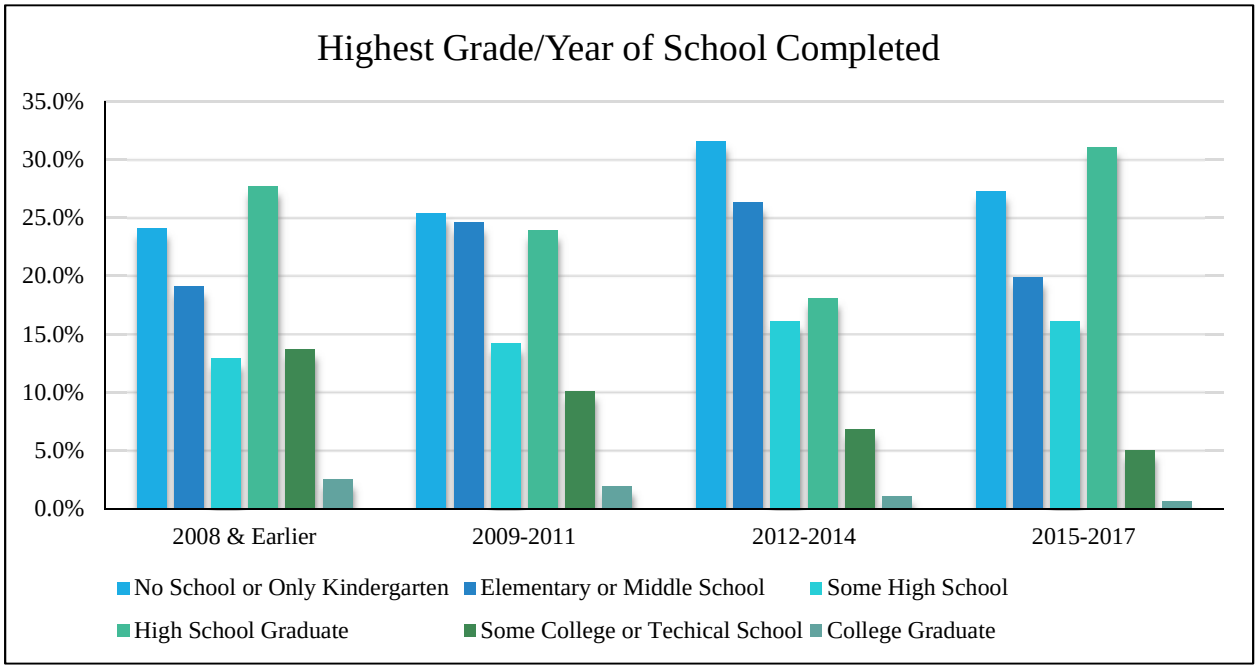
	No School or Only Kindergarten	Some Elementary or Middle School	Some High School	High School Graduate	Some College or Techical School	College Graduate
Total	27.8%	22.9%	14.6%	23.8%	9.2%	1.7%
Male	28.9%	20.9%	16.5%	24.6%	7.9%	1.2%
Female	26.9%	24.7%	12.9%	23.1%	10.3%	2.1%

Educational Attainment

The below chart represents the highest level of education completed by Omaha refugees.

By Year of Arrival

- Omaha refugees arriving in 2012-2014 (31.6%) were most likely to report having no education or having only completed kindergarten, followed by Omaha refugees arriving in 2015-2017 (27.3%).
- Approximately 27% of Omaha refugees arriving in 2015-2017 reported having no education or having only attended kindergarten (27.3%) and almost 20% having only some elementary or middle school education (19.9%).
- Omaha refugees arriving in 2008 and earlier (2.5%) were four times more likely to report being college graduates than those arriving in 2015-2017 (0.6%). The percentage of Omaha refugees who reported having some college or being a college graduate decreased gradually with more recent arrival to the U. S.



Year	Percent					
	No School or Only Kindergarten	Elementary or Middle School	Some High School	High School Graduate	Some College or Technical School	College Graduate
2008 & Earlier	24.1%	19.1%	12.9%	27.7%	13.7%	2.5%
2009-2011	25.4%	24.6%	14.2%	23.9%	10.1%	1.9%
2012-2014	31.6%	26.3%	16.1%	18.1%	6.8%	1.1%
2015-2017	27.3%	19.9%	16.1%	31.1%	5.0%	0.6%

Annual Household Income

What is your annual household income from all sources?

The link between income and health is complex, but it is clear that higher income is positively correlated with lower rates of death and disease.[13] Those with higher incomes are often more likely to live in better areas and to be able to purchase healthier groceries, while those with lower incomes are often faced with limited funds to spend on health care needs.

The below table represents the annual household income of Omaha refugees surveyed.

Key Findings by Gender

- Approximately half of the Omaha refugee population (45.5%) reported their annual household income to be $20,000 to less than $25,000.
- Female refugees (50.9%) were 1.3 times more likely than male refugees (39.4%) to report an annual household income to be $20,000 to less than $25,000.
- Almost three-quarters of Omaha refugees (74%) reported an annual household income as between $20,000 to less than $35,000.
- Only 12.1% of Omaha refugees reported a household income of more than $35,000.

Household Income	Total	Male	Female
Less than $10,000	5.8%	5.4%	6.2%
$10,000 to less than $15,000	2.0%	2.4%	1.6%
$15,000 to less than $20,000	6.2%	6.6%	5.9%
$20,000 to less than $25,000	45.5%	39.4%	50.9%
$25,000 to less than $35,000	28.5%	31.6%	25.6%
$35,000 to less than $50,000	9.5%	11.9%	7.3%
$50,000 to less than $75,000	2.0%	2.1%	1.9%
$75,000 or more	0.6%	0.6%	0.5%

[13] National Center for Health Statistics. (2012). Health, United States, 2011: with special feature on socioeconomic status and health. Retrieved from www.cdc.gov/nchs/data/hus/hus11.pdf

Annual Household Income

The below table represents the annual household income of Omaha refugees surveyed.

By Year of Arrival

- In Omaha, more than half (55.1%) of the most recently arrived refugee population (2015-2017) reported a household income to be $20,000-- $25,000. This percentage was 1.3 times that of refugees with the longest stay in the U.S. (2008 & earlier) at 41.3%.
- Approximately 10% of Omaha refugees arriving in 2008 and earlier reported an annual household income to be $35,000 -- $50,000. This percentage was twice that of refugees arriving in 2015-2017 (4.7%).
- For Omaha refugees arriving in 2015-2017, annual household incomes of $50,000 or more were not reported.

Household Income	2008 & earlier	2009 2011	2012 2014	2015 2017
Less than $10,000	6.4%	6.6%	6.3%	2.8%
$10,000 to less than $15,000	2.3%	3.6%	0%	2.8%
$15,000 to less than $20,000	4.1%	4.2%	8.7%	8.4%
$20,000 to less than $25,000	41.3%	41.6%	47.8%	55.1%
$25,000 to less than $35,000	34.4%	24.1%	27.1%	26.2%
$35,000 to less than $50,000	10.1%	15.1%	7.7%	4.7%
$50,000 to less than $75,000	1.4%	3.6%	1.9%	0.0%
$75,000 or more	0.0%	1.2%	0.5%	0.0%

Employment Status

Employment Status

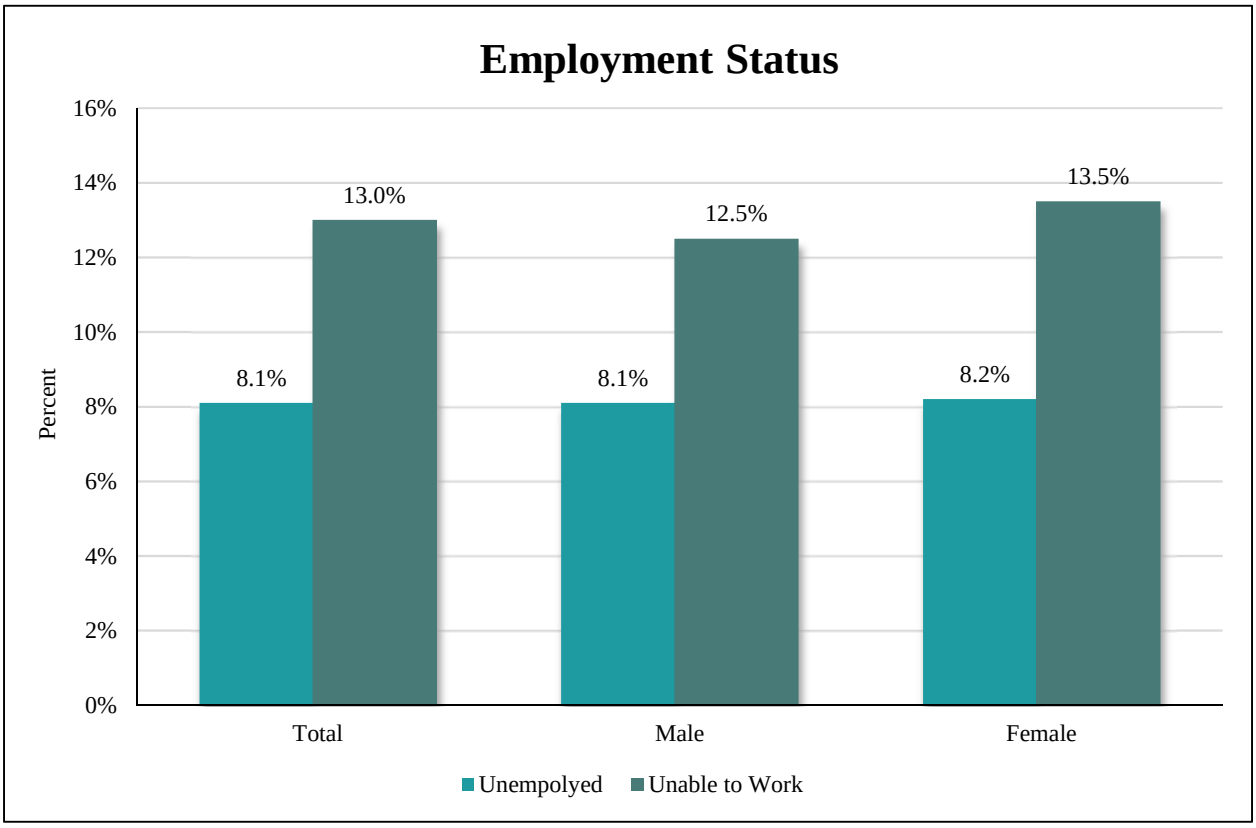
Employed for Wages • Self-employed • Out of Work • Homemaker • Student • Retired • Unable to work

A secure job that pays well makes affording health care and maintaining a healthy lifestyle easier. In contrast, unemployed individuals are more likely to lack funds for health services and to be diagnosed with depression or develop a stress-related condition.[14]

The below chart represents the proportion of Omaha refugees surveyed who were unemployed or unable to work.

By Gender

- Over one-tenth of Omaha refugees (13.0%) reported being unable to work and approximately 8% reported being unemployed (8.1%).
- Similar proportions of unemployment and inability to work were seen for male and female refugees.



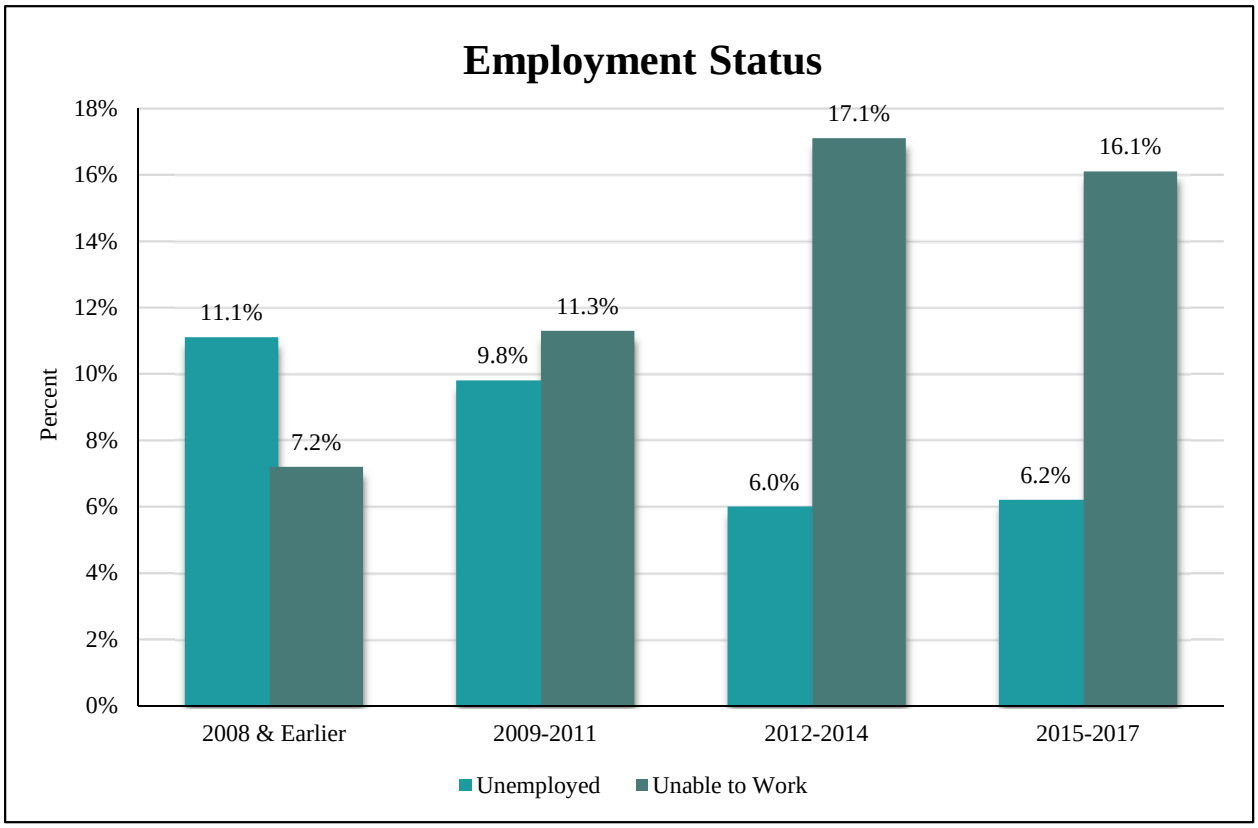
[14] Jin, R. L., Shah, C. P., & Svoboda, T .J. (1995). The impact of unemployment on health: a review of the evidence. *Canadian Medical Association Journal, 153*(5), 529-540.

Employment Status

The below chart represents the proportion of Omaha refugees surveyed who were unemployed or unable to work.

By Year of Arrival

- Omaha refugees arriving in 2012-2014 were most likely to be unable to work at 17.1%. The next arrival group likely to report the same were those arriving in 2015-2017 at 16.1%.
- Omaha refugees arriving in 2008 & earlier (11.1%) were most likely to be unemployed, followed by Omaha refugees arriving in 2009-2011 (9.8%).
- Similar proportions of Omaha refugees arriving in 2012-2014 (6.0%) and Omaha refugees arriving in 2015-2017 (6.2%) reported being unemployed.
- In general, the rate of unemployment decreased and the rate of inability to work increased the longer refugees were in the U.S.



English Not Spoken at Home

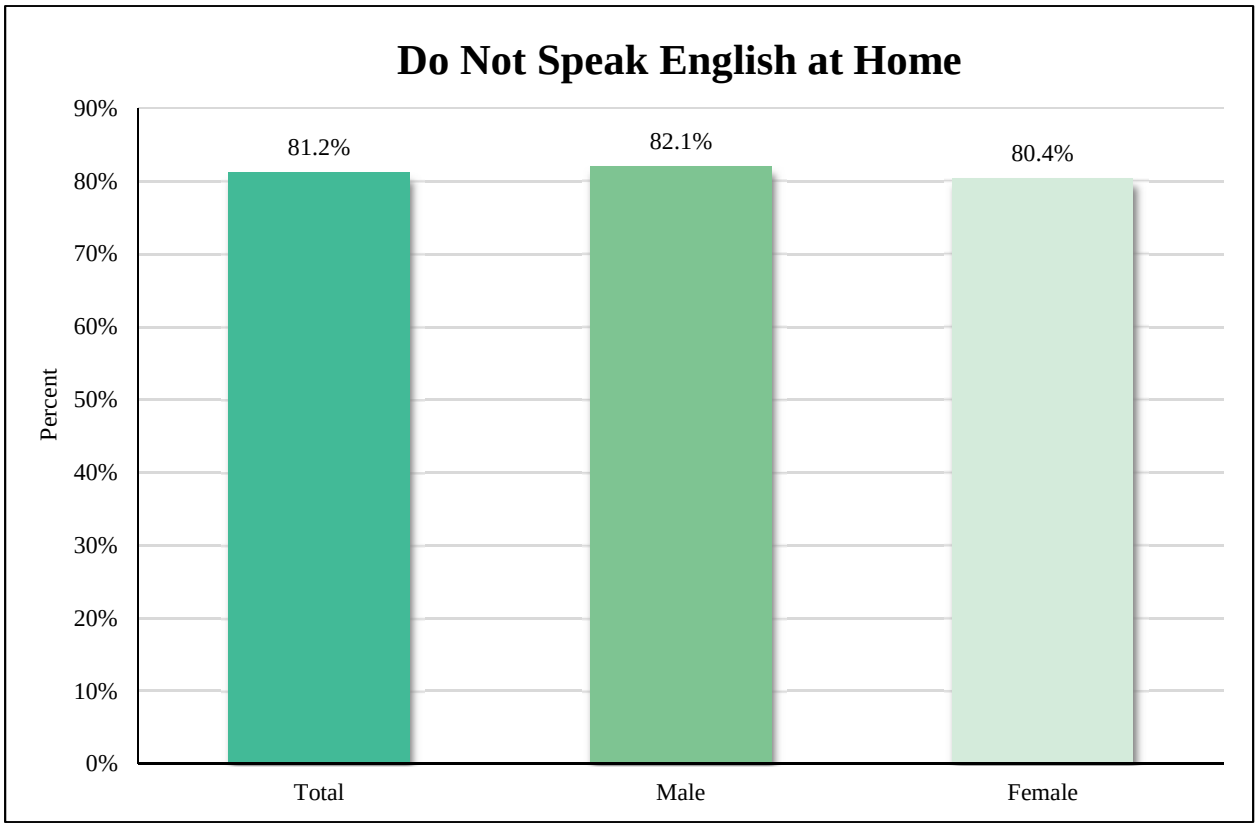
Do you speak English at home?

Language spoken at home can be a useful indicator when evaluating health care needs. While this indicator is not an accurate measure of English proficiency, research has shown that children and adults from non-English primary language homes report lower health outcomes for numerous indicators.[15]

The below chart represents the proportion of Omaha refugees who reported that English was not the primary language spoken in their home.

By Gender

- Approximately eight out of every ten Omaha refugees (81.2%) reported speaking a language other than English at home.
- Male refugees (82.1%) were slightly more likely than female refugees (80.4%) to report speaking a language other than English at home.



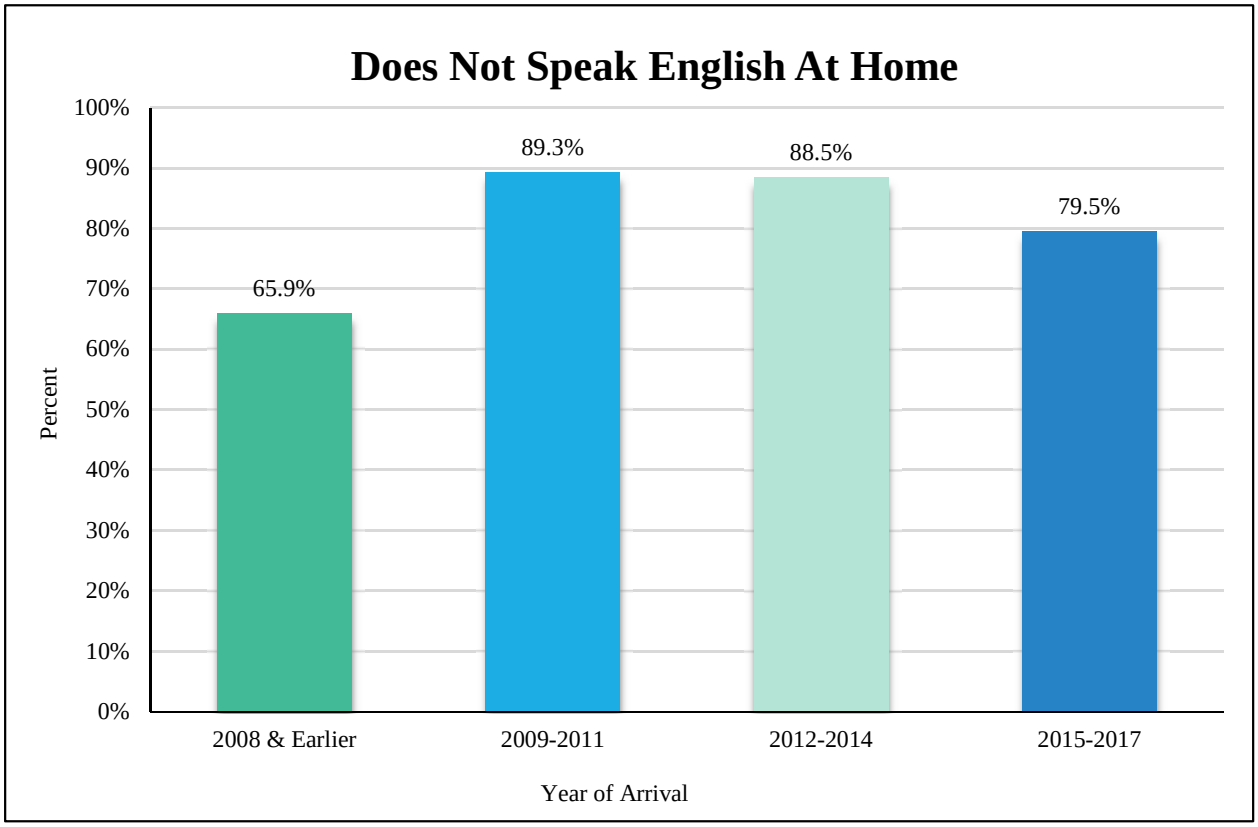
[15] Lau, M., Lin, H., & Flores, G. (2012). Primary language spoken at home and disparities in the health and healthcare of US adolescents. *Diversity and Equality in Healthcare, 9, 267-80.*

English Not Spoken at Home

The below chart represents the proportion of Omaha refugees who reported that English was not the primary language spoken in their home.

By Year of Arrival

- Approximately 80% of Omaha refugees arriving in 2015-2017 reported speaking a language other than English at home, compared to approximately 65.9% of Omaha refugees arriving in 2008 and earlier.
- Refugees arriving in 2009-2011 (89.3%) and 2012-2014 (88.5%) were most likely to report not speaking English at home.



Limited English Proficiency

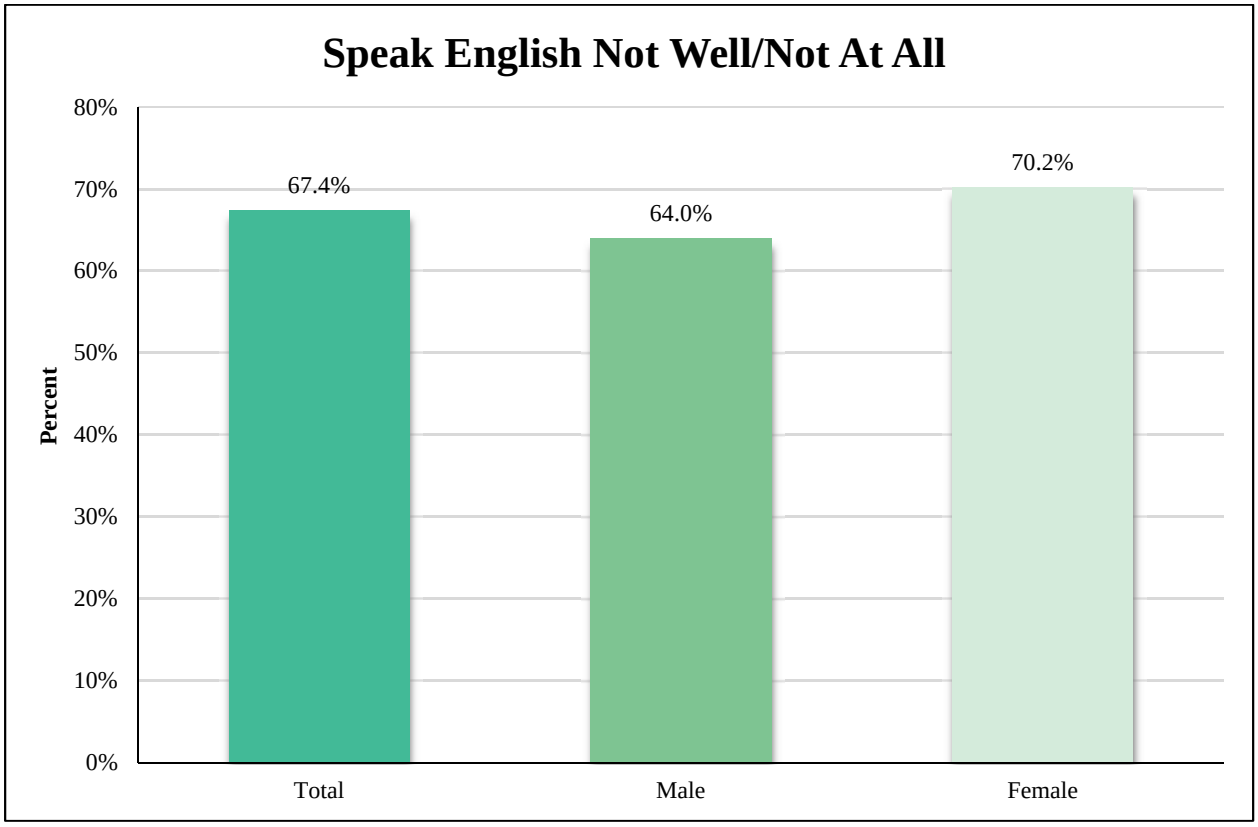
How well do you speak English?
Very Well • *Well* • *Not Well* • *Not At All*

In Nebraska, English language knowledge is often essential in navigating the health care system. Research has shown that those with limited English proficiency are more likely to have difficulty understanding medical situations, more likely to have trouble understanding labels, and more likely to have adverse reactions to medications.[16]

The below chart represents the proportion of Omaha refugees with limited English proficiency. Refugees considered to have limited English proficiency are those who reported speaking English "not well" or "not at all".

By Gender

- Approximately 68% of Omaha refugees reported having limited English proficiency (67.4%).
- Female refugees (70.2%) had a higher rate of limited English proficiency than male refugees (64%).



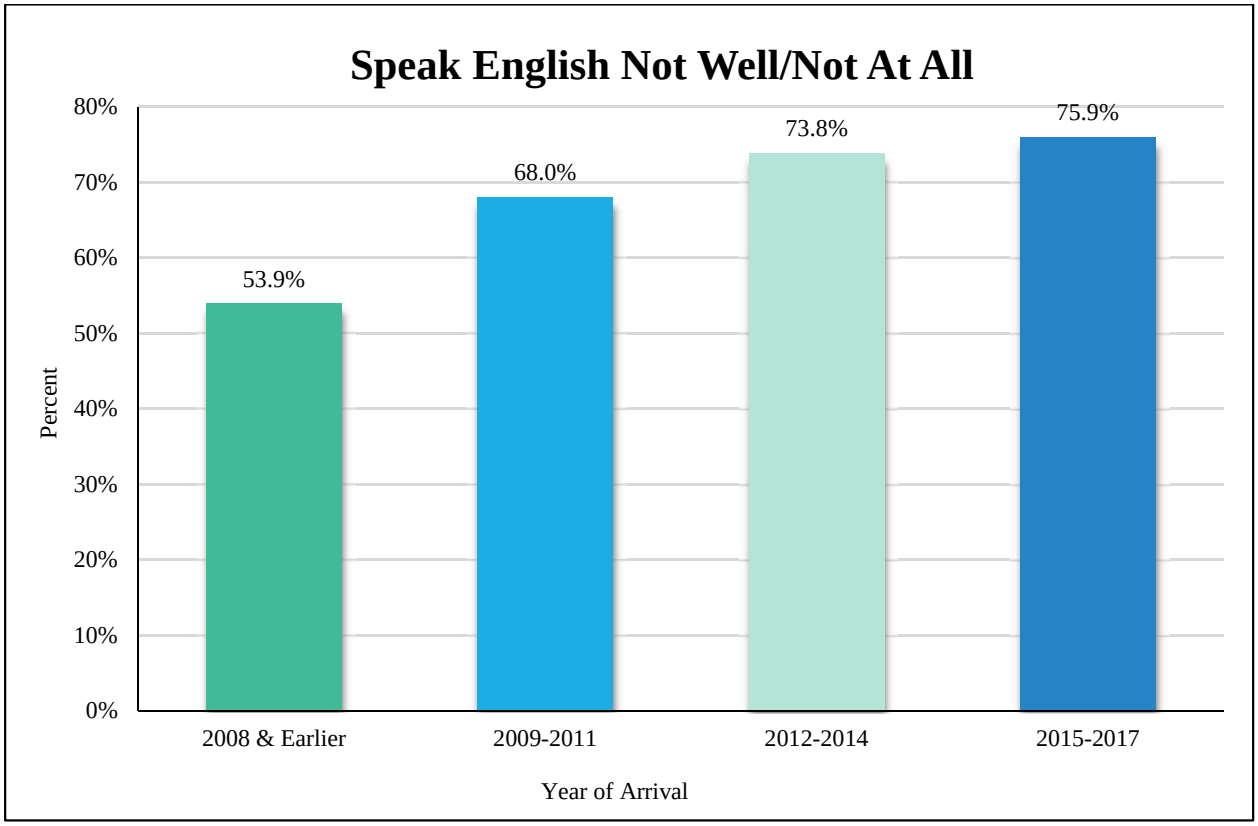
[16] Wilson, E., Chen, A. H., Grumbach, K., Wang, F., & Fernandez, A. (2005). Effects of limited English proficiency and physician language on health care comprehension. *Journal of General Internal Medicine, 20*, 800–806.

Limited English Proficiency

The below chart represents the proportion of Omaha refugees with limited English proficiency. Refugees considered to have limited English proficiency are those who reported speaking English “not well” or “not at all”.

By Year of Arrival

- The percentage of Omaha refugees with limited English proficiency decreased with length of stay in the United States.
- The most recently arrived Omaha refugee population (2015-2017) was most likely to report having limited English proficiency at 75.9%. This was 1.4 times the rate of those with the longest stay in the U.S. (2008 & earlier) at 53.9%.



Marital Status

Marital Status

Married • Divorced • Widowed • Separated • Never Married • Member of an Unmarried Couple

Marital status and changes in marital status can have implications for an individual's health. Evidence has shown that, in general, married individuals are in better health and have lower mortality rates than those who are single. Additionally, children of married parents tend to be healthier.[17]

The below table represent the marital status of Omaha refugees surveyed.

By Gender

- Approximately 67% of Omaha refugees reported being married and 22% reported having never been married.
- Female refugees (4.3%) were 2.7 times more likely than male refugees (1.6%) to report being widowed. Female refugees (1.2%) were also twice as likely as male refugees (0.6%) to report being separated.
- Male refugees (9.2%) were approximately 1.8 times more likely than female refugees (5.0%) to report being divorced.

	Married	Divorced	Widowed	Separated	Never Married	Member of Unmarried Couple
Total	66.5%	7.3%	3.1%	0.9%	22.0%	0.3%
Male	67.5%	5.0%	1.6%	0.6%	25.0%	0.2%
Female	65.4%	9.2%	4.3%	1.2%	19.5%	0.3%

[17] Gallagher, M. & Waite, L. (2000). The case for marriage: why married people are happier, healthier, and better off financially. New York, NY: Broadway Books.

Marital Status

The below table represent the marital status of Omaha refugees surveyed.

By Year of Arrival

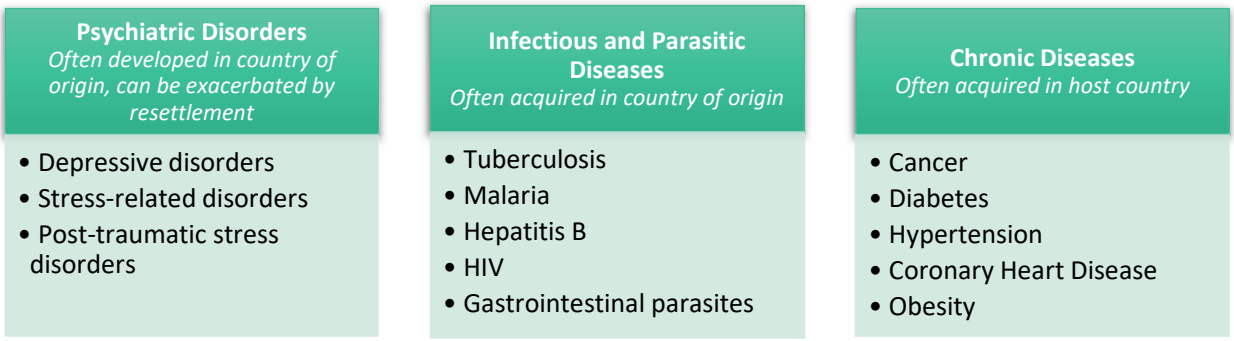
- In Omaha, refugees arriving in 2009-2011 (69.4%) were most likely to be married, followed by those arriving in 2012-2014 (68.6%), 2008 and earlier (67.4%) and 2015-2017 (57.3%).
- Omaha refugees arriving in 2015-2017 (17.5%) were most likely to report being divorced, followed by those arriving in 2008 and earlier (6.4%).
- Refugees arriving in 2015-2017 were most likely to report being separated (2.9%).
- All arrival groups were unlikely to report being a member of an unmarried couple.

	Married	Divorced	Widowed	Separated	Never Married	Member of an Unmarried Couple
2008 & earlier	67.4%	6.4%	3.2%	0.4%	22.3%	0.4%
2009-2011	69.4%	5.9%	2.6%	0.4%	21.4%	0.4%
2012-2014	68.6%	4.4%	3.0%	0.5%	23.5%	0.0%
2015-2017	57.3%	17.5%	2.9%	2.9%	18.7%	0.6%

Health Status

Measuring the overall health status of refugees is a complex issue, as health concerns among refugees often occur in stages depending on the duration of residence in the host country. These stages, which often overlap, are outlined below.

The Stages of Refugee Health



Adapted from Palinkas, L. A., Pickwell, S. M., Brandstein, K., Clark, T. J., Hill, L. L., Moser, R. J., & Osman, A. (2003). The journey to wellness: stages of refugee health promotion and disease prevention. *Journal of Immigrant Health, 5*(1), 19-28.

The first stage, psychiatric disorders, includes mental health issues that often occur among refugees due to the conditions faced in their countries of origin, including war, violence, poverty, and famine. Though these mental health issues are often developed in the country of origin, they often continue for years after resettlement. The stress of the resettlement process, difficulties adjusting to the new country, and loss of social support can exacerbate mental health issues.[18]

Despite pre-departure screenings, refugees sometimes arrive with infectious or parasitic diseases due to exposure in countries of origin or during the migration process. Unlike mental health issues, this stage of diseases is often resolved soon after resettlement through refugee screening and treatment programs that occur within the first 30 to 90 days after arrival. During these screenings, refugees are often tested for tuberculosis, parasitic infections, and hepatitis B, and are provided with immunizations.[19] As many of the refugees surveyed in Nebraska have resided in the United States for multiple years, parasitic and infectious diseases will not be focused on in this report.

After residing in the United States for years, many refugees may encounter chronic diseases. Most research has attributed this to the adoption of a Western diet and lifestyle. One study conducted in Denmark found that the occurrence of stroke, diabetes, and breast cancer increased along with duration of residence.[20] Another study found that refugees who experienced food

[18] Porter, M. & Haslam, N. (2005). Predisplacement and post displacement factors associated with mental health of refugees and internally displaced persons. *Journal of the American Medical Association, 294*(5), 602-612.
[19] Centers for Disease Control and Prevention. (2018). Refugee health guidelines. Retrieved from www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html
[20] Norredam, M., Agyemang, C., Hoejbjerg Hansen, O. K., Petersen, J. H., Byberg, S., Krasnik, A., & Kunst, A. (2014). Duration of residence and disease occurrence among refugees and reunited immigrants: test of the 'healthy migrant' hypothesis. *Tropical Medicine and International Health, 19*(8), 958-967.

insecurity or deprivation were more likely to become overweight or obese after resettlement, due to unhealthy eating.[21] While weight gain may be valuable to an extent, rapid weight gain leading to obesity can put refugees at risk for chronic diseases.

Currently, limited research exists surrounding refugees and chronic diseases. Subsequent sections of this report will focus on chronic diseases in detail, along with related issues, such as access to health care and health behaviors. The following section will first give an overview of the general health status of refugees, as measured by perceived health status and the number of physically and mentally healthy days. When examining the following data, it is important to keep in mind the stages of refugee health and the way in which health status may change among individual refugees as they transition and integrate into their host countries.

[21] Peterman, J. N., Wilde, P. E., Liang, S., Bermudez, O. I., Silka, L., & Rogers, B. L. (2010). Relationship between past food deprivation and current dietary practices and weight status among Cambodian refugee women in Lowell, MA. *American Journal of Public Health, 100*(10), 1930-1937.

Omaha Refugee Population

Health Status

4.1% Approximately 5% of Omaha refugees reported being in poor physical health on 14 or more of the past 30 days.

1.8x Female refugees (5.1%) were more likely than male refugees (2.9%) to report being in poor physical health on 14 or more of the past 30 days.

2.7% Just 2.7% of Omaha refugees reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.

Perceived Health Status

How an individual views his or her own health

26.7% More than one-quarter Omaha refugees reported being in fair or poor health.

32.6% Refugees arriving in 2015-2017 were most likely to report being in fair or poor health compared to other arrival groups.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Perceived Health Status

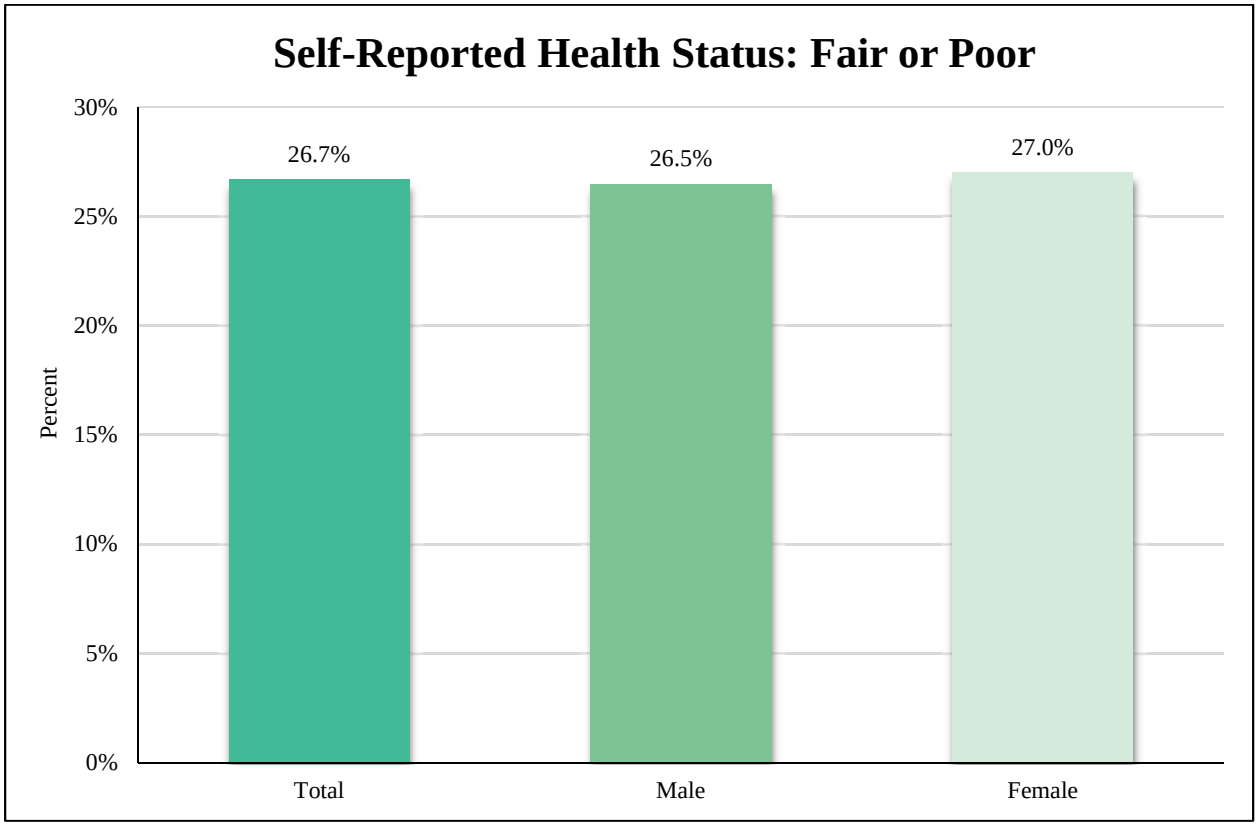
Would you say that in general your health is ___?
Excellent • Very Good • Good • Fair • Poor

Perceived health status measures how an individual views his or her health – excellent, very good, good, fair, or poor. Individuals who are poor or uninsured are more likely to report being in fair or poor health and have higher rates of hospitalization and mortality compared to those who report excellent or good health.[22]

The below chart represents the proportion of Omaha refugees who considered their health to be "fair" or "poor."

By Gender

- More than one-quarter refugees in Omaha (26.7%) reported their health status was fair or poor.
- There is no obvious percentage difference between Female refugees (27.0%) and Male refugees (26.5%) to report that their health status was fair or poor.



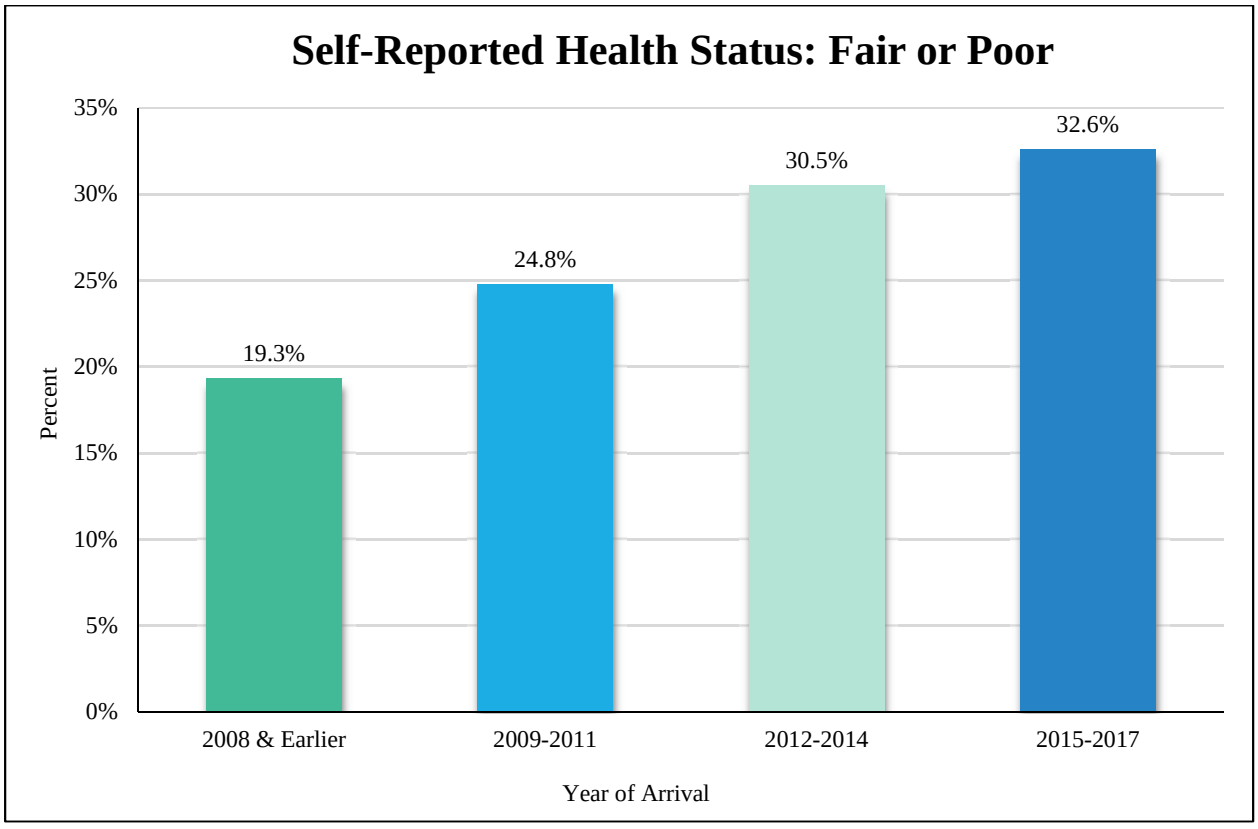
[22] United States Office of Disease Prevention and Health Promotion. (2016). General health status. Retrieved from www.healthypeople.gov/2020/about/foundation-health-measures/General-Health-Status

Perceived Health Status

The below chart represents the proportion of Omaha refugees who considered their health to be "fair" or "poor."

By Year of Arrival

- The percentage of Omaha refugees reporting their health status as fair or poor increased gradually with length of stay in the U. S.
- In Omaha, refugees arriving in 2015-2017 (32.6%) were most likely to report their health status as fair or poor, followed by refugees arriving in 2012-2014 (30.5%).
- Omaha refugees arriving in 2008 and earlier (19.3%) were least likely to report their health status as fair or poor. This percentage was much lower than that of those arriving in 2015-2017 (32.6%).



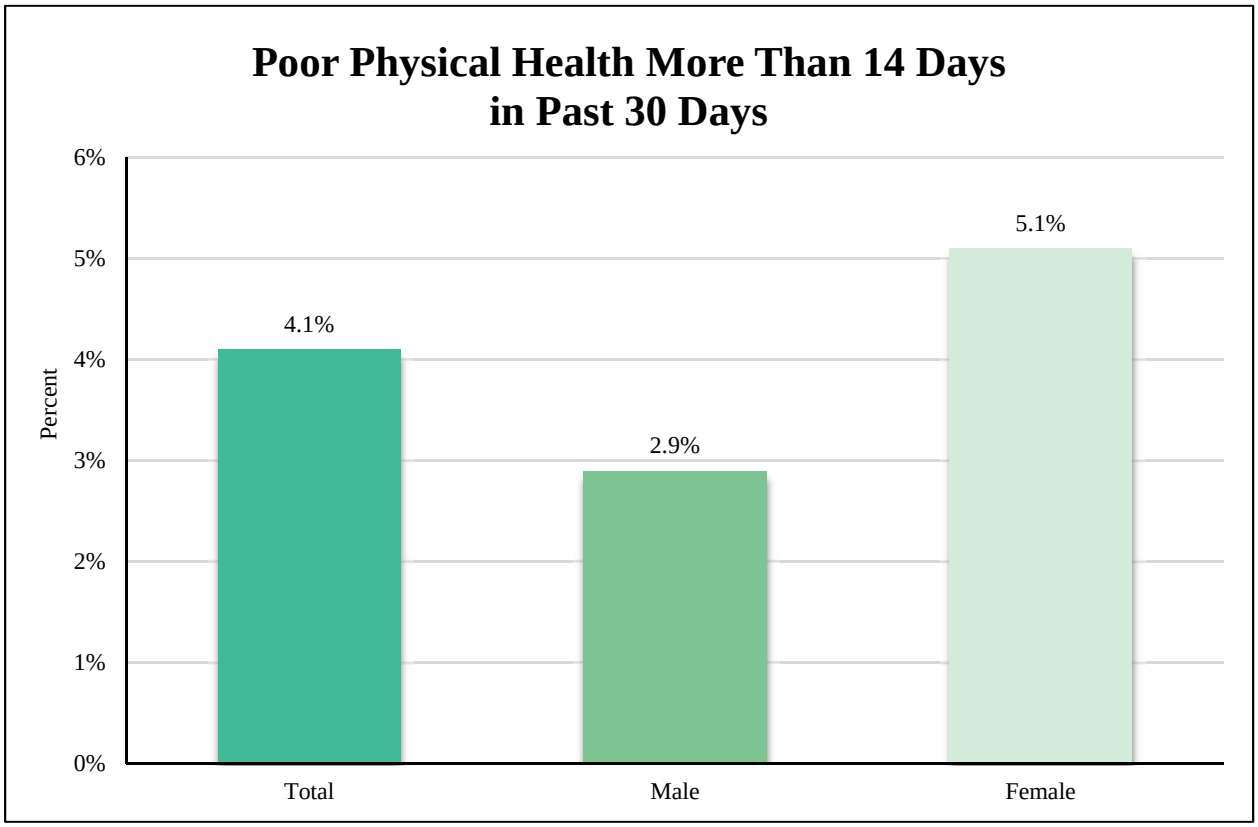
Poor Physical Health

Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

The below chart represents the proportion of Omaha refugees who reported that their physical health was not good on 14 or more of the past 30 days.

By Gender

- Approximately 4.1% of Omaha refugees reported that their physical health was poor on 14 or more of the past 30 days.
- Female refugees (5.1%) were 1.8 times more likely than male refugees (2.9%) to report their physical health was poor on 14 or more of the past 30 days.

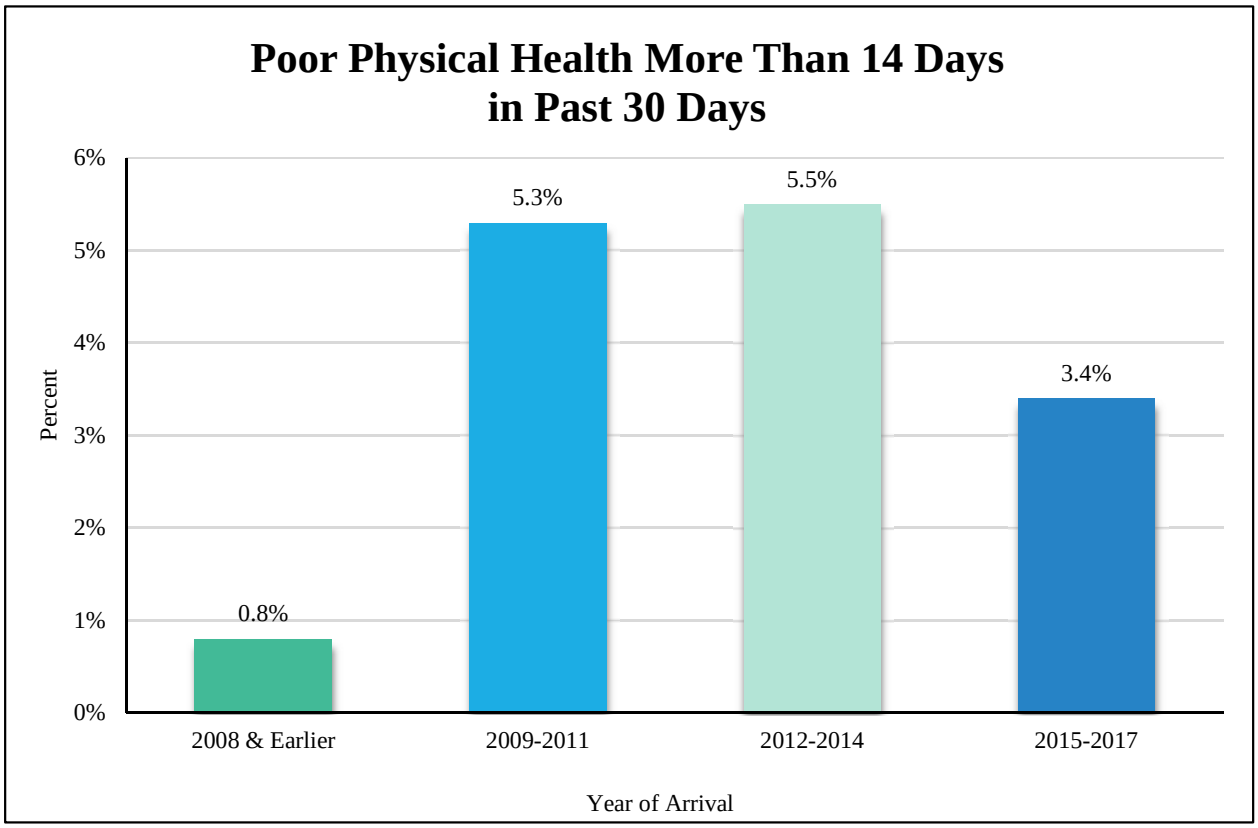


Poor Physical Health

The below chart represents the proportion of Omaha refugees who reported that their physical health was not good on 14 or more of the past 30 days.

By Year of Arrival

- In Omaha, refugees arriving in 2012-2014 (5.5%) were most likely to report poor physical health on 14 or more of the past 30 days, followed by refugees arriving in 2009-2011 (5.3%).
- Just 3.4% Omaha refugees arriving in 2015-2017 and 0.8% Omaha refugees arriving in 2008 and earlier reported being in poor physical health on 14 or more of the past 30 days.



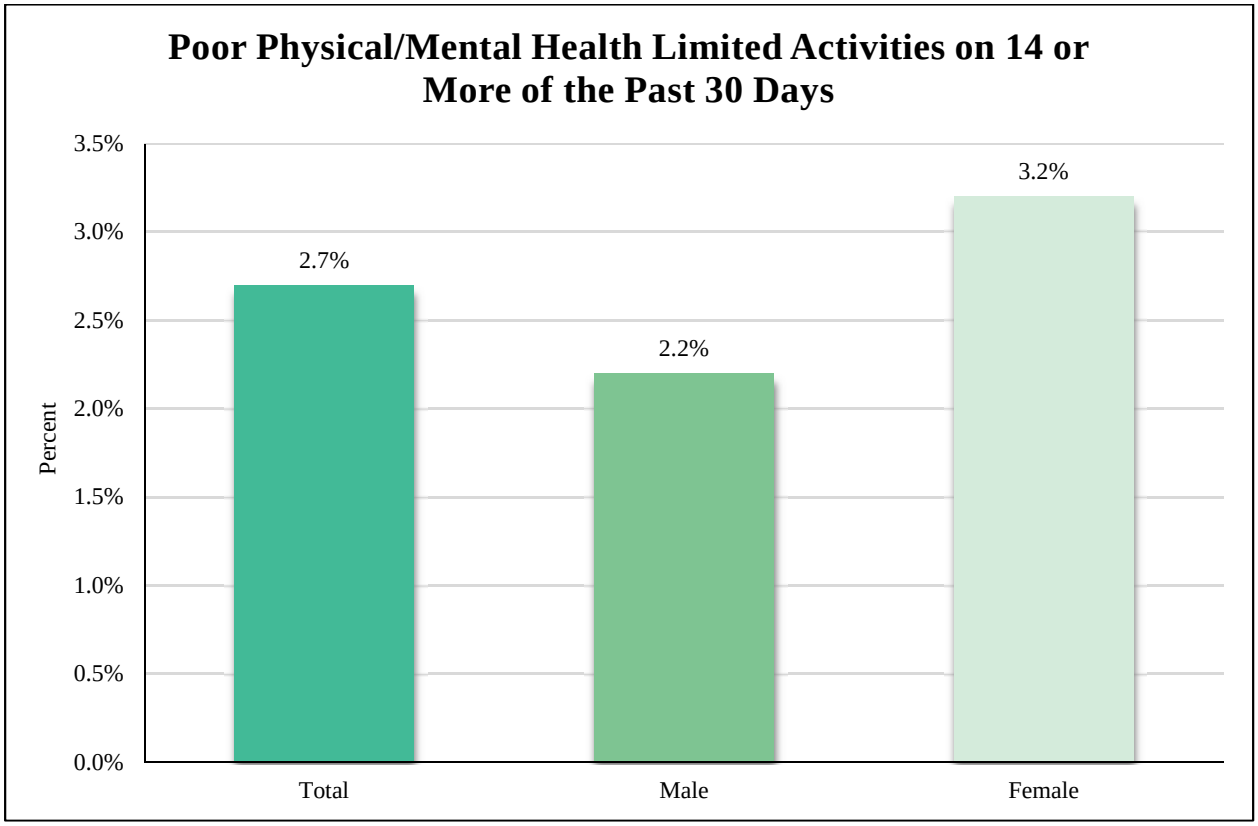
Activity Limitations

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or reaction?

The below chart represents the proportion of Omaha refugees who reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.

Key Findings by Gender

- Just 2.7% Omaha refugees reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.
- Female refugees (3.2%) were more likely than male refugees (2.2%) to report poor physical or mental health limited their usual activities on 14 or more of the past 30 days.

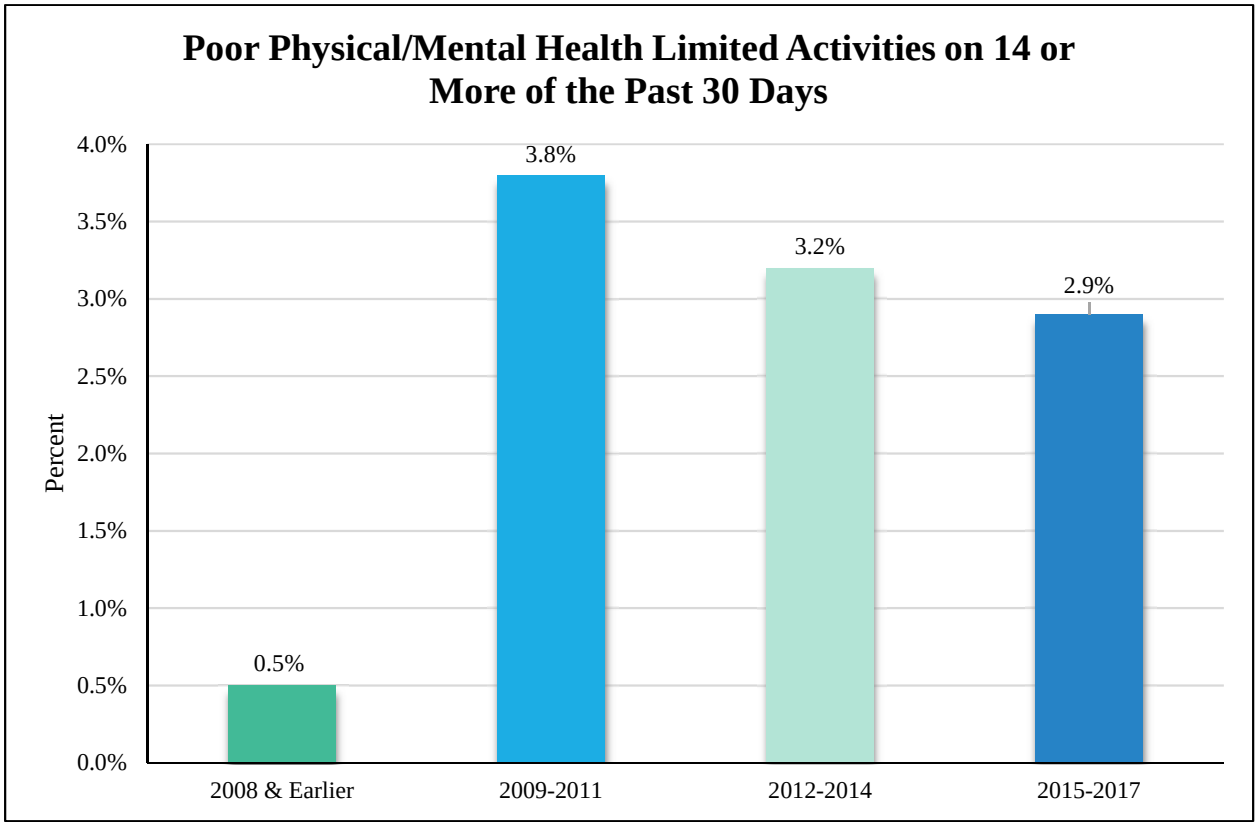


Activity Limitations

The below chart represents the proportion of Omaha refugees who reported that poor physical or mental health limited their usual activities on 14 or more of the past 30 days.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 were most likely to report that poor physical or mental health limited activities on 14 or more of the past 30 days at 3.8%. This percentage was almost 7.5 times that of the proportion of refugees arriving in 2008 and earlier (0.5%) to report the same.
- Omaha refugees arriving in 2012-2014 (3.2%) and 2015-2017 (2.9%) also were likely to report poor physical or mental health limited their activities on 14 or more of the past 30 days.



Access to Health Care

Before refugees arrive in the United States, they are subject to medical examinations as part of the application process. These examinations are used to identify any communicable diseases that may result in ineligibility for admission to the United States. These diseases include gonorrhea, infectious leprosy, infectious syphilis, and clinically active tuberculosis.[23] Once refugees arrive in the United States, the Office of Refugee Resettlement is responsible for a second medical screening and medical treatment as needed. In Nebraska, this screening process is administered by the Nebraska Department of Health and Human Services. This health screening generally occurs within the first 90 days after arrival and addresses any issues identified in the overseas medical exam, evaluates current health status, provides immunizations, and ensures that refugees are referred for follow-up when needed. [24]

In addition to these health screenings, refugees are often able to get short-term health insurance called Refugee Medical Assistance (RMA). However, this federally funded program is available only up to eight months from the date of admission.[25] Once the eight months is over, refugees who do not qualify for Medicaid must find another source of health insurance. While some refugees may be able to obtain health insurance through an employer, others must buy private health insurance, which can be expensive. Without education in the United States and with limited English proficiency, many refugees may find themselves in jobs without health insurance or unable to pay the premiums even with insurance. Among newly arrived refugees, even filling out paperwork can be a barrier to obtaining health care due to language and cultural barriers.

In addition to obtaining health insurance, refugees face other barriers to accessing health care. Language and communication barriers are often the biggest challenge and can affect all stages of accessing health care from making an appointment to understanding treatments and medicine.[26] While interpreters are required during visits to the doctor, this is not always the case and refugees may often use family members as interpreters.[27] In addition to language barriers, cultural beliefs may influence an individual's perspective on health care. For example, refugees may be unfamiliar with preventative care and less likely to use these types of health services. Furthermore, health professionals in the United States may have little experience in working with refugees and lack understanding of the unique health needs of refugees.

[23] U.S. Citizenship and Immigration Services. (2018). Admissibility. *In USCIS policy manual*. Washington, District of Columbia: U.S. Citizenship and Immigration Services.
[24] Nebraska Department of Health and Human Services. (2016). *Nebraska Refugee Health Screening Procedures.* Lincoln, NE: Nebraska Department of Health and Human Services
[25] Office of Refugee Resettlement. (2015). Health insurance. Retrieved from www.acf.hhs.gov/orr/health
[26] Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S. K., & Brouwer, K. C. (2009). *Journal of Community Health, 34*(6), 529-538.
[27] Title V of the Civil Rights Act of 1964, 42 U.S.C. (1964).

Omaha Refugee Population

Access to Health Care

46.2% Approximately half of Omaha refugees not having health care coverage of any kind.

49.4% Approximately half of Omaha refugees reported not having a personal physician.

17.6% Approximately 18% of Omaha refugees were unable to see a doctor due to cost in the past year.

Understanding Health Information

43.2% Approximately 45% of Omaha refugees had difficulty understanding information in English from health care providers.

51.7% Over half of Omaha refugees arriving in 2015-2017 had difficulty understanding information in English from health care providers.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

No Health Care Coverage

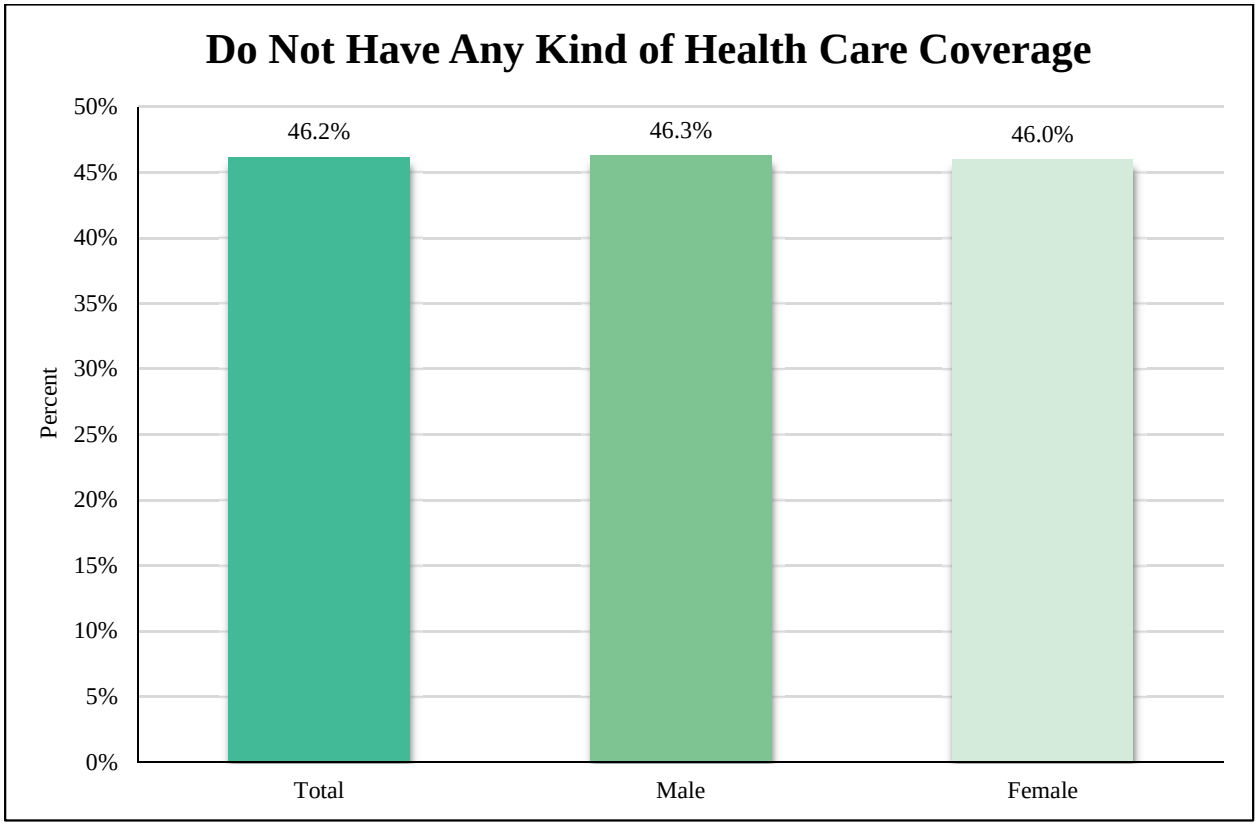
Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Services?

Individuals with health insurance are generally more likely to have a primary care provider and to have received appropriate preventative care, such as early prenatal care, immunizations, or health screenings.

The below chart represents the proportion of Omaha refugees surveyed age 18 and older who reported not having health care coverage.

By Gender

- Approximately half of Omaha refugees (46.2%) reported not having health care coverage.
- Similar percentages of Female refugees (46.0%) and male refugees (46.3%) reported not having health care coverage.

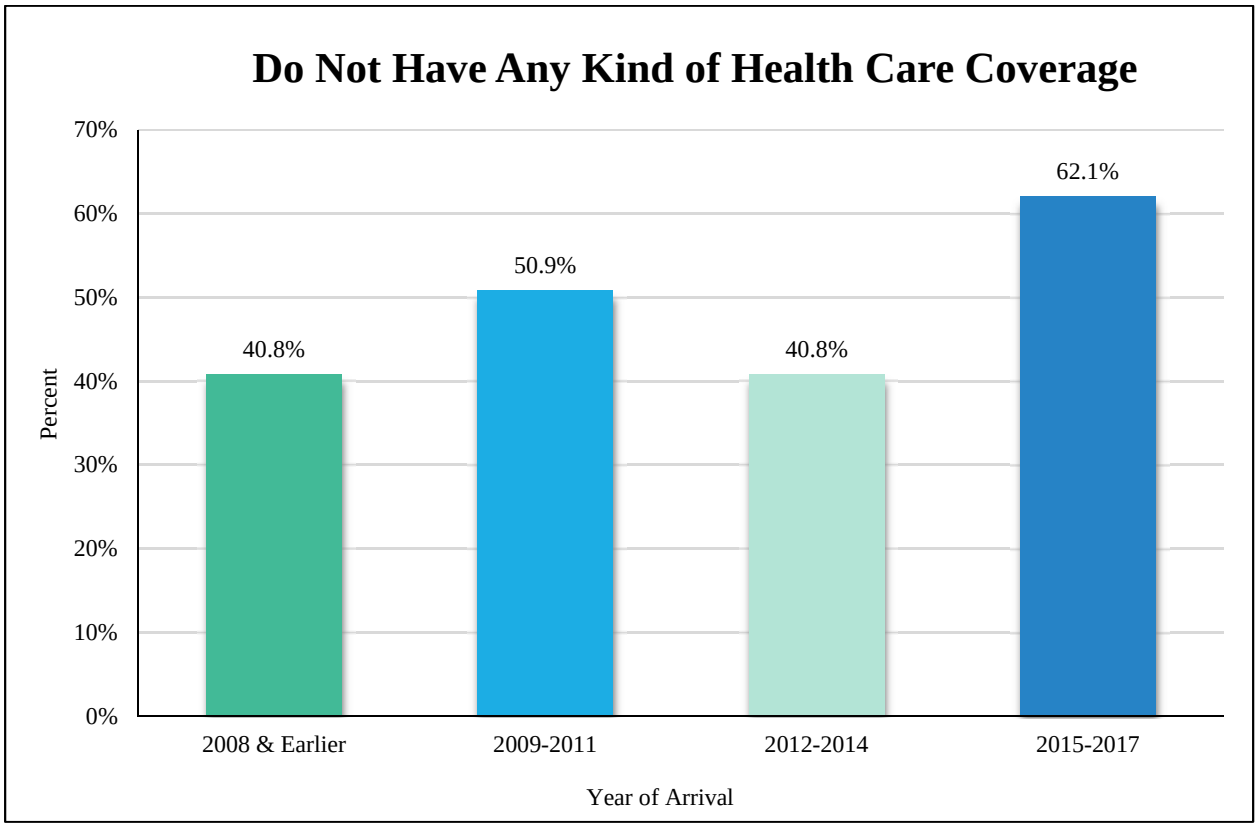


No Health Care Coverage

The below chart represents the proportion of Omaha refugees surveyed age 18 and older who reported not having health care coverage.

By Year of Arrival

- The most recently arrived group of refugees (2015-2017) were most likely to not have health care coverage at 62.1%, followed by those arriving in 2009-2011 (50.9%).
- Omaha refugees arriving in 2008 and earlier (40.8%) and refugees arriving in 2012-2014 (40.8%) were least likely to report not having health care coverage.



No Health Care Coverage (Age 18-64)

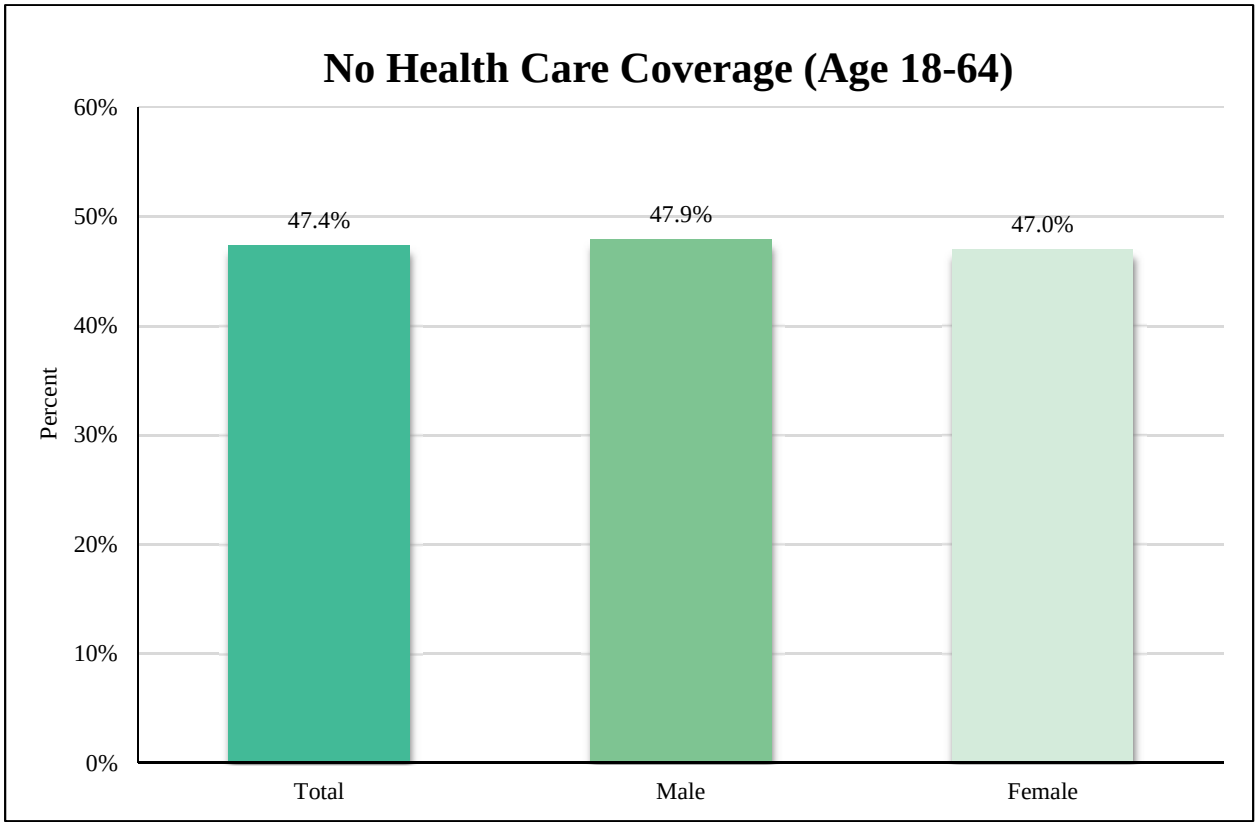
Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Services?

Individuals with health insurance are generally more likely to have a primary care provider and to have received appropriate preventative care, such as early prenatal care, immunizations, or health screenings.

The below chart represents the proportion of Omaha refugees surveyed age 18 to 64 who reported not having health care coverage.

By Gender

- Approximately half of Omaha refugees (47.4%) age 18 to 64 reported not having health care coverage.
- Similar percentages of female refugees (47.0%) and male refugees (47.9%) age 18 to 64 reported not having health care coverage.

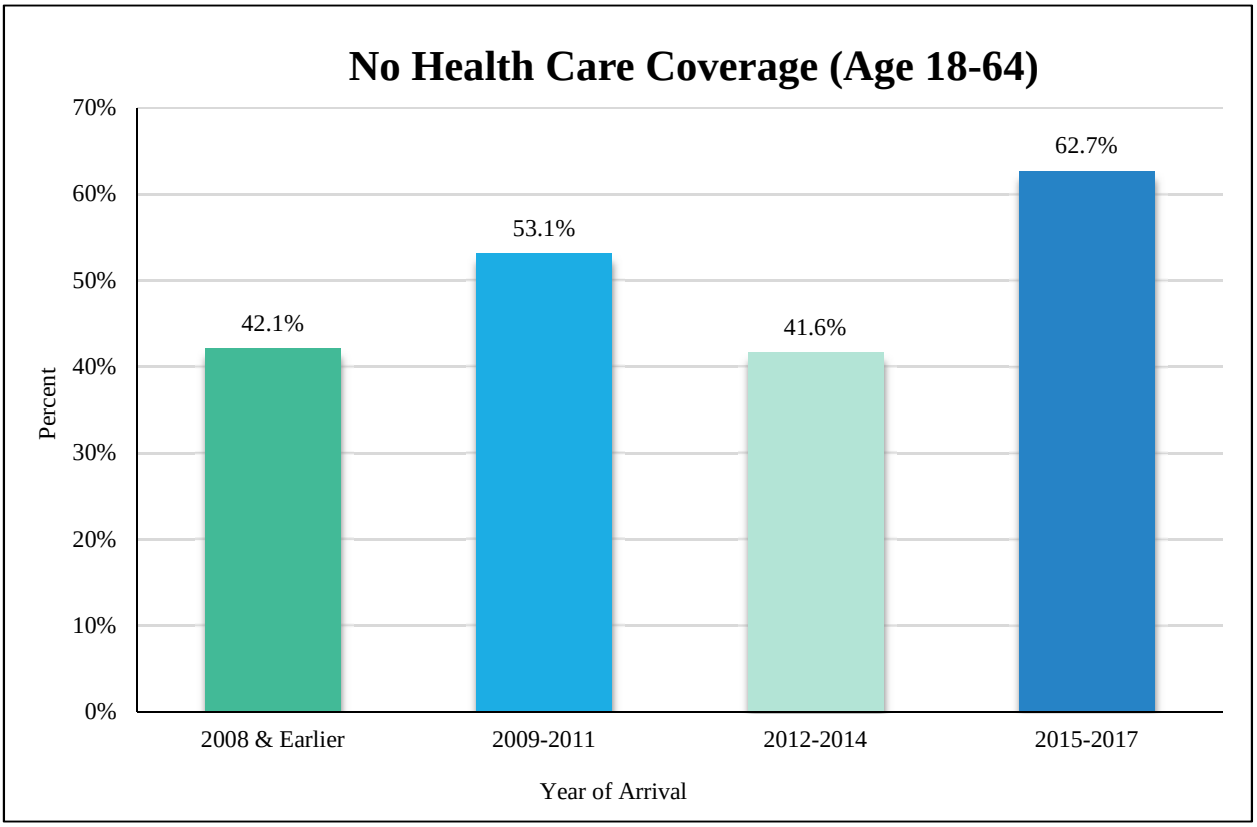


No Health Care Coverage (Age 18-64)

The below chart represents the proportion of Omaha refugees, age 18 to 64, who reported not having health care coverage.

By Year of Arrival

- For refugees (age 18 to 64) arriving in 2015-2017, 62.7% reported not having health care coverage and 53.1% of refugees arriving in 2009-2011 reported the same.
- Omaha refugees arriving in 2008 and earlier (42.1%) and refugees arriving in 2012-2014 (41.6%) were least likely to report not having health care coverage.



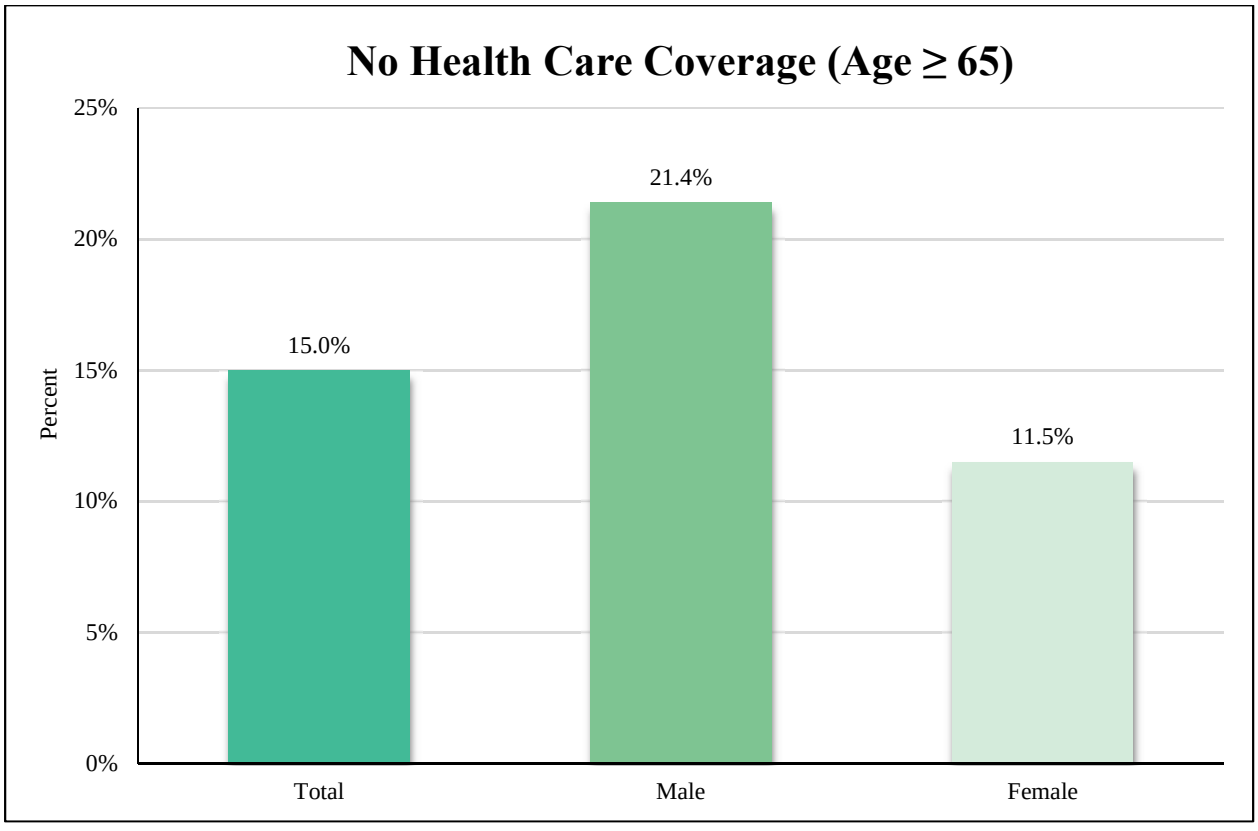
No Health Care Coverage (Age ≥ 65)

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Services?

The below chart represents the proportion of Omaha refugees, age 65 and older, who reported not having health care coverage.

By Gender

- Among Omaha refugees aged 65 and older, 15% reported not having health care coverage.
- In the age 65 and older age group, male refugees (21.4%) were approximately 1.9 times more likely than female refugees (11.5%) to report not having health care coverage.

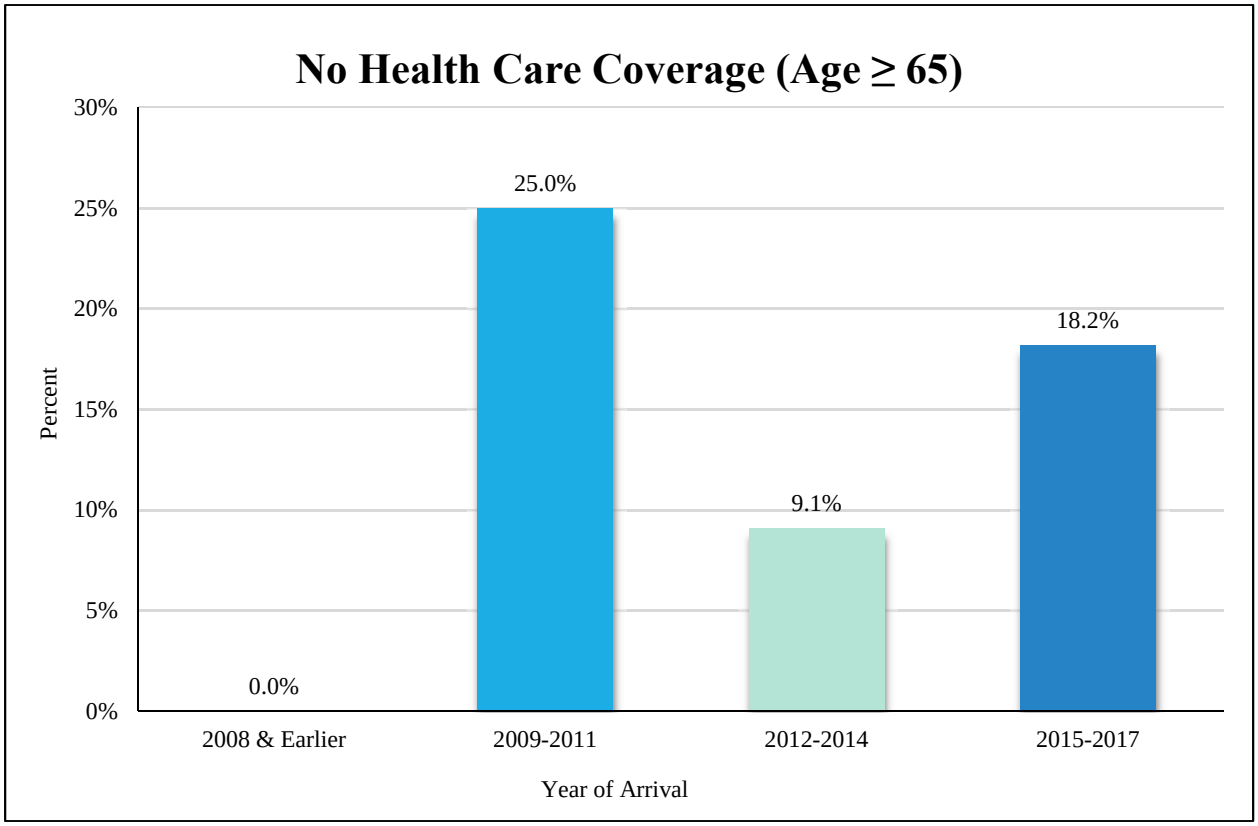


No Health Care Coverage (Age ≥ 65)

The below chart represents the proportion of Omaha refugees surveyed age 65 and older who reported not having health care coverage.

By Year of Arrival

- In Omaha, 18.2% refugees arriving in 2015-2017 age 65 and older reported not having health care coverage and 9.1% refugees arriving in 2012-2014 reported the same.
- Omaha refugees age 65 and older arriving in 2012-2014 (25.0%) were most likely to report not having health care coverage.



No Personal Physician

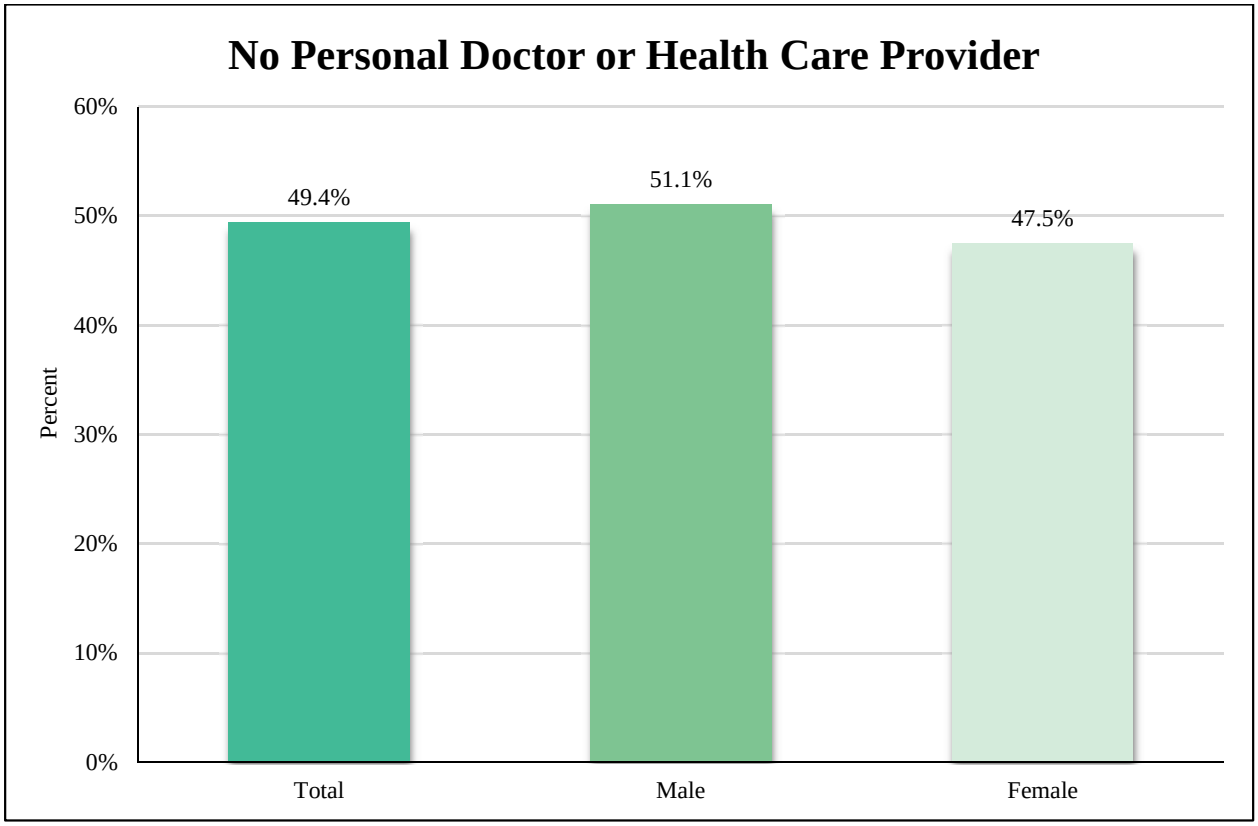
Do you have one person (or more than one person) you think of as your personal doctor or health care provider?

Primary care physicians provide a combination of direct care and, as necessary, counsel patients in the appropriate use of specialists and treatments. Individuals with a medical home are more likely to have routine medical visits and health screenings.[28]

The below chart represents the proportion of Omaha refugees who reported not having a personal doctor or health care provider.

By Gender

- Approximately half of Omaha refugees (49.4%) reported not having a personal doctor or health care provider.
- Male refugees (51.1%) were slightly more likely than female refugees (47.5%) to report not having a personal doctor or health care provider.



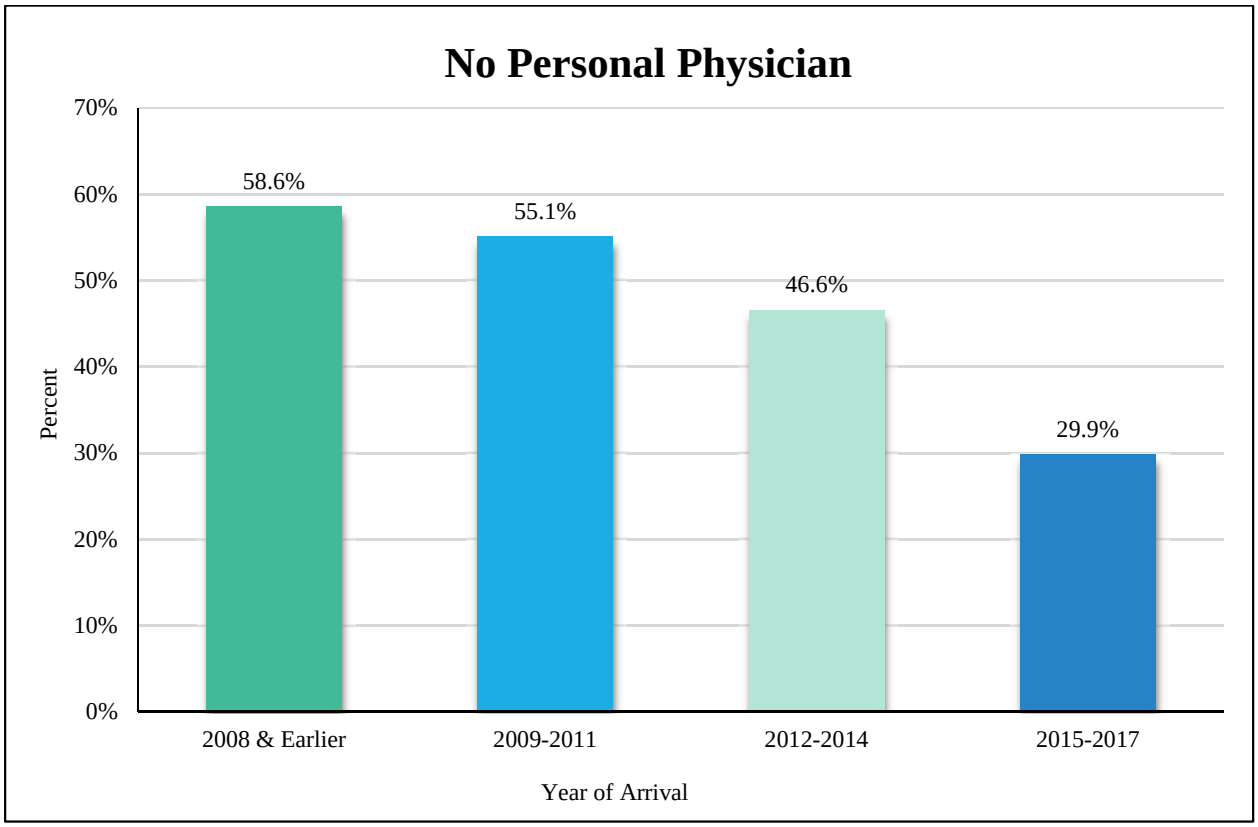
[28] National Institutes of Health. (2015). Choosing a primary care provider. Retrieved from https://medlineplus.gov/ency/article/001939.htm

No Personal Physician

The below chart represents the proportion of Omaha refugees who reported not having a personal doctor or health care provider.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (29.9%) were less likely to report not having a personal doctor or health care provider.
- The likelihood of not having a personal doctor or health care provider increased with length of stay in the U. S. Refugees arriving in 2008 and earlier (58.6%) were most likely to report not having a personal doctor or health care provider.
- Approximately half of Omaha refugees arriving in 2009-2011 (55.1%) reported not having a personal doctor or health care provider and 46.6% of refugees arriving in 2012-2014 reported the same.



Unable to See Physician Due to Cost

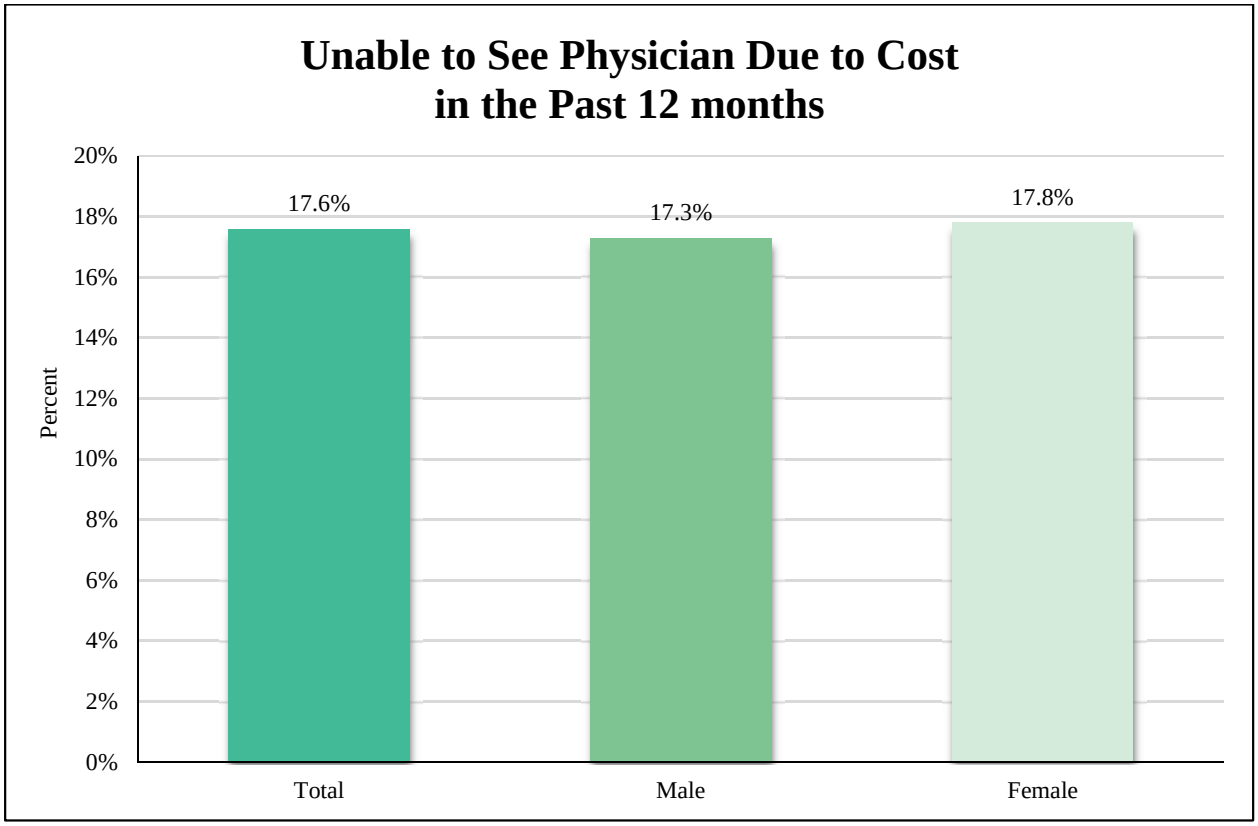
Was there a time in the past 12 months when you needed to see a doctor, but could not because of cost?

For people with no insurance and limited financial resources, the decision of whether or not to see a doctor is often a financial choice rather than a medical one. Even when health benefits are available, they may not be sufficient to ensure access to needed health care services.

The below chart represents the proportion of Omaha refugees who reported being unable to see a doctor due to cost in the past 12 months.

By Gender

- In Omaha, 17.6% refugees reported being unable to see a physician due to cost at least once in the past 12 months.
- Male refugees (17.3%) were as likely as female refugees (17.8%) to report being unable to see a physician due to cost in the past 12 months.

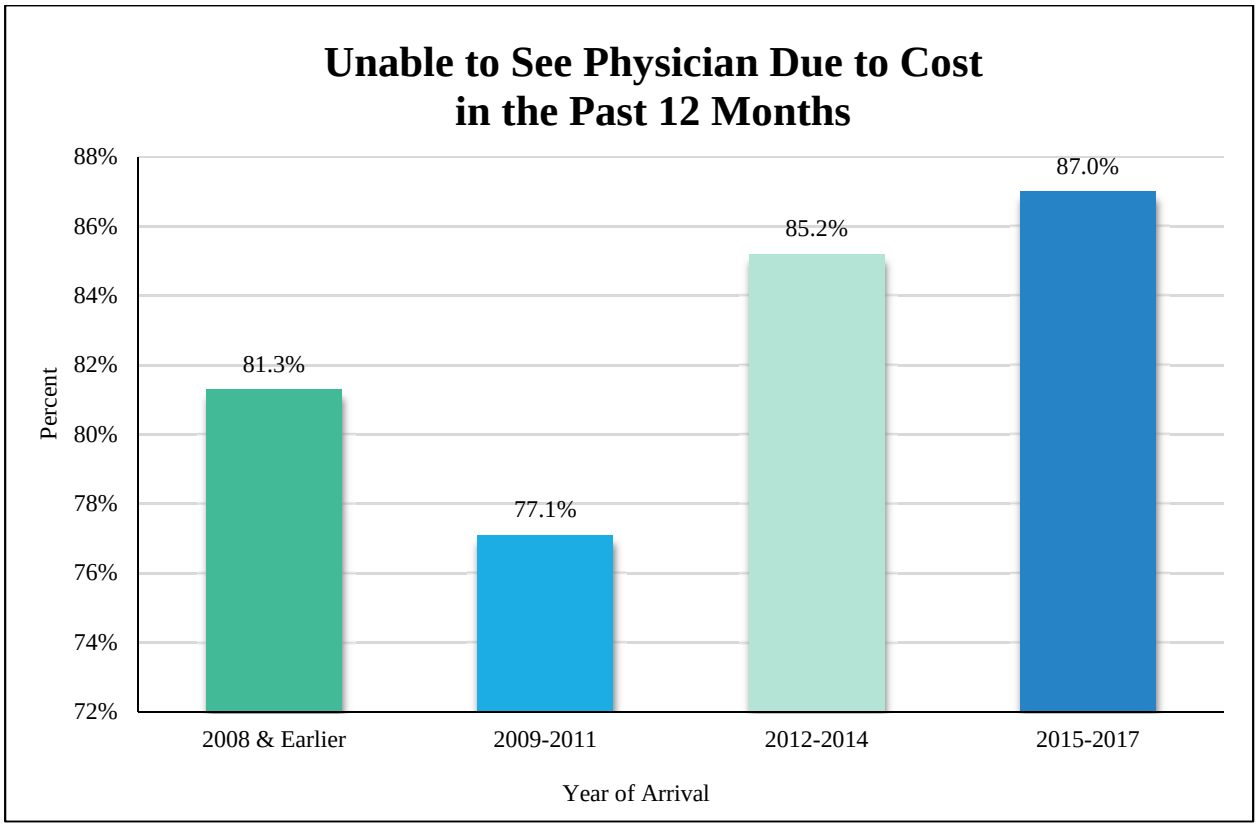


Unable to See a Physician Due to Cost

The below chart represents the proportion of Omaha refugees who reported being unable to see a doctor due to cost in the past 12 months.

By Year of Arrival

- All Omaha refugee arrival groups reported not being able to see a physician due to cost in the past 12 months.
- Omaha refugees arriving in 2015-2017 (87%) were most likely to report being unable to see a physician due to cost, followed by those arriving in 2012-2014 (85.2%) and 2008 and earlier (81.3%).
- Omaha refugees arriving in 2009-2011 (77.1%) were least likely to report being unable to see a physician due to cost.



Medicaid as Primary Source of Health Care Coverage

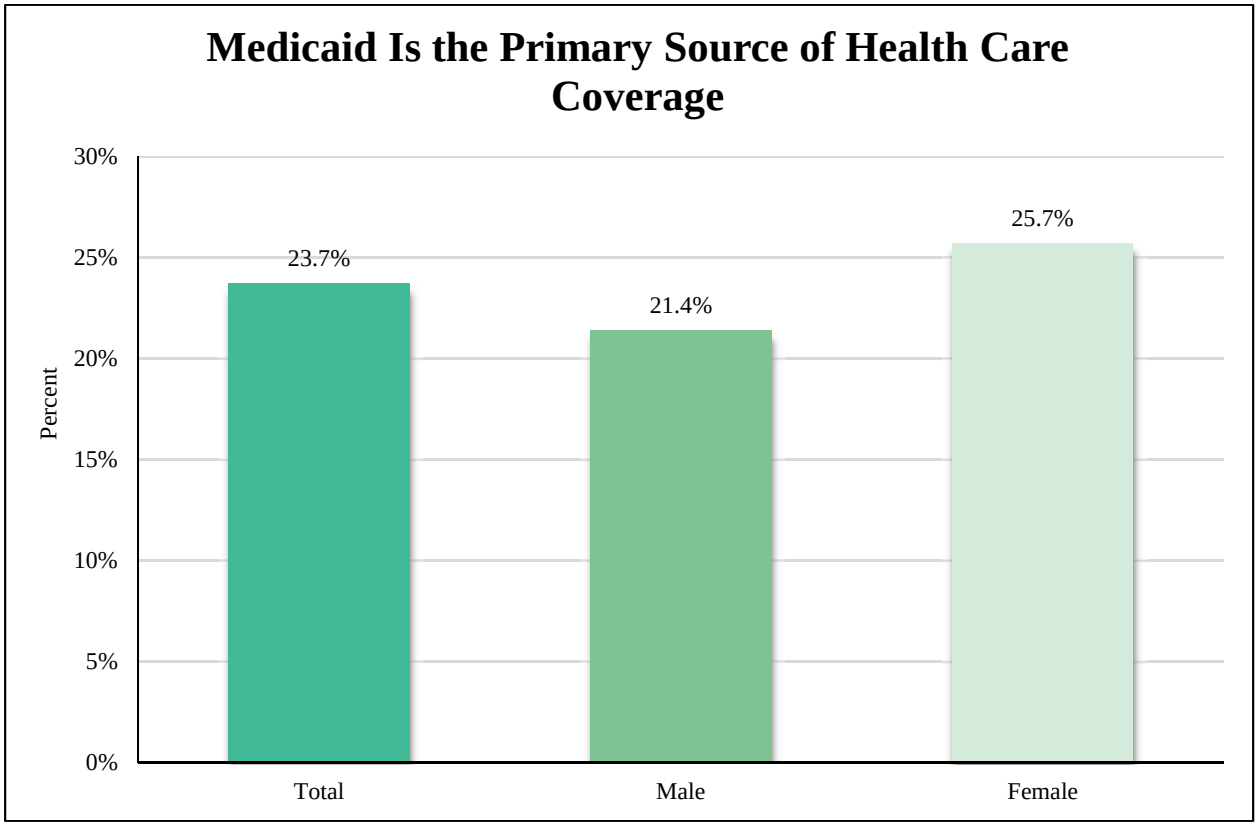
What is the primary source of your health care coverage?

Individuals with health insurance are generally more likely to have a primary care provider and to have received appropriate preventative care, such as early prenatal care, immunizations, or health screenings. Medicaid in the United States is a federal and state program that helps with medical costs for some people with limited income and resources.

The below chart represents the proportion of Omaha refugees who reported Medicaid as their primary source of health care coverage.

By Gender

- Approximately one-quarter of Omaha refugees (23.7%) reported Medicaid as their primary source of health care coverage.
- Female refugees (25.7%) were slightly more likely than Male refugees (21.4%) to report Medicaid as their primary source of health care coverage.

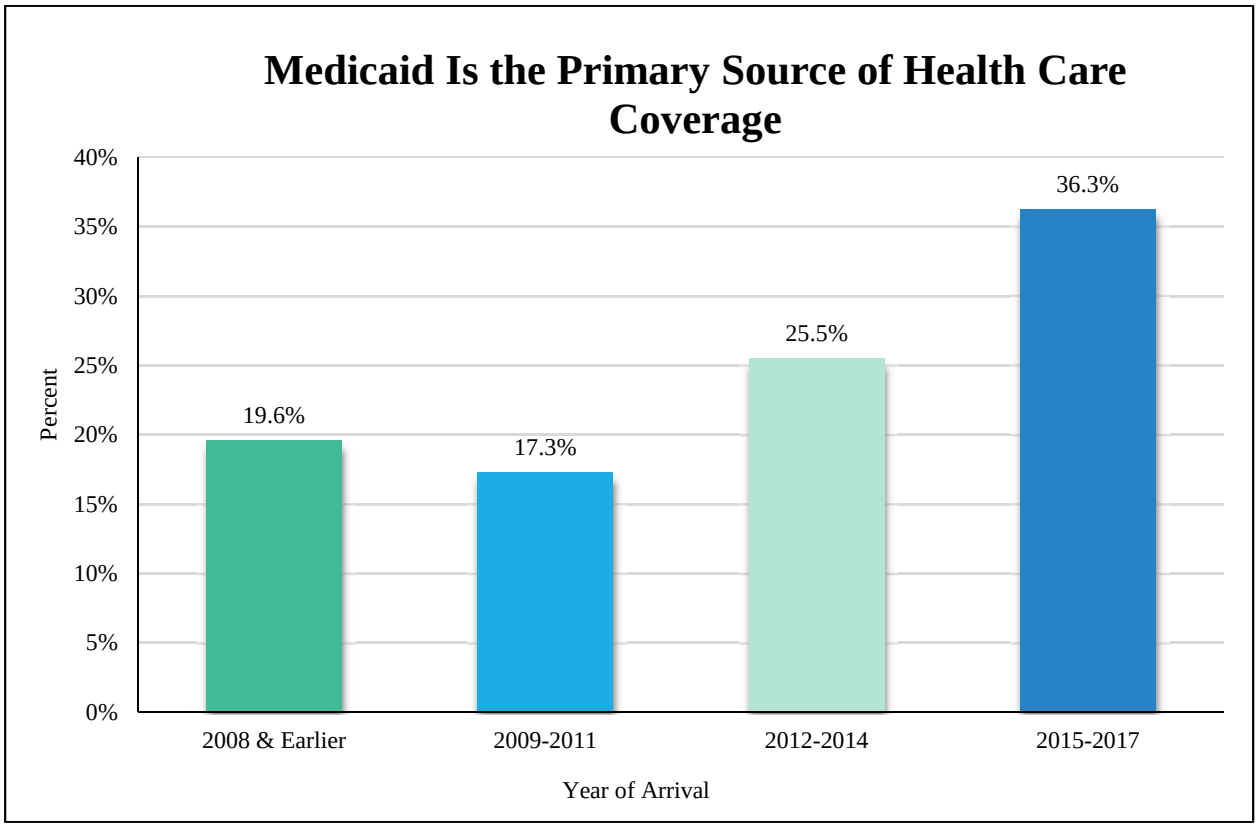


Medicaid as Primary Source of Health Care Coverage

The below chart represents the proportion of Omaha refugees who reported Medicaid as their primary source of health coverage.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (36.3%) were most likely to report Medicaid as their primary source of health care coverage.
- Omaha refugees arriving in 2009-2011 (17.3%) were least likely to report Medicaid as their primary source of health care coverage.
- The percentage of Omaha refugees reporting Medicaid as their primary source of health care coverage increased from Omaha refugees arriving in 2008 & earlier to arriving in 2015-2017.



Understanding Health Information

How difficult is it for you to understand information that doctors, nurses, and other health professionals tell you in English?

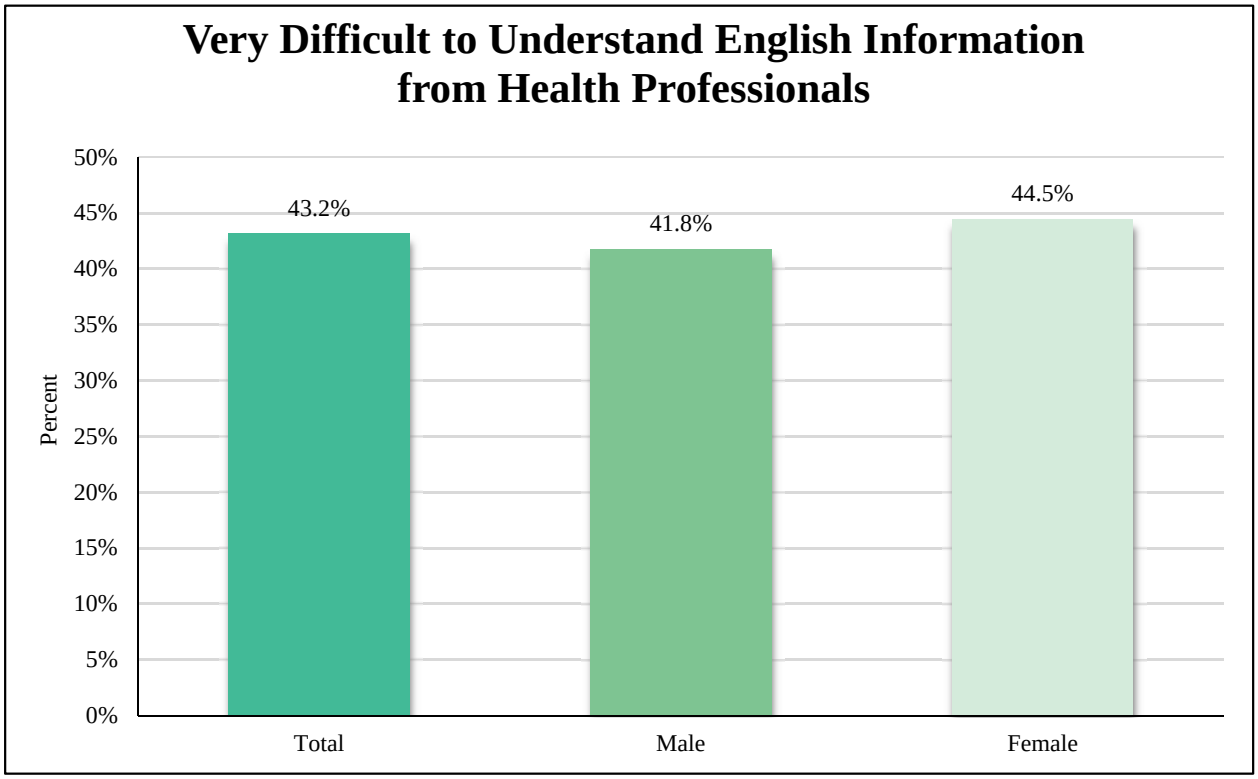
Very Easy • Somewhat Easy • Somewhat Difficult • Very Difficult

Health literacy is defined as "the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions."[29] Having the ability to understand spoken health information in English is essential to receiving necessary and adequate health care in Nebraska.

The below chart represents the proportion of Omaha refugees who reported it being very difficult to understand spoken health information in English from health professionals.

By Gender

- Just under half of Omaha refugees (43.2%) reported that it is very difficult to understand verbal information in English from health care professionals.
- Female refugees (44.5%) were somewhat more likely than male refugees (41.8%) to report it being very difficult to understand verbal information in English from health care professionals.



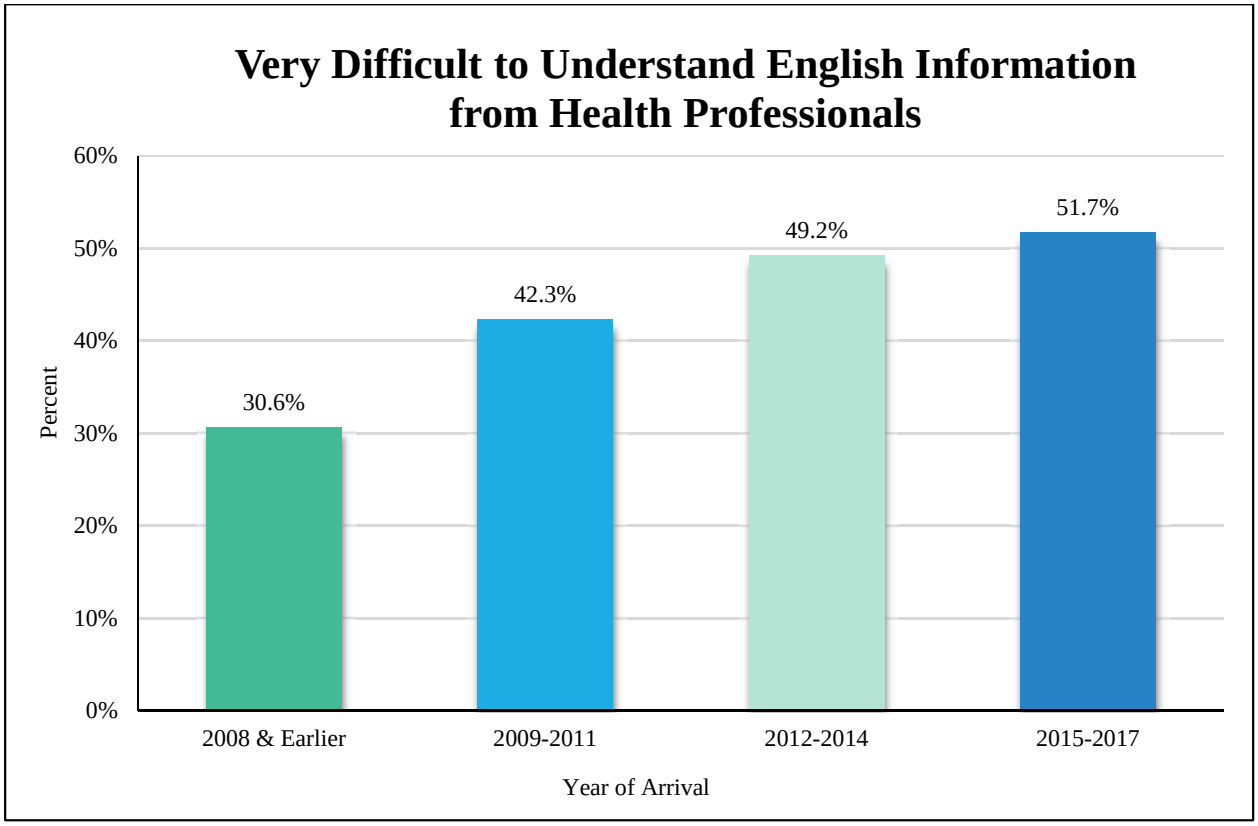
[29] Title V of the Patient Protection and Affordable Care Act, 42 U.S.C. § 5002 (2010).

Understanding Health Information

The below chart represents the proportion of Omaha refugees who reported it being very difficult to understand spoken health information in English from health professionals.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (51.7%) were most likely to report it being very difficult to understand verbal information from health care professionals, followed closely by those arriving in 2012-2014 (49.2%).
- Approximately half of Omaha refugees arriving in 2012-2014 (49.2%) and 2009-2011 (42.3%) reported it being very difficult to understand verbal information form health care professionals.
- Just under two-thirds of Omaha refugees arriving in 2008 and earlier (30.6%) were by far the least likely population to report having difficulty understanding verbal information from health care professionals.
- The percentage of reporting being very difficult to understand verbal information from health care professionals increased from Omaha refugees arriving in 2008 and earlier to refugees arriving in 2015-2017.



Understanding Written Health Information

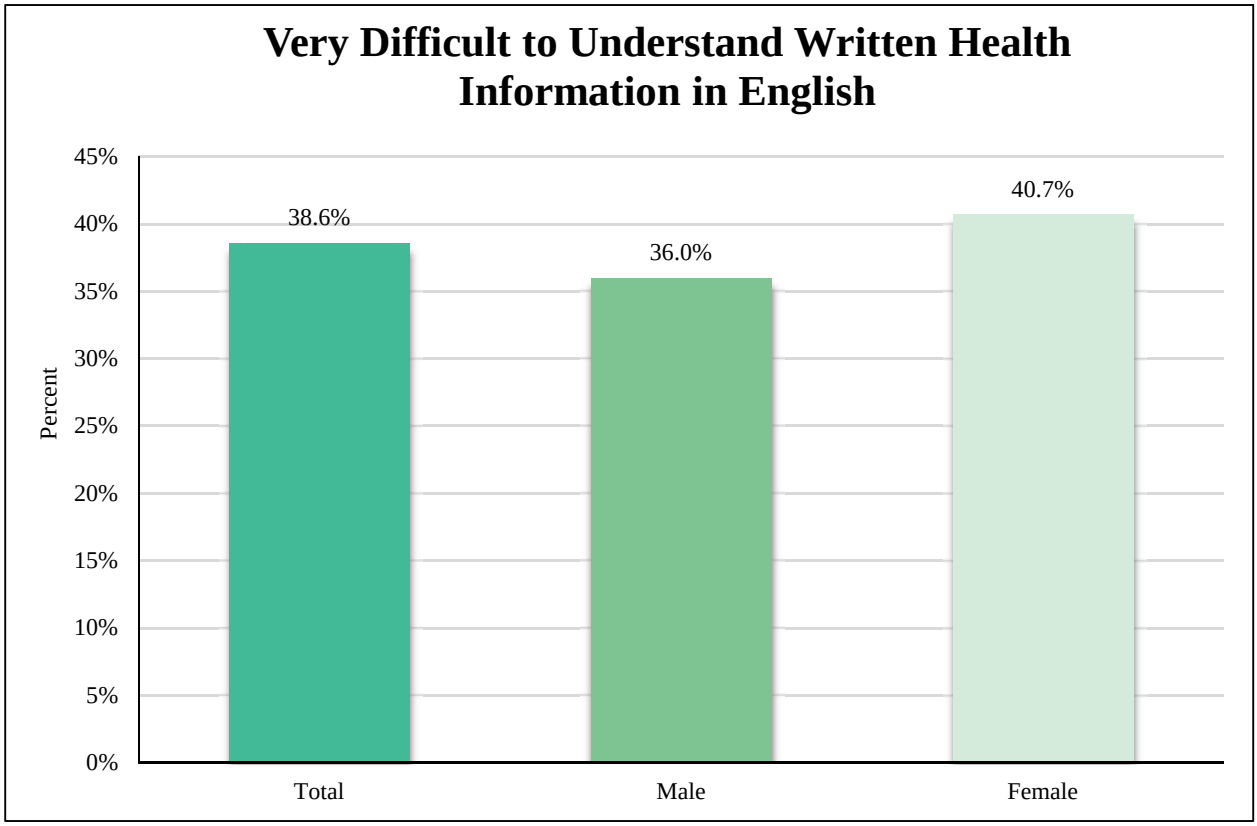
You can find written information about health on the internet, in newspapers and magazines, and in brochures in the doctor's office and clinic. In general, how difficult is it for you to understand written health information in English?

Very Easy • Somewhat Easy • Somewhat Difficult • Very Difficult

The below chart represents the proportion of Omaha refugees who reported it being very difficult to understand written health information in English.

By Gender

- In Omaha, 38.6% refugees reported it being very difficult to understand written health information in English.
- Female refugees (40.7%) were more likely than were male refugees (36.0%) to report it being very difficult to understand written health information in English.

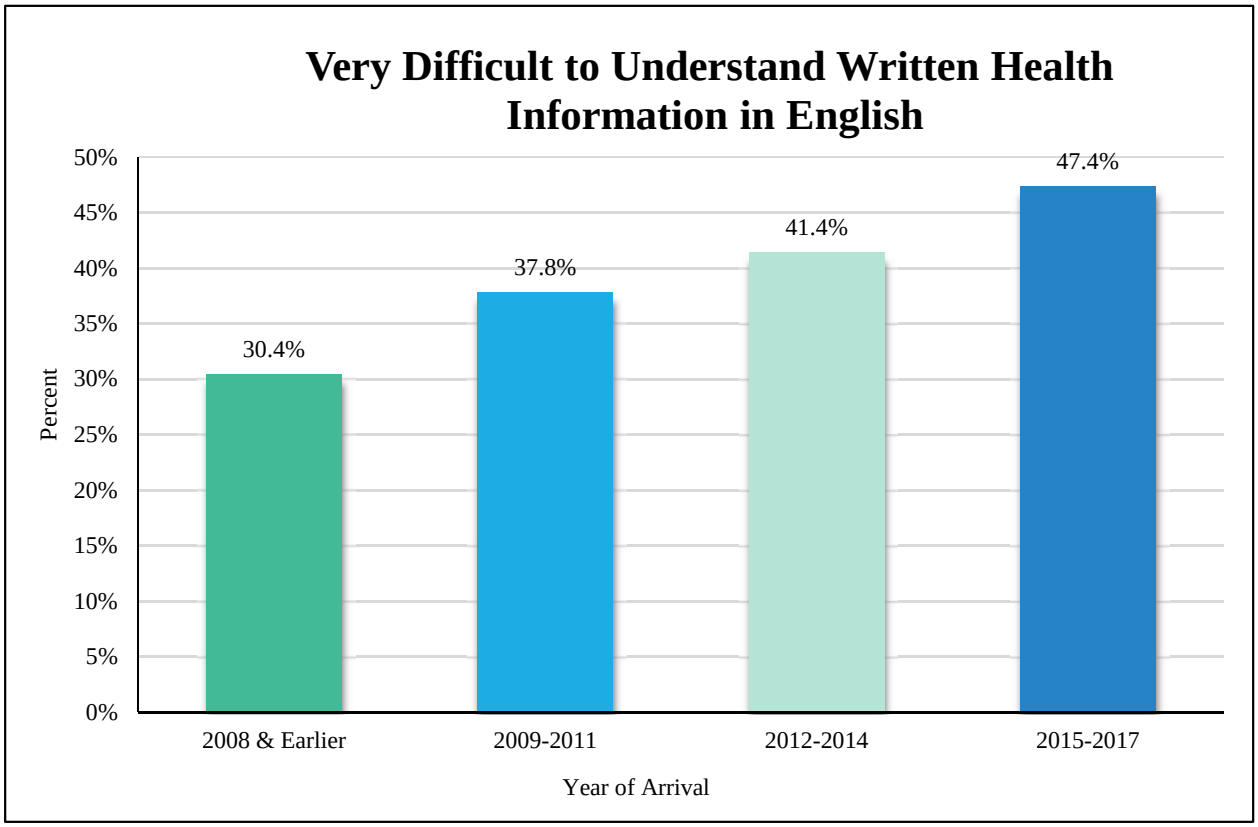


Understanding Written Health Information

The below chart represents the proportion of Omaha refugees who reported it being very difficult to understand written health information in English.

By Year of Arrival

- Just under half of Omaha refugees arriving in 2015-2017 (47.4%) were the most likely population to report having difficulty understanding written health information in English. This percentage was 1.6 times more than that of Omaha refugees arriving in 2008 and earlier (30.4%).
- Similar percentages of Omaha refugees arriving in 2012-2014 (41.4%) and Omaha refugees arriving in 2009-2011 (37.9%) reported having difficulty understanding written health information in English.
- The percentage of reporting being very difficult to understand written health information in English increased from Omaha refugees arriving in 2008 and earlier to refugees arriving in 2015-2017.



Family Member Interpretation

When you visit the doctor, if you need an interpreter is someone –

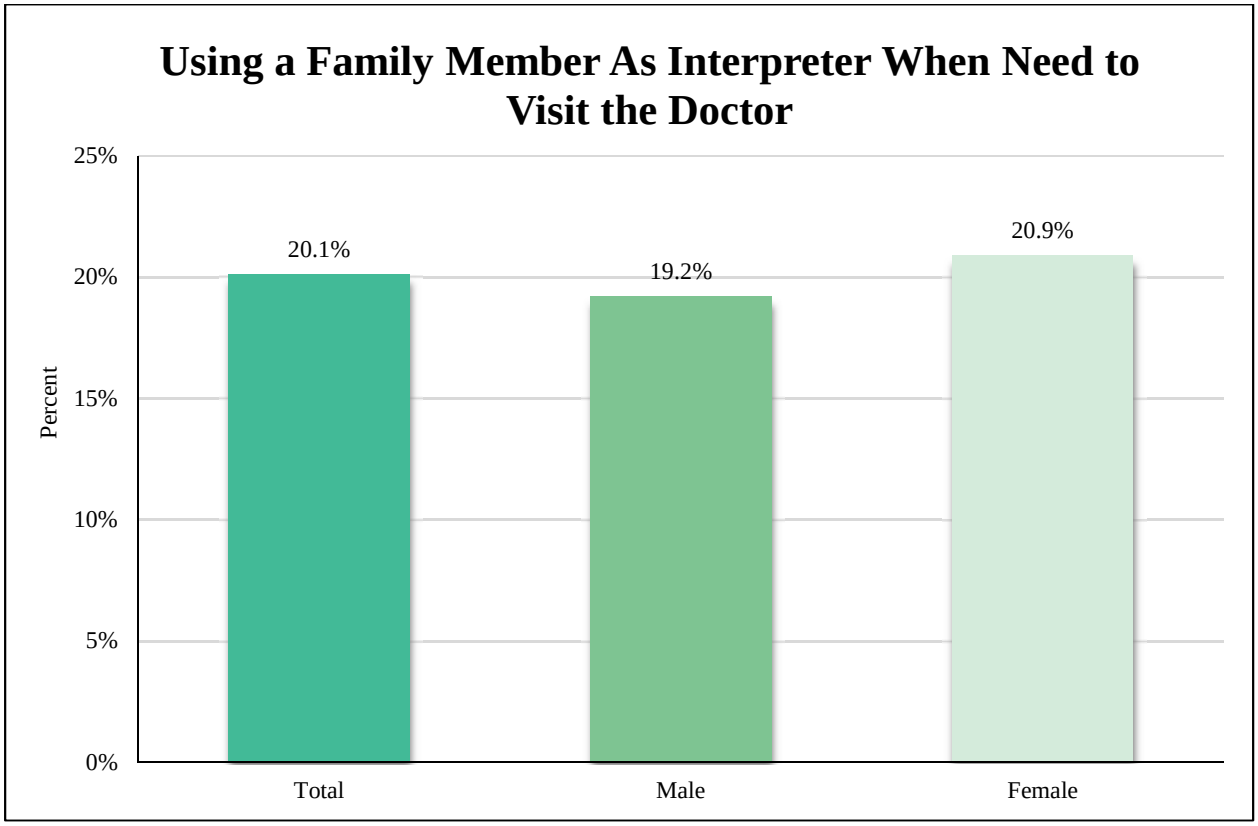
No interpreter • Family member • One is provided in person • One is provided by phone • Unsure • Refused

Using family members for medical interpretation has several disadvantages. Family members are not impartial and may not be able to accurately interpret medical information, in part due to a lack of knowledge of medical terminology and issues. Using a qualified medical interpreter is important for patients to receive an accurate diagnosis and treatment information.

The below chart represents the proportion of Omaha refugees who reported using a family member as their interpreter when visiting a doctor.

By Gender

- Approximately 20% of Omaha refugees reported using a family member as an interpreter when visiting a doctor.
- Similar percentages of male refugees (19.2%) and female refugees (20.9%) reported using a family member as an interpreter when visiting a doctor.

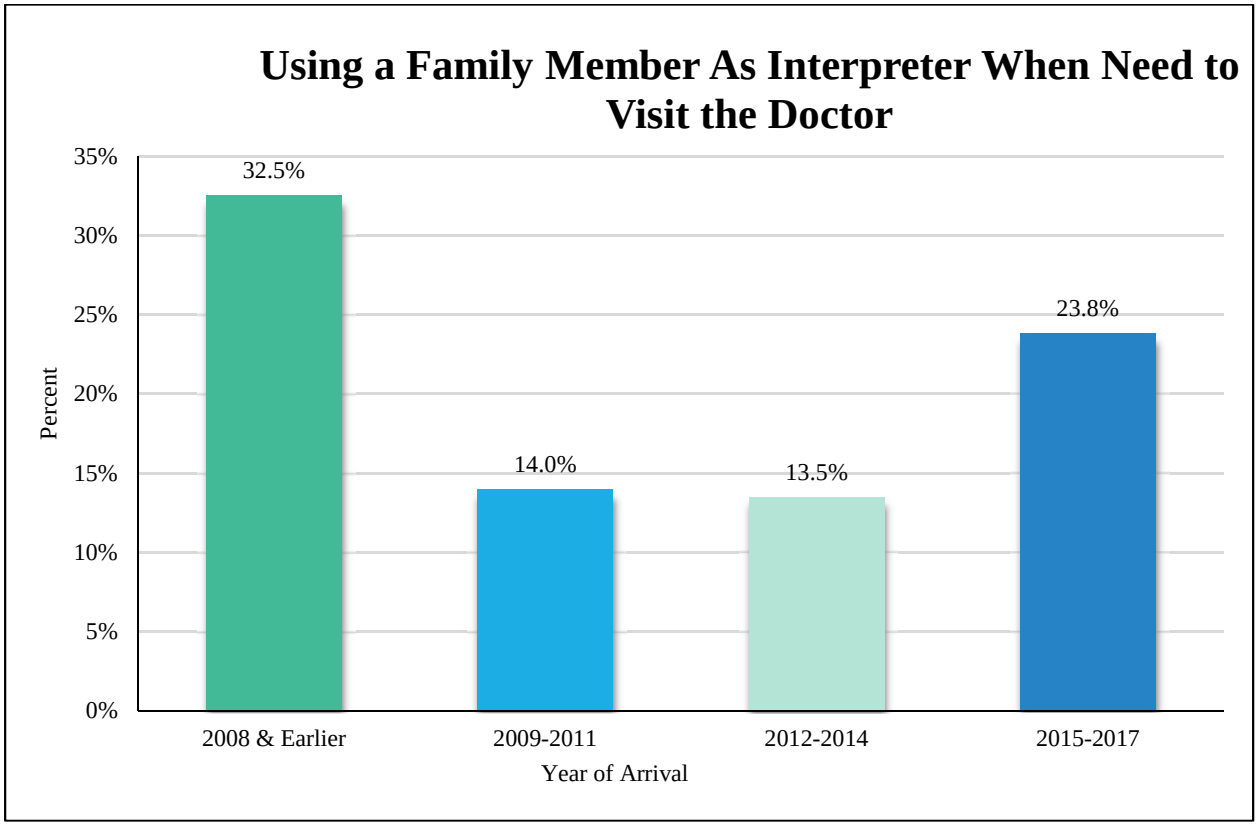


Family Member Interpretation

The below chart represents the proportion of Omaha refugees who reported using a family member as their interpreter when visiting a doctor.

By Year of Arrival

- In Omaha, refugees arriving in 2008 and earlier (32.5%) were the most likely population to report using a family member as an interpreter when visiting a doctor. This percentage was more than twice that of the least likely population to report the same – refugees arriving in 2012-2014 (13.5%)
- Omaha refugees arriving in 2015-2017 (23.8%) and arriving in 2009-2011 (14.0%) reported using a family member as an interpreter when visiting a doctor.



Chronic Disease

The majority of research surrounding refugee health concentrates on health prior to resettlement and focuses on infectious disease. Limited data exists on the prevalence of chronic non-communicable diseases and associated risk factors among refugees. To adequately assist refugees in settling in and thriving in their new communities, post-resettlement health issues, and particularly chronic disease prevalence, must also be considered.

Though more research is needed, recent studies have shown that refugees may be entering the United States with preexisting chronic conditions at a higher rate than previously thought, namely, with diabetes and hypertension.[30,31] One study attributed the prevalence of diabetes among refugees to a history of trauma and malnutrition, various socioeconomic factors, and health care systems that are not accustomed to treating their complex issues.[32] Upon arrival in the United States, these issues may not be a priority for refugees who often face more immediate concerns, including finding housing and employment.

A recent study also showed that diabetes and hypertension increased significantly among refugees with increasing length of stay in the United States.[33] This correlation between the development of chronic diseases and length of residence in the United States is a relatively new topic that needs further exploration. Circumstances unique to resettled refugees should be considered when examining chronic disease. For example, barriers to accessing health care and cultural beliefs surrounding health may contribute to refugees' willingness to seek diagnoses and treatment. Additionally, as length of stay in the United States increases, refugees may adopt unhealthy lifestyle habits as a part of acculturation. These habits, such as alcohol consumption, unhealthy eating habits, and smoking can increase an individual's risk for chronic disease.[34]

Refugees are also less likely to have health insurance and chronic disease generally requires long-term treatment. Left untreated, chronic disease can cause serious complications and even death. Additionally, chronic disease can hinder an individual's ability to work. Both early detection and access to treatment will be essential in managing chronic diseases among refugees. The following section aims to address the gap in chronic disease data among refugees by identifying the prevalence of certain chronic diseases among the top refugee populations in Nebraska.

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[30] Yun, K., Hebrank, K., Graber, L., Sullivan, M., Chen, I., & Gupta, J. (2012). High prevalence of chronic non-communicable conditions among adult refugees: implications for practice and policy. *Journal of Community Health, 37*(5), 1110-1118.
[31] Doocy, S., Lyles, E., Roberton, T., Akhu-Zaheya, L., Oweis, A., & Burnham, G. (2015). Prevalence and care-seeking for chronic diseases among Syrian refugees in Jordan. *Conflict and Health, 10*(21).
[32] Wagner, J., Berthold, S.M., Buckley, T., & Scully, M. (2015) Diabetes among refugee populations: what newly arriving refugees can learn from resettled Cambodians. *Current Diabetes Reports, 15*(8), 618.
[33] Golub, N., Seplaki, C., Stockman, D., Thevenet-Morrison, K., Fernandez, D., & Fisher, S. (2017). *Journal of Immigrant and Minority Health, 20*(2), 296-306.
[34] Hunter, P. (2016). The refugee crisis challenges national health care systems. *EMBO Reports, 17*(4), 492-495.

Omaha Refugee Population

Chronic Disease

6.0% Six percent of Omaha refugees had been diagnosed with high cholesterol.

Male refugees reported higher rates of heart attack, coronary heart disease, stroke, asthma, COPD, kidney disease, and high blood cholesterol than female refugees.

1.6x Female refugees (7.1%) were more likely than male refugees (4.3%) to have ever been diagnosed with diabetes.

Chronic Disease by Year of Arrival

3.3x Refugees arriving in 2008 and earlier (7.2%) were more likely than refugees arriving in 2015-2017 (2.2%) to have ever been diagnosed with high blood cholesterol.

1.9x Refugees arriving in 2008 and earlier (2.5%) were almost twice as likely as refugees arriving in 2015-2017 (1.3%) to have ever been diagnosed with coronary heart disease.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

High Cholesterol

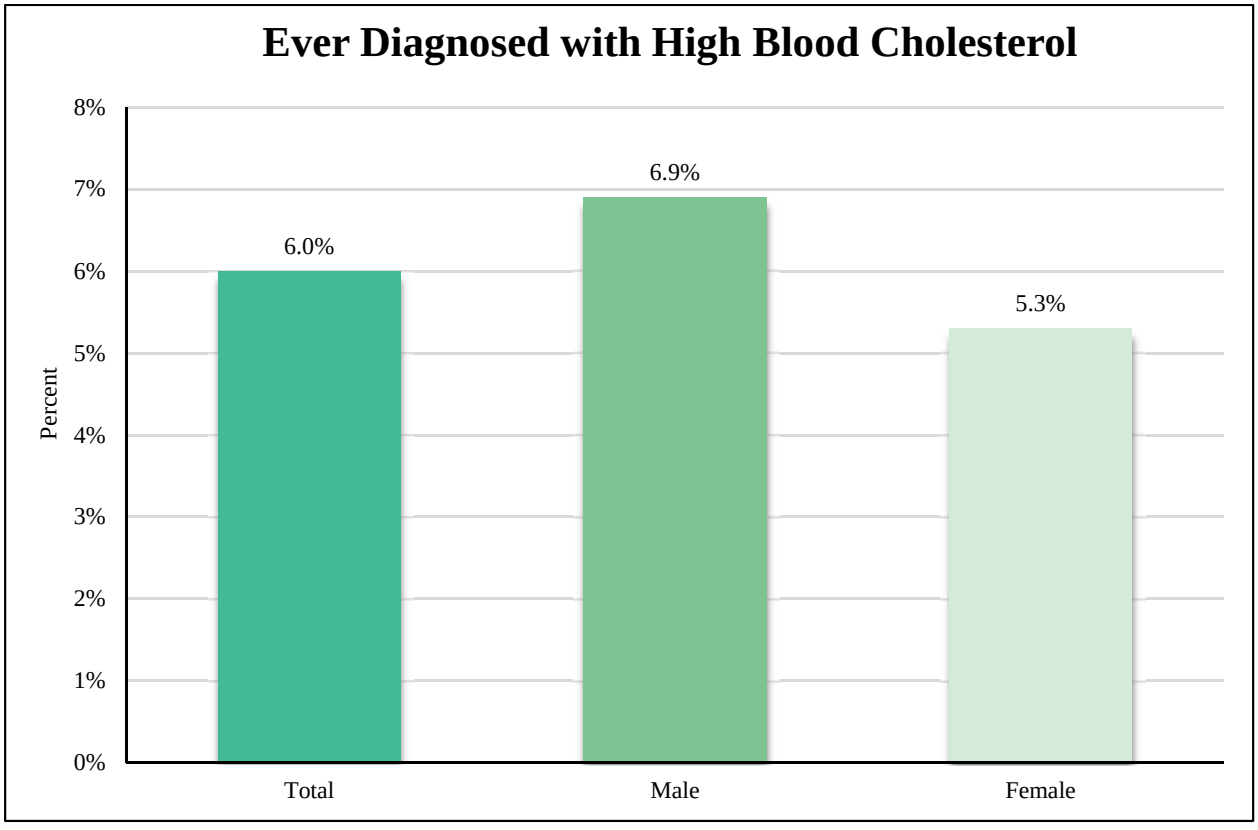
Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?

High cholesterol occurs when low-density lipoprotein (LDL) levels are high. LDL, often called bad cholesterol, makes up most of the body's cholesterol. An estimated 73.5 million adults in the United States (31.7%) have high LDL, or high cholesterol.[35] Health conditions, lifestyle, and family history are the most common factors that can increase the risk of high cholesterol.[36]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with high cholesterol.

Key Findings by Gender

- Six percent of Omaha refugees reported having ever been diagnosed with high cholesterol.
- Male refugees (6.9%) were slightly more likely than female refugees (5.3%) to report having ever been diagnosed with high cholesterol.



[35] American Heart Association. (2015). Heart disease and stroke statistics. Retrieved from http://circ.ahajournals.org/content/early/2014/12/18/CIR.0000000000000152/tab-article-info

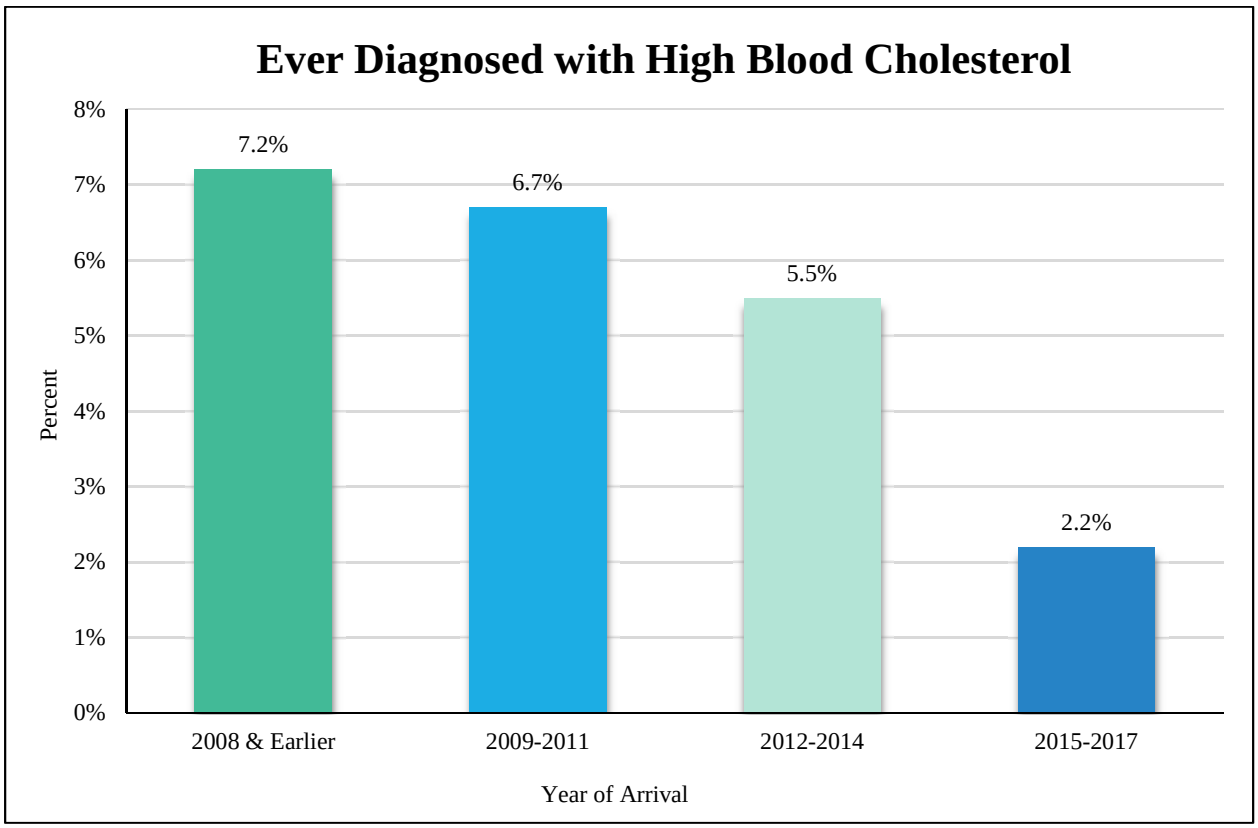
[36] Centers for Disease Control and Prevention. (2016). High cholesterol risk factors. Retrieved from www.cdc.gov/cholesterol/risk_factors.htm

High Cholesterol

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with high cholesterol by year of arrival.

Key Findings by Year of Arrival

- Refugees arriving in 2008 and earlier were most likely to report having ever been diagnosed with high cholesterol at 7.2%, followed by those arriving in 2009-2011 (6.7%).
- Refugees arriving in 2012-2014 reported having ever been diagnosed with high cholesterol at 5.5%
- Refugees with the shortest stay in the United States, those arriving in 2015-2017, were least likely to report having ever been diagnosed with high cholesterol at 2.2%.



Heart Attack

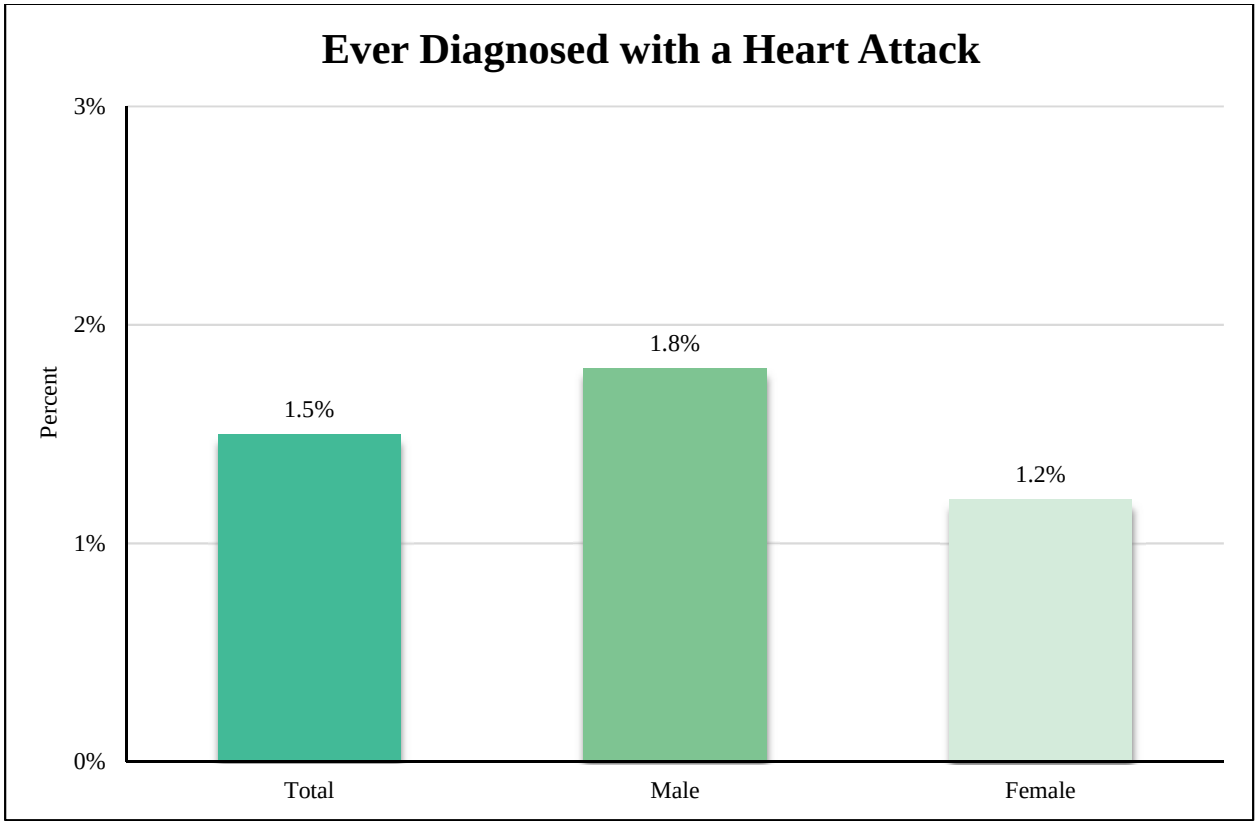
Has a doctor, nurse, or other health professional ever told you that you had a heart attack, also called a myocardial infarction?

A heart attack or myocardial infarction (MI) is permanent damage to the heart muscle. Heart attacks can occur when the heart cannot get enough oxygen, due to oxygen-rich blood being blocked off from the heart muscle.[37]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with a heart attack.

By Gender

- Overall, 1.5% Omaha refugees reported having ever been diagnosed with a heart attack.
- Male refugees (1.8%) were slightly more likely than female refugees (1.2%) to report having ever been diagnosed with a heart attack.



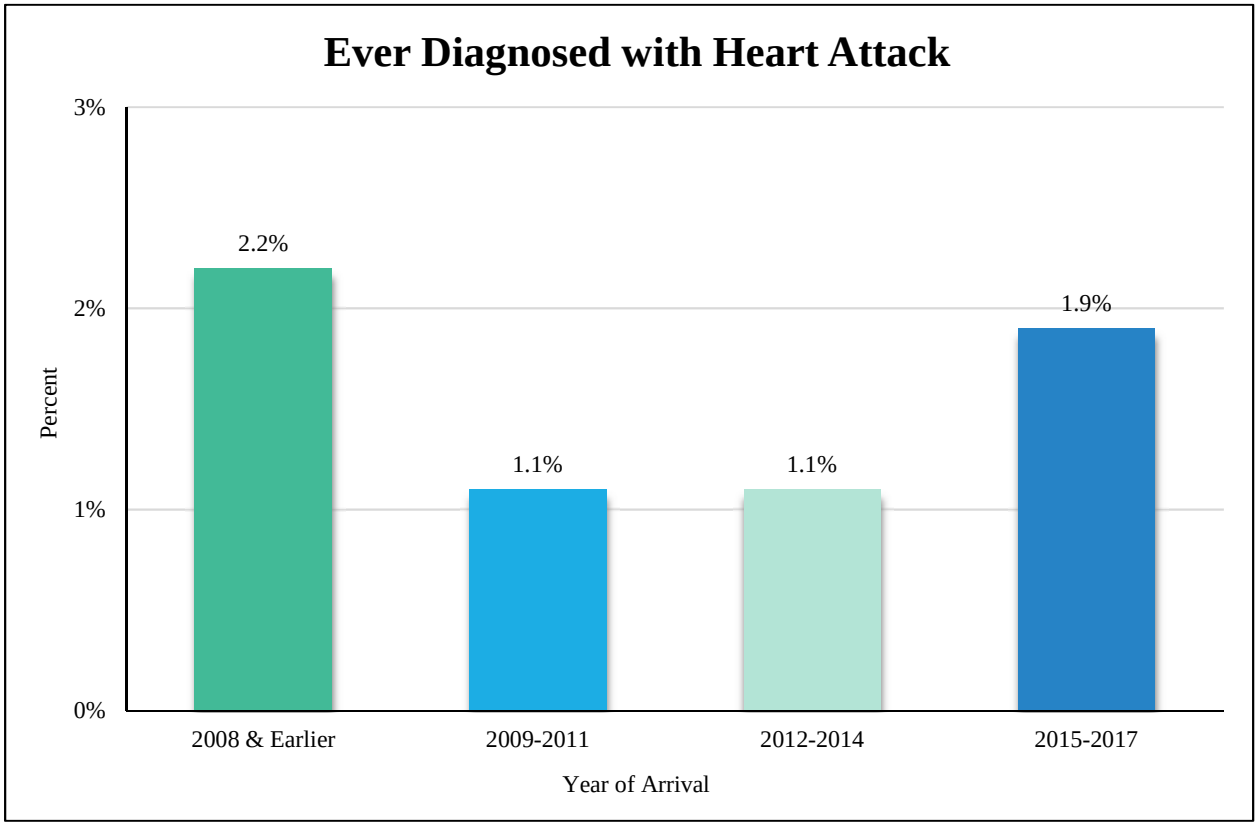
[37] National Institutes of Health. (2016). Myocardial infarction. Retrieved from www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0021982

Heart Attack

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with a heart attack.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 and arriving in 2012-2014 were least likely to report having ever been diagnosed with a heart attack at 1.1%.
- Omaha refugees arriving in 2008 and earlier (2.2%) were most likely to report having ever been diagnosed with a heart attack, followed by those arriving in 2015-2017 (1.9%).



Coronary Heart Disease

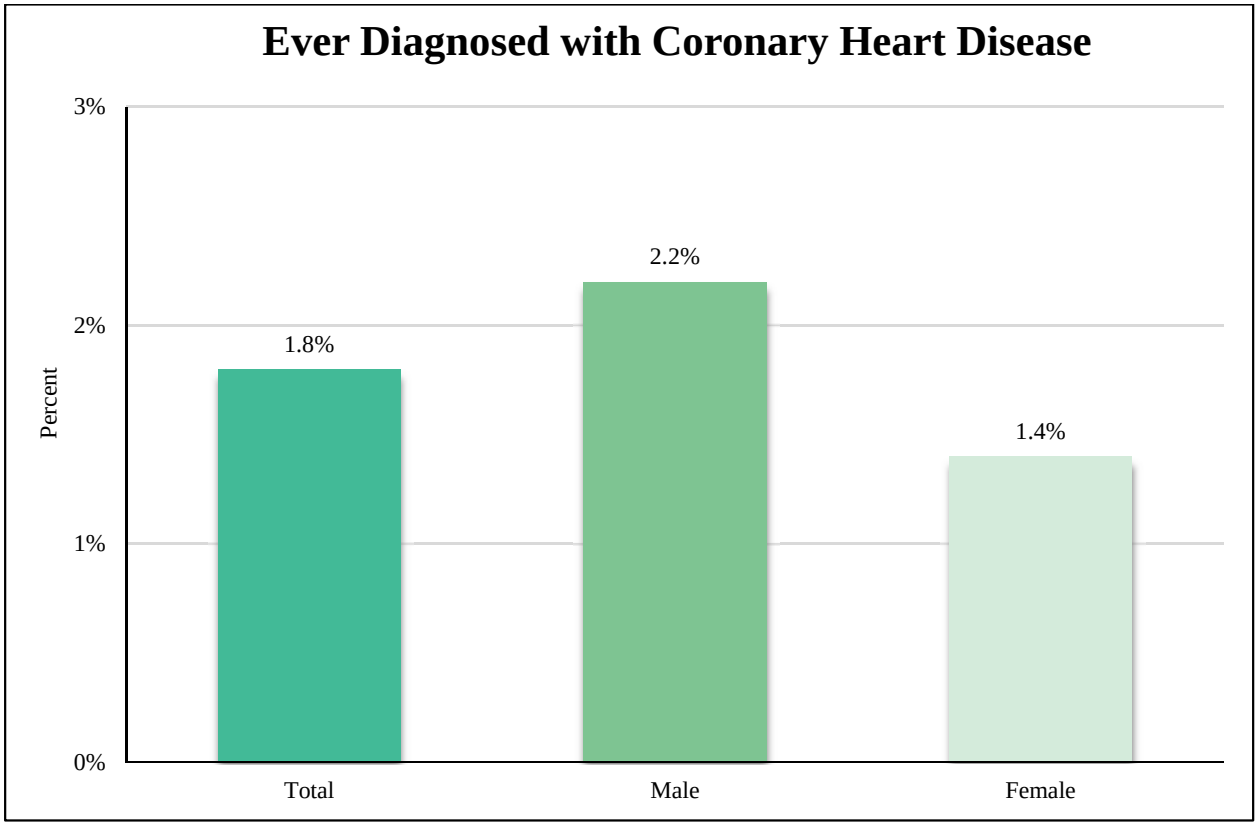
Has a doctor, nurse, or other health professional ever told you that you had angina or coronary heart disease?

Coronary heart disease is the narrowing of coronary arteries due to the buildup of plaque. With narrowed passageways, the amount of blood delivered is lessened, thus increasing the risk for a heart attack.[38]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with coronary heart disease.

By Gender

- Approximately 2% of Omaha refugees reported having ever been diagnosed with coronary heart disease.
- Male refugees (3.5%) were over three times more likely than female refugees (1.1%) to report having ever been diagnosed with coronary heart disease.



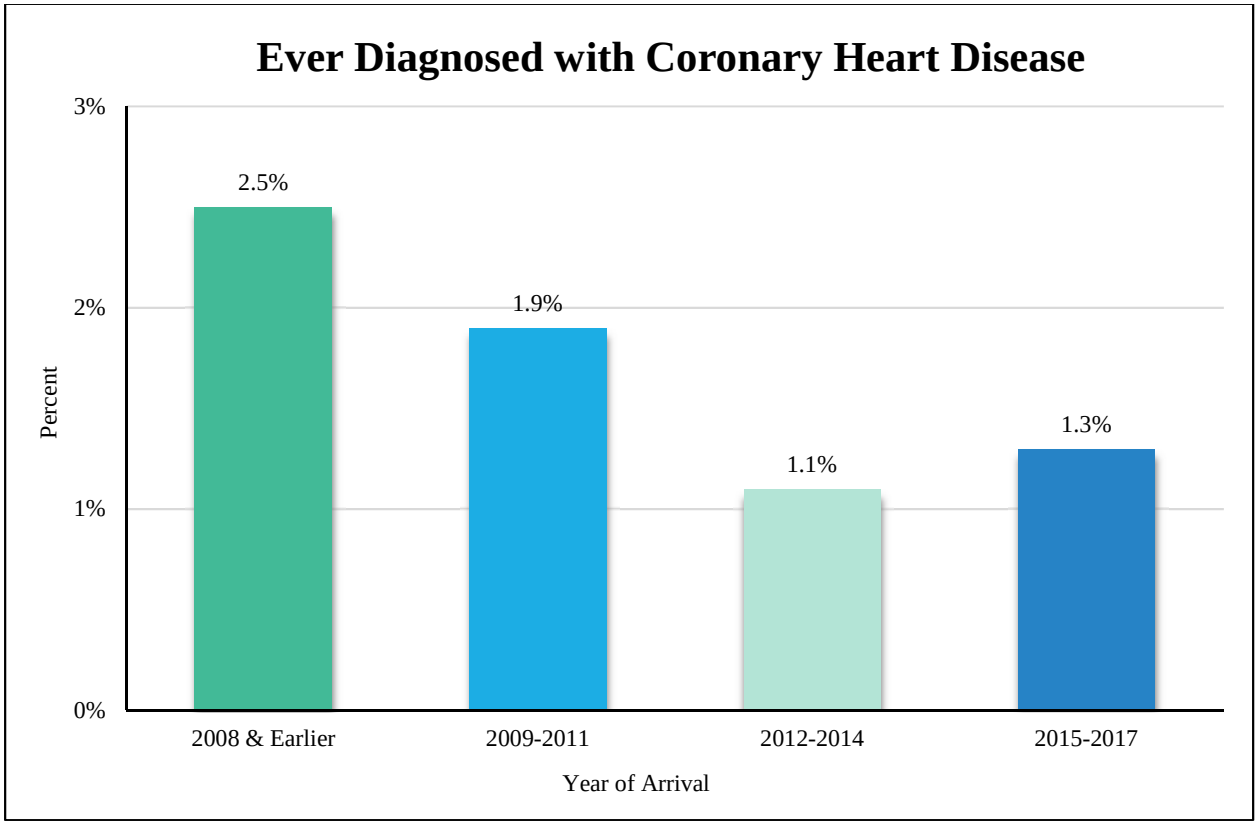
[38] National Institutes of Health. (2016). What is coronary heart disease. Retrieved from www.nhlbi.nih.gov/health/health-topics/topics/cad

Coronary Heart Disease

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with coronary heart disease.

By Year of Arrival

- Omaha refugees arriving in 2008 and earlier were most likely to report having ever been diagnosed with coronary heart disease at 2.5%.
- Omaha refugees arriving in 2015-2017 (1.3%) and Omaha refugees arriving in 2012-2014 (1.1%) were somewhat less likely to report having ever been diagnosed with coronary heart disease.



Stroke

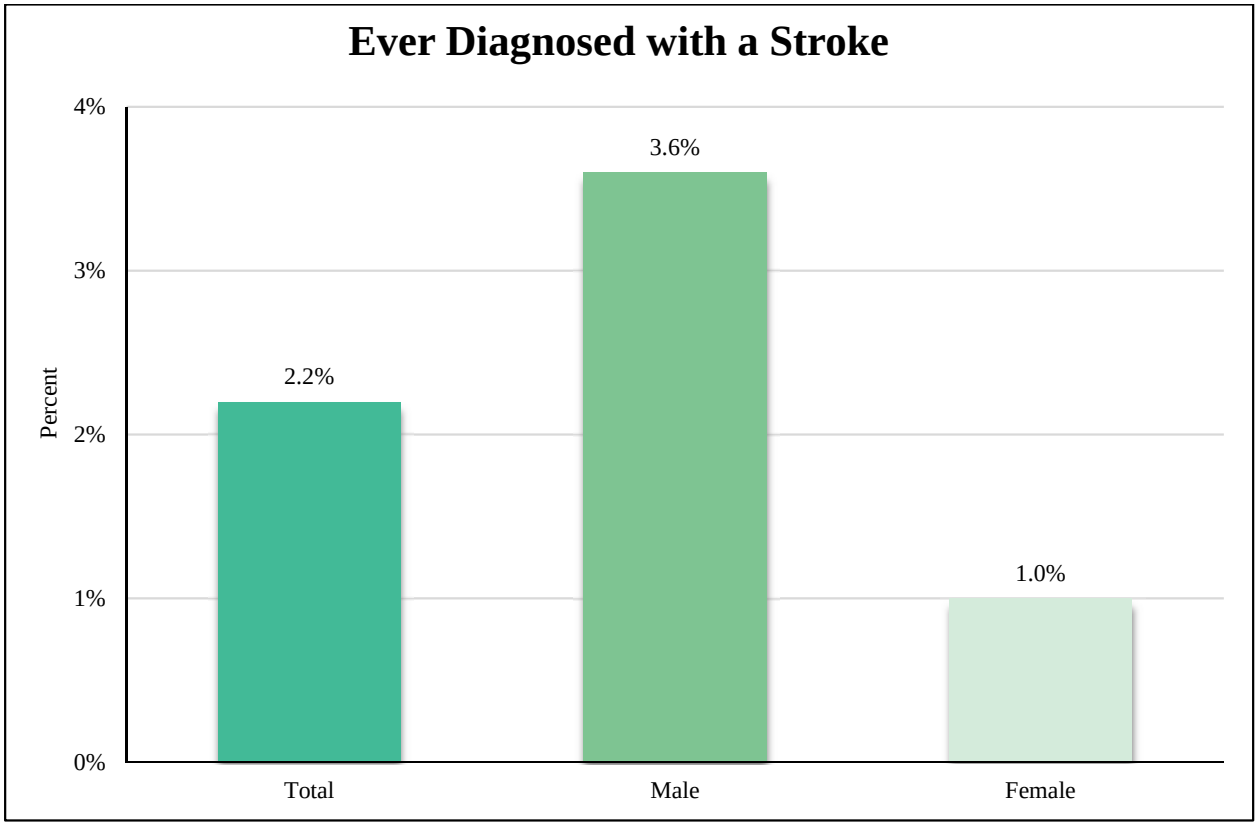
Has a doctor, nurse, or other health professional ever told you that you had a stroke?

A stroke occurs when blood flow to part of the brain stops. As the blood flow is interrupted, brain cells begin to die, as they cannot get the necessary oxygen. Strokes can cause brain damage, long-term disability, or death.[39]

The below chart represents the proportion of Omaha refugees surveyed that reported having ever been diagnosed with a stroke.

By Gender

- Approximately two percent of Omaha refugees (2.2%) reported having ever been diagnosed with a stroke.
- Male refugees (3.6%) were 3.6 times more likely than female refugees (1.0%) to report having ever been diagnosed with a stroke.



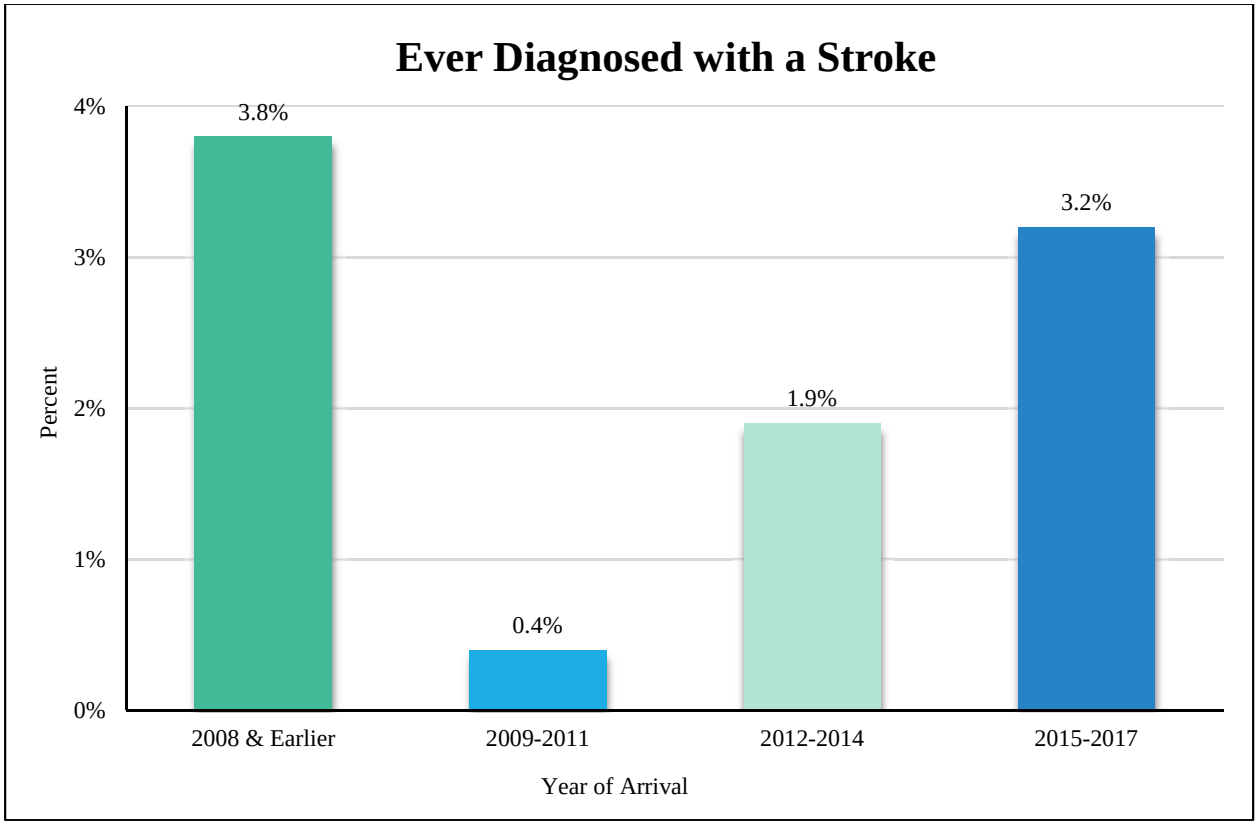
[39] Centers for Disease Control and Prevention. (2016). About stroke. Retrieved from www.cdc.gov/stroke/about.htm

Stroke

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with a stroke.

By Year of Arrival

- Omaha refugees arriving in 2008 and earlier (3.8%) were most likely to report having ever been diagnosed with a stroke. This was almost 10 times higher than refugees arriving in 2009-2011 (0.4%) who had the lowest reported rate.
- Omaha refugees arriving in 2012-2014 (1.9%) and 2015-2017 (3.2%) reported having ever been diagnosed with a stroke.



Asthma

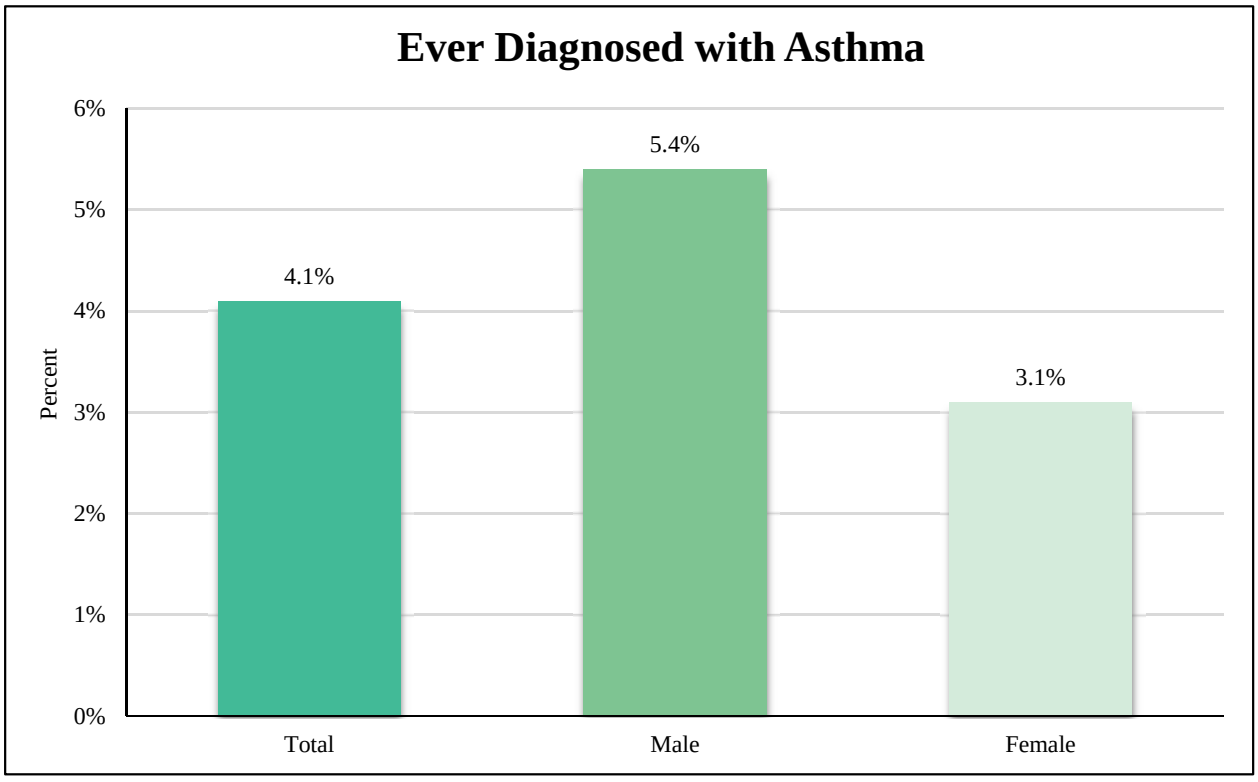
Has a doctor, nurse, or other health professional ever told you that you had asthma?

Asthma is a chronic inflammatory disease of the airways that is characterized by recurring symptoms such as wheezing, breathlessness, chest tightness, and coughing. In persons with asthma, the airways are more responsive to various stimuli, such as pollen, cigarette smoke, respiratory infections, or exercise. When exposed to these stimuli, the airways narrow or become obstructed, which results in respiratory symptoms.[40]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with asthma.

By Gender

- Approximately 4% of Omaha refugees (4.1%) reported having ever been diagnosed with asthma.
- Male refugees (5.4%) were 1.7 times more likely than female refugees (3.1%) to report having ever been diagnosed with asthma.



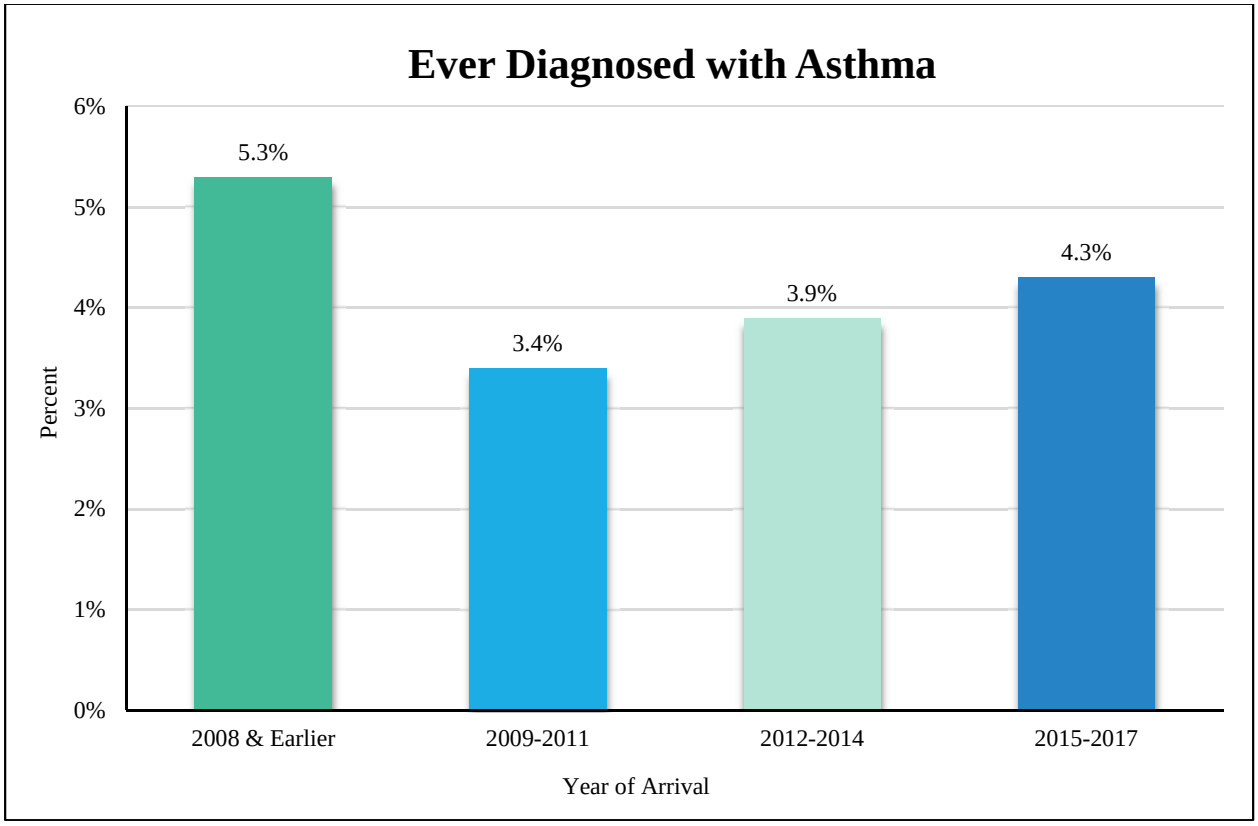
[40] Centers for Disease Control and Prevention. (2016). Asthma. Retrieved from www.cdc.gov/asthma/default.htm

Asthma

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with asthma.

By Year of Arrival

- Omaha refugees with the longest stay in the U.S. (2008 and earlier) were most likely to report having ever been diagnosed with asthma at 5.3%. This percentage was 1.7 times higher than refugees who arrived in 2009-2011 (3.4%).
- Rates of asthma reported by Omaha refugees increased gradually from 2009-2011 (3.4%) to the most recently arrived group, 2015-2017 (4.3%).



Chronic Obstructive Pulmonary Disease (COPD)

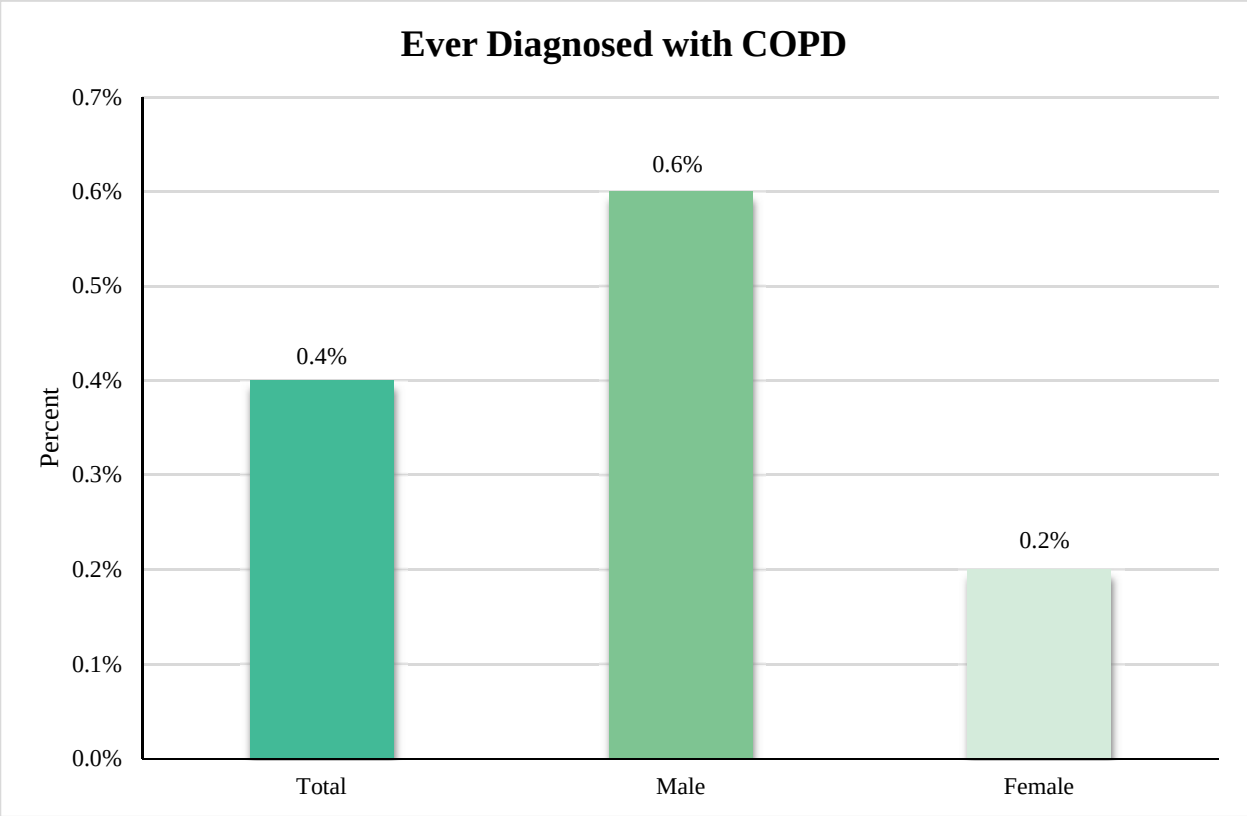
Has a doctor, nurse, or other health professional ever told you that you have Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis?

Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term for diseases that impair lung function and create breathlessness. Smoking is the leading cause of COPD, though individuals who are exposed to dust, air pollution or other irritants long-term are also at a higher risk for COPD.[41] Chronic bronchitis and emphysema are common types of COPD.

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with COPD, emphysema, or chronic bronchitis.

By Gender

- Less than 1% of Omaha refugees (0.4%) reported having ever been diagnosed with COPD.
- Male refugees (0.6%) were three times more likely than female refugees (0.2%) to report having ever been diagnosed with COPD.



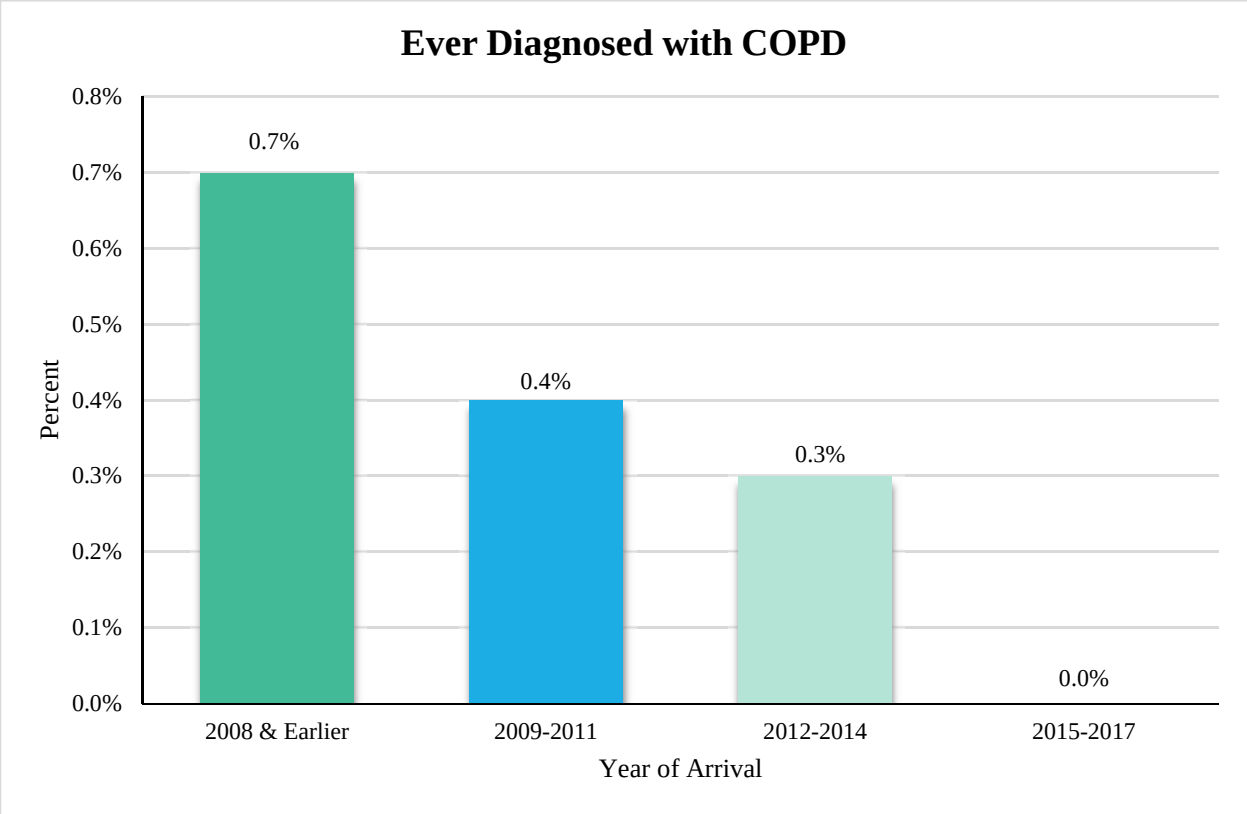
[41] National Institutes of Health. (2013). What is COPD. Retrieved from www.nhlbi.nih.gov/health/health-topics/topics/copd

Chronic Obstructive Pulmonary Disease (COPD)

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with COPD, emphysema, or chronic bronchitis.

By Year of Arrival

- The percentage of Omaha refugees reporting having ever been diagnosed with COPD increased with length of stay in the U. S.
- Omaha refugees arriving in 2008 and earlier (0.7%) were most likely to report having ever been diagnosed with COPD, followed by Omaha refugees arriving in 2009-2011(0.4%) and in 2012-2014 (0.3%). Those arriving in 2015-2017 did not report having ever been diagnosed with COPD.



Arthritis, Gout, Lupus, or Fibromyalgia

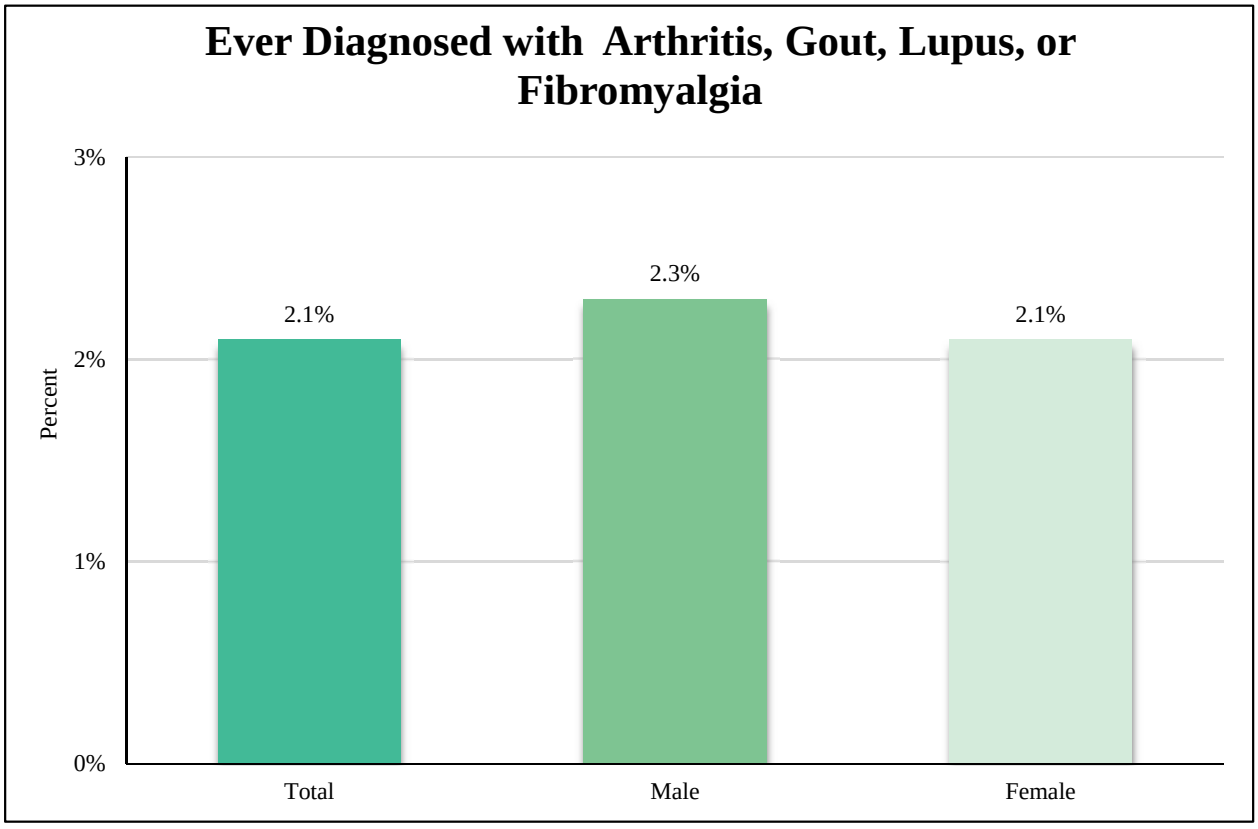
Has a doctor, nurse, or other health professional ever told you that you have arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

Arthritis includes more than 100 diseases that affect joints and the surrounding tissues and can cause pain and stiffness in the affected areas.[42]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with arthritis, gout, lupus, or fibromyalgia.

By Gender

- Approximately 2% of Omaha refugees (2.1%) reported having ever been diagnosed with arthritis, gout, lupus, or fibromyalgia.
- Male refugees (2.3%) were slightly more likely than female refugees (2.1%) to report having ever been diagnosed with arthritis, gout, lupus, or fibromyalgia.



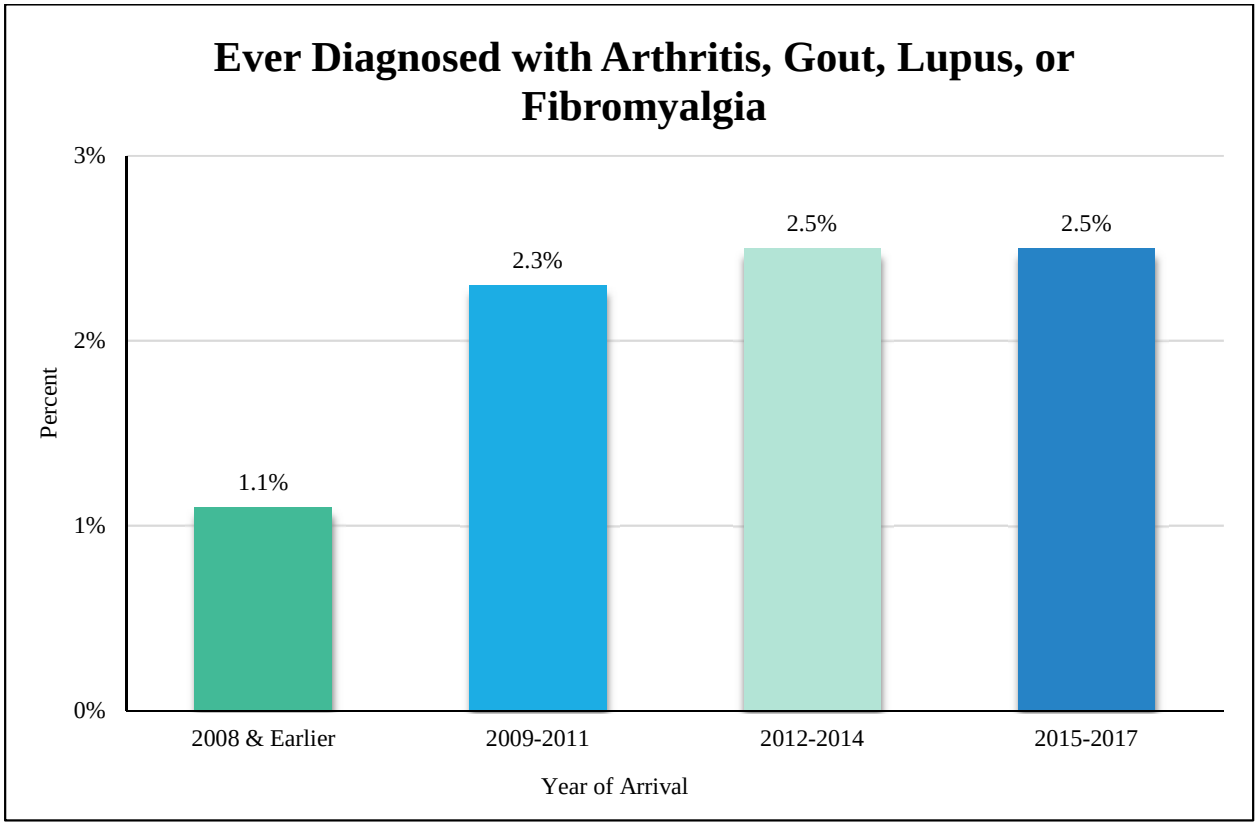
[42] Centers for Disease Control and Prevention. (2016). Arthritis. Retrieved from www.cdc.gov/arthritis/basics/faqs.htm

Arthritis, Gout, Lupus, or Fibromyalgia

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with Arthritis, Gout, Lupus, or Fibromyalgia.

By Year of Arrival

- Omaha refugees arriving in 2012-2014 (2.5%) and 2015-2017 (2.5%) were most likely to report having ever been diagnosed with arthritis, gout, lupus, or fibromyalgia. This proportion was 2.3 times that of those arriving in 2008 and earlier (1.1%) who had the lowest reported rate.
- Omaha refugees arriving in 2009-2011 (2.3%) were also more likely to report having ever been diagnosed with arthritis, gout, lupus, or fibromyalgia.



Diabetes

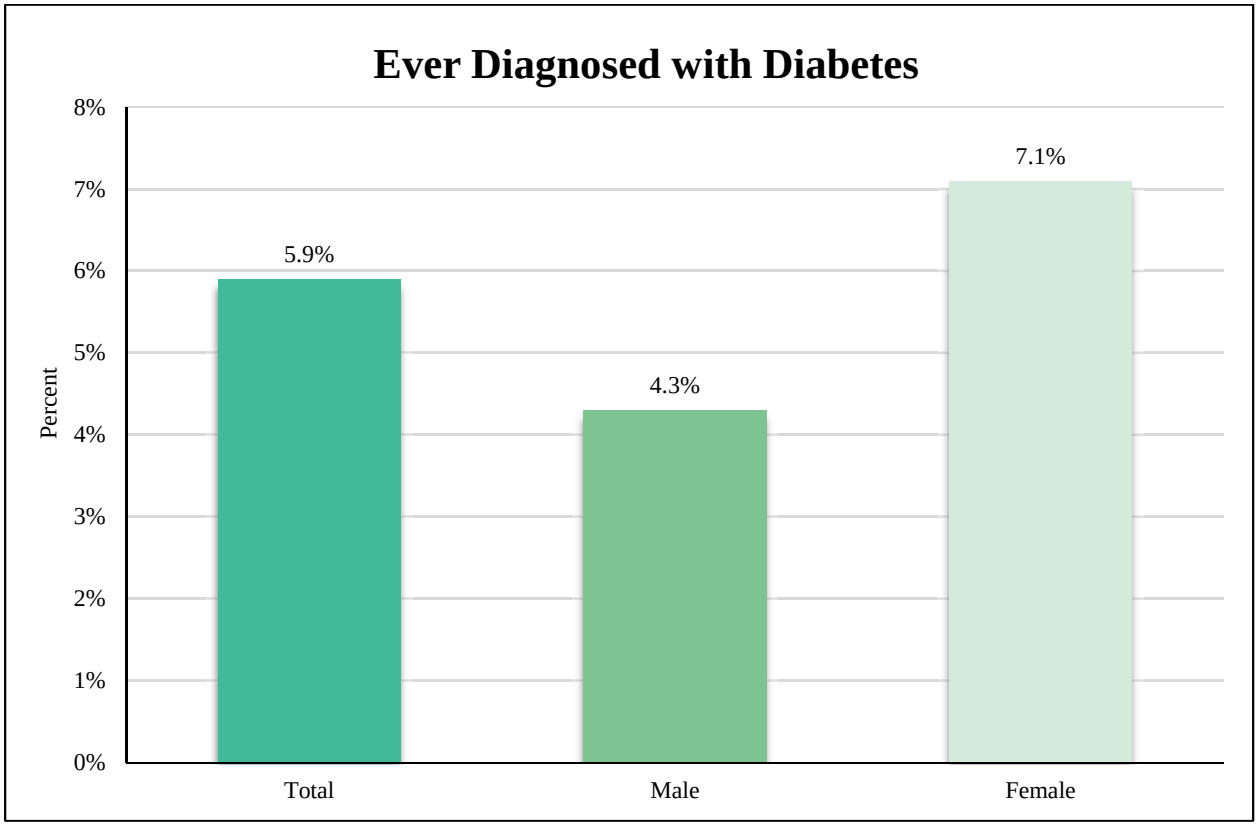
Has a doctor, nurse, or other health professional ever told you that you have diabetes?

Diabetes is a chronic disease, characterized by high levels of sugar in the blood. Diabetes can be caused by the resistance to or creation of too little insulin, a hormone produced to control blood sugar. While the cause of type 1 diabetes is unknown, some cases of type 2 diabetes can be prevented by increasing physical activity, eating a healthy diet, and decreasing excess body weight.[43]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with diabetes.

By Gender

- Just under 6% of Omaha refugees (5.9%) reported having ever been diagnosed with diabetes.
- Female refugees (7.1%) were 1.7 times more likely than male refugees (4.3%) to report having ever been diagnosed with diabetes.



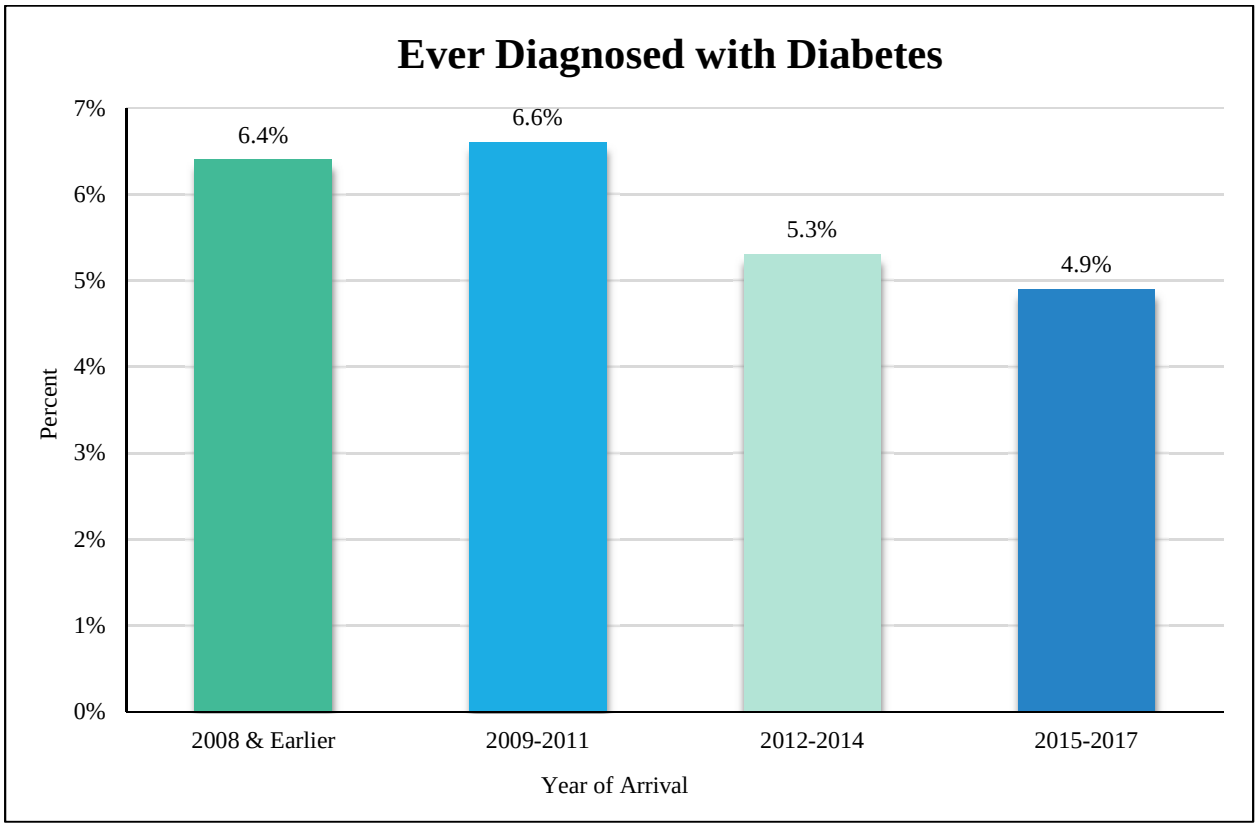
[43] A.D.A.M Medical Encyclopedia. (2012). Diabetes. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002194/

Diabetes

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with diabetes.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 (6.6%) were most likely to report having ever been diagnosed with diabetes, followed by refugees arriving in 2008 and earlier (6.4%).
- Omaha refugees arriving in 2015-2017 were less likely than other arrival groups to have ever been diagnosed with diabetes at 4.9%.



Kidney Disease

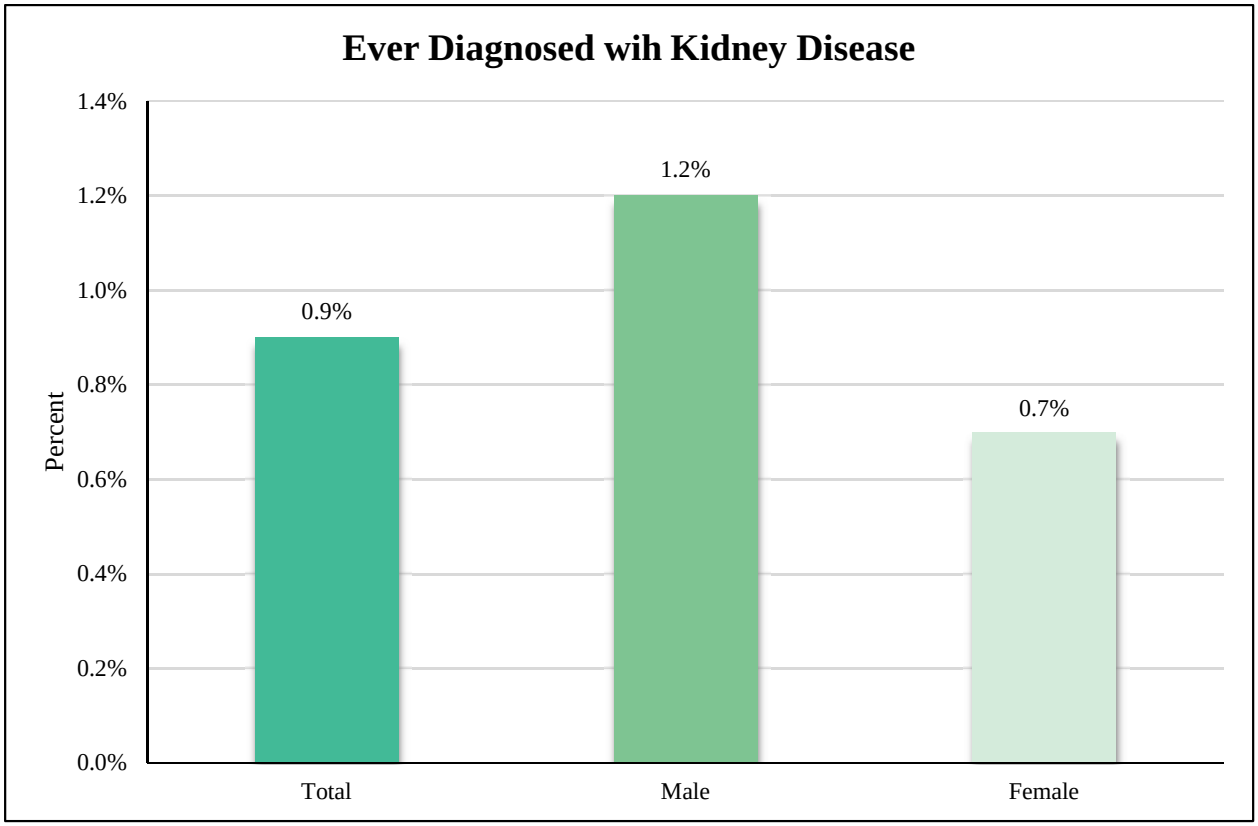
Has a doctor, nurse, or other health professional ever told you that you have kidney disease?

Kidneys help to regulate blood chemicals and control blood pressure. When the kidneys are damaged, they cannot filter blood properly, causing excess fluid and waste to remain in the body. This can cause other health problems, such as heart disease and stroke.[44]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with kidney disease.

By Gender

- Just under 1% of Omaha refugees (0.9%) reported having ever been diagnosed with kidney disease.
- Male refugees (1.2%) were 1.7 times more likely than female refugees (0.7%) to report having ever been diagnosed with kidney disease.



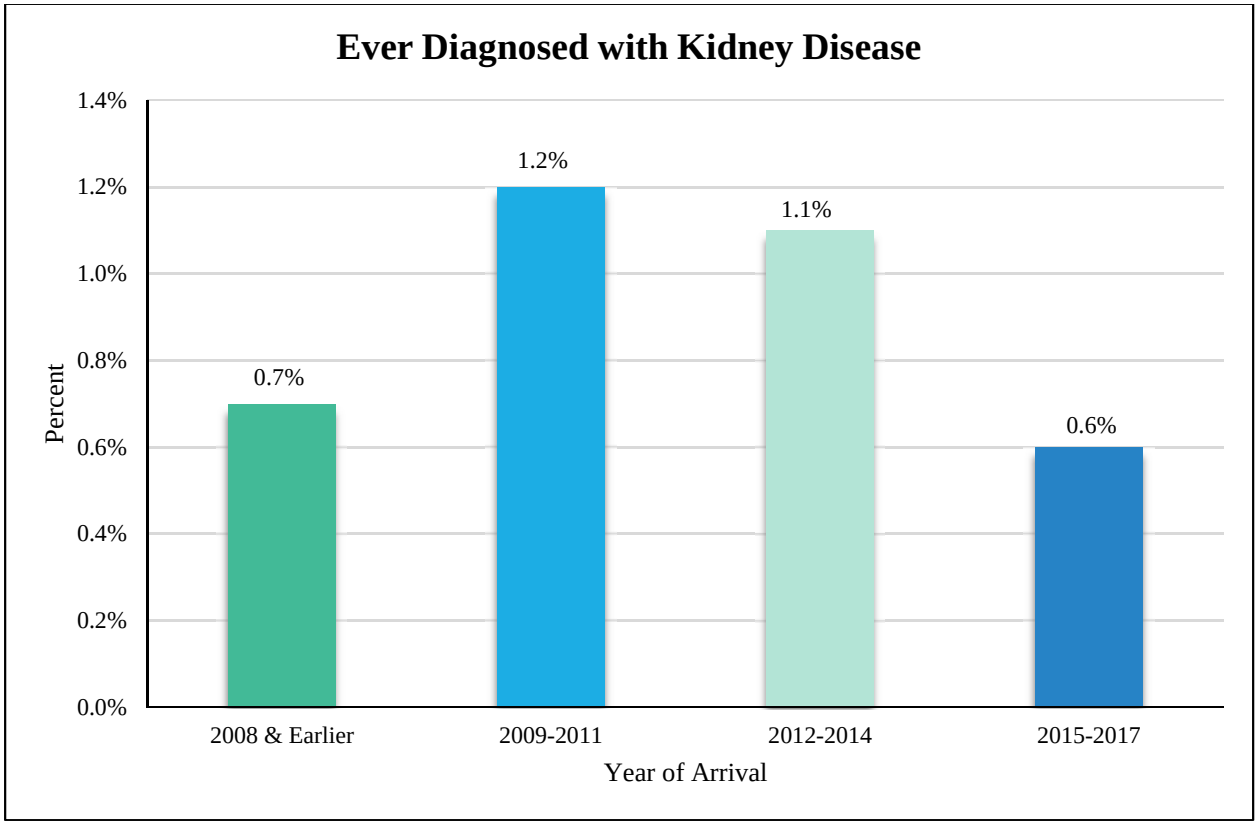
[44] Centers for Disease Control and Prevention. (2018). Chronic kidney disease basics. Retrieved from www.cdc.gov/kidneydisease/basics.html

Kidney Disease

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with kidney disease.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 (1.2%) were more likely than other arrival groups to report having ever been diagnosed with kidney disease.
- Omaha refugees arriving in 2015-2017 (0.6%) were least likely to report having ever been diagnosed with kidney disease, followed closely by those arriving in 2008 and earlier at 0.7%.



High Blood Pressure

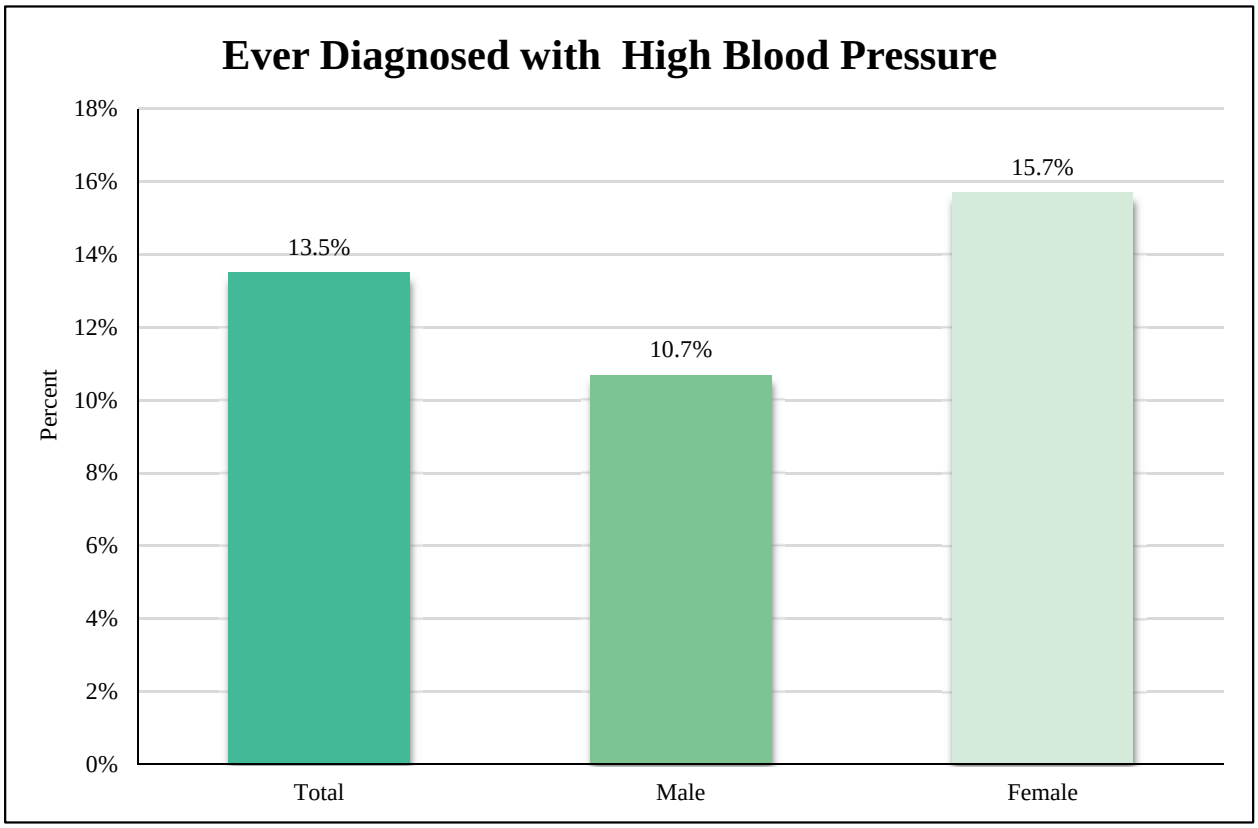
Has a doctor, nurse, or other health professional ever told you that you have high blood pressure?

High blood pressure, clinically known as hypertension, occurs when blood flows through the vessels with a greater force than usual. Conditions of the kidney or nervous system, body hormone levels, and water or salt levels in the body can affect blood pressure.[45]

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with high blood pressure.

By Gender

- Approximately 14% of Omaha refugees reported having ever been diagnosed with high blood pressure.
- Female refugees (15.7%) were somewhat more likely than male refugees (10.7%) to report having ever been diagnosed with high blood pressure.



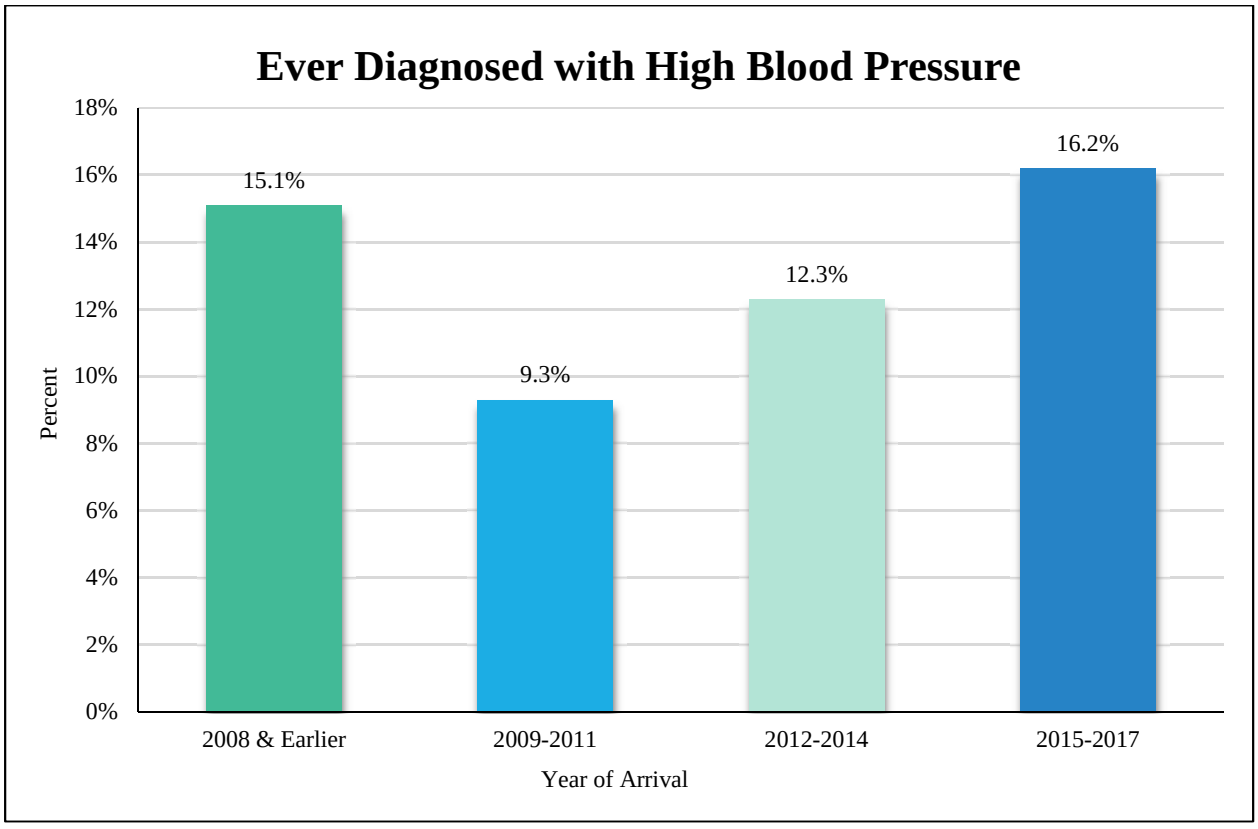
[45] National Institutes of Health. (2016). Hypertension. Retrieved from www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024199/

High Blood Pressure

The below chart represents the proportion of Omaha refugees that reported having ever been diagnosed with high blood pressure.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (16.2%) were most likely to report having ever been diagnosed with high blood pressure, followed closely by those arriving in 2008 and earlier at 15.1%.
- Approximately one-tenth of Omaha refugees arriving in 2009-2011 (9.3%) reported having ever been diagnosed with high blood pressure, making this arrival group the least likely to report so.
- Approximately one-tenth of Omaha refugees arriving in 2012-2014 (12.3%) reported have ever been diagnosed with high blood pressure.



Mental Health

Research has found that depression, anxiety, and post-traumatic stress disorder (PTSD) may affect an average of one out of three refugees.[46] These high rates of mental health disorders are often related to the number of traumatic experiences and stressors experienced before, during, and after resettlement. The most traumatic circumstances are likely to occur pre-resettlement, when refugees are often exposed to war, persecution, and human rights violations. During this time, many refugees suffer violence, loss of family and friends, imprisonment, physical assault, torture, loss of property, and malnutrition.[47]

Upon arrival in the United States, refugees face additional stressors, which can negatively influence mental health. Difficulties in adapting to a new culture and experiencing the loss of culture and support are risk factors that have been linked to post-traumatic stress disorder symptoms and emotional distress.[48] Refugees with certain pre-resettlement characteristics are also more susceptible to these issues. These pre-resettlement risk factors include having a high socioeconomic status, having a higher level of education, and living in a rural area. Additionally, older refugees and female refugees have been found to have poorer mental health outcomes. Post-resettlement factors that may be associated with poor mental health include unstable living arrangements, lack of economic opportunities, and lack of resolution of conflict in the home country.[49]

While the research documenting mental health disorders among refugees is considerable, little information exists on the effectiveness and appropriateness of mental health services for refugees. This gap in research is, in part, due to the variety of obstacles that refugees may face when seeking treatment for mental health issues. These obstacles include cost, lack of appropriate services, language barriers, cultural beliefs, and differences in perceptions of health.[50]

Especially upon arrival in the United States, mental health is not a priority for many refugees, who face more immediate needs, such as securing employment and housing. Even once immediate needs are resolved, cultural beliefs often play a role in the underuse of mental health services. For example, discussing mental health can be considered taboo in some populations. Additionally, a fatalistic mentality is common among certain cultures, which may prevent refugees from seeking mental health services.[51] As refugees continue to arrive in Nebraska, it

[46] Turrini, G., Purgato, M., Ballette, F., Nose, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: Umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems, 11*(51).
[47] Lindert, J., Carta, M. G., Schaefer, I., & Mollica, R. F. (2016). Refugee mental health – a public mental health challenge. *European Journal of Public Health, 26*(3), 374-375.
[48] Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry, 57*(2), 107-119.
[49] Ringold, S. (2005). Refugee mental health. *The Journal of the American Medical Association, 294*(5), 646.
[50] Ovitt, N., Larrison, C. R., Nackerud, L. (2003). Refugees' response to mental health screening. *International Social Work, 49*(2), 235-250.
[51] Asgary, R. & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved, 22*(2), 506-522.

will be essential to keep these obstacles in mind to improve the availability of culturally sensitive mental health services and practitioners.

Omaha Refugee Population

Mental Health

Approximately one of every ten Omaha refugees reported having difficulty concentrating on ten or more days in the past two weeks.

2.0x

Female refugees (14.3%) were more likely than male refugees (7.0%) to report having difficulty concentrating on ten or more days in the past two weeks.

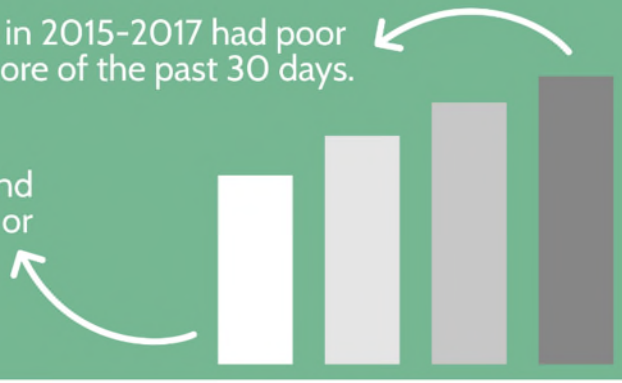
3.2%

Approximately 3% of Omaha refugees had been diagnosed with a depressive disorder.

Poor Mental Health

2.7% of refugees arriving in 2015-2017 had poor mental health on 14 or more of the past 30 days.

0.8% of refugees arriving in 2008 and earlier had poor mental health on 14 or more of the past 30 days.



Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Poor Mental Health More Than 14 Days

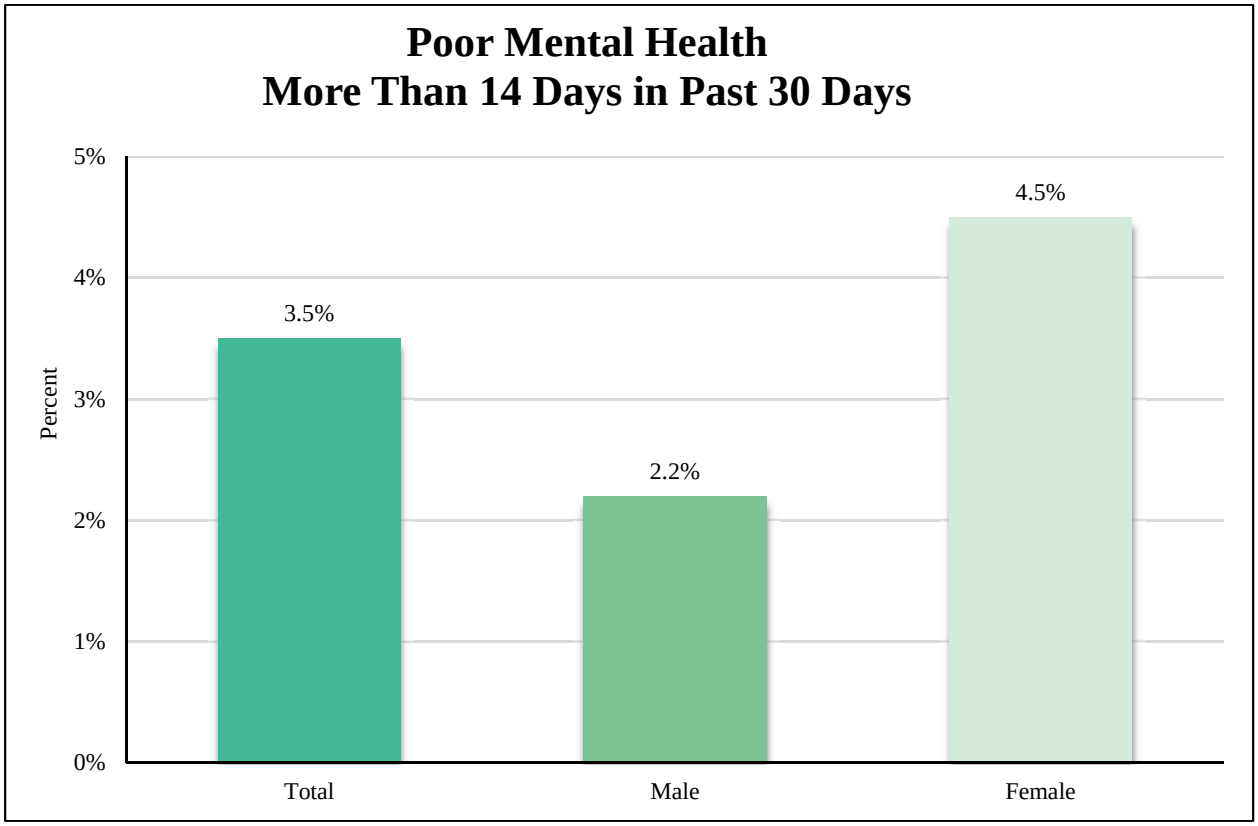
Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental not good?

Mental health includes our emotional, psychological, and social well-being. Mental health can affect daily life, relationships, and even physical health. Mental health also includes a person's ability to enjoy life - to attain a balance between life activities and efforts to achieve psychological resilience.

The below chart represents the proportion of Omaha refugees who reported their mental health was not good on 14 or more of the past 30 days.

By Gender

- Approximately four percent of Omaha refugees (3.5%) reported their mental health was poor on 14 or more of the past 30 days.
- Female refugees (4.5%) were two times more likely than male refugees (2.2%) to report their mental health was poor on 14 or more of the past 30 days.

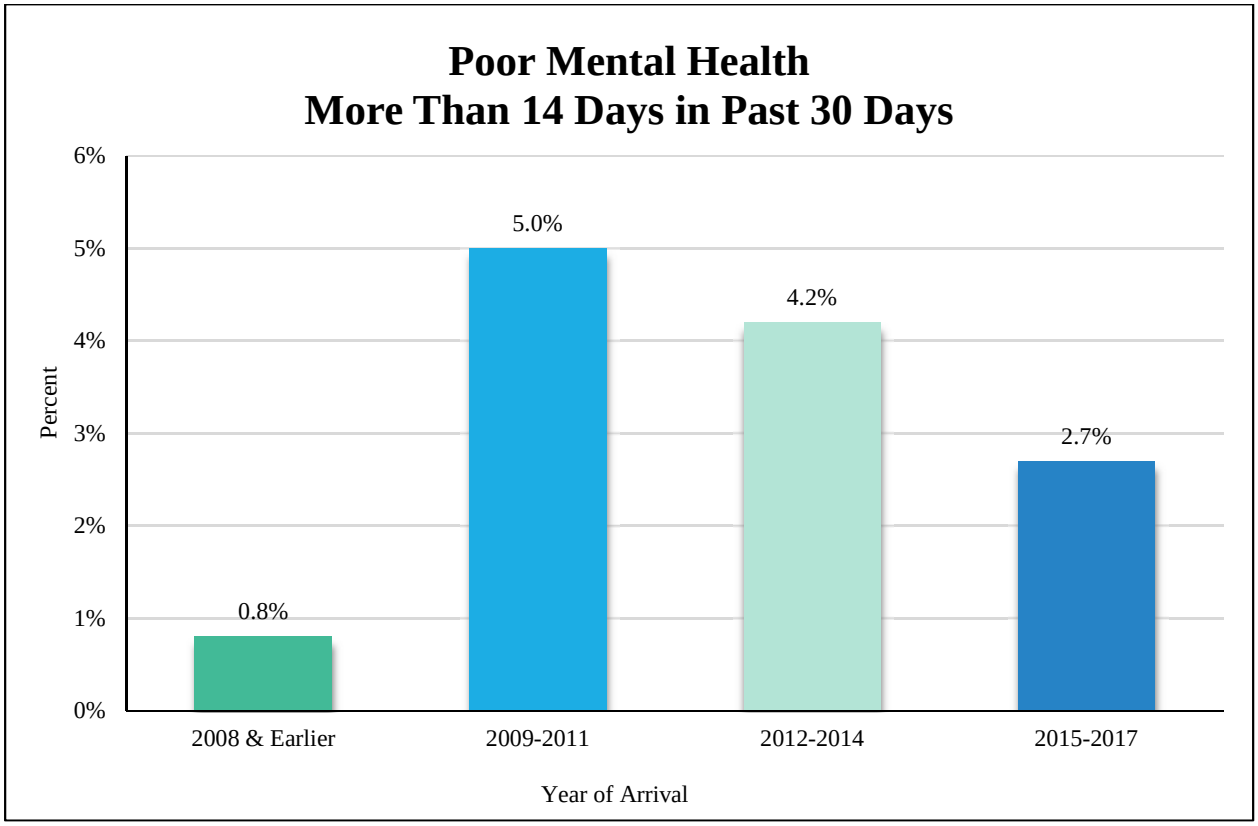


Poor Mental Health More Than 14 Days

The below chart represents the proportion of Omaha refugees who reported their mental health was not good on 14 or more of the past 30 days.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 (5.0%) were most likely to report poor mental health on 14 or more of the past 30 days, followed by refugees arriving in 2012-2014 (4.2%).
- Just 2.7% Omaha refugees arriving in 2015-2017 and 0.8% Omaha refugees arriving in 2008 and earlier reported being in poor mental health on 14 or more of the past 30 days.



Poor Mental Health More Than 10 Days

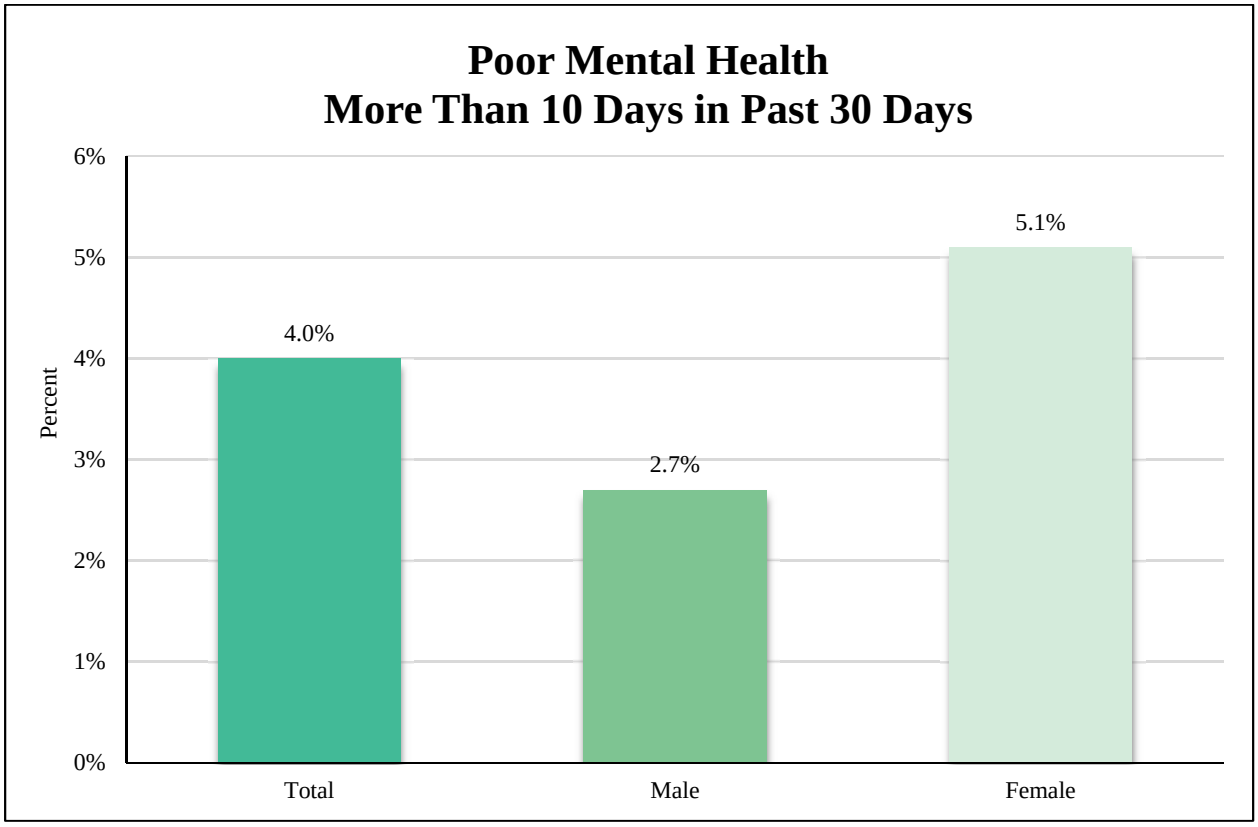
Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental not good?

Mental health includes our emotional, psychological, and social well-being. Mental health can affect daily life, relationships, and even physical health. Mental health also includes a person's ability to enjoy life - to attain a balance between life activities and efforts to achieve psychological resilience.

The below chart represents the proportion of Omaha refugees who reported that their mental health was not good on 10 or more of the past 30 days.

By Gender

- Four percent of Omaha refugees (4.0%) reported that their mental health was poor on 10 or more of the past 30 days.
- Female refugees (5.1%) were 1.9 times more likely than male refugees (2.7%) to report having poor mental health on 10 or more of the past 30 days.

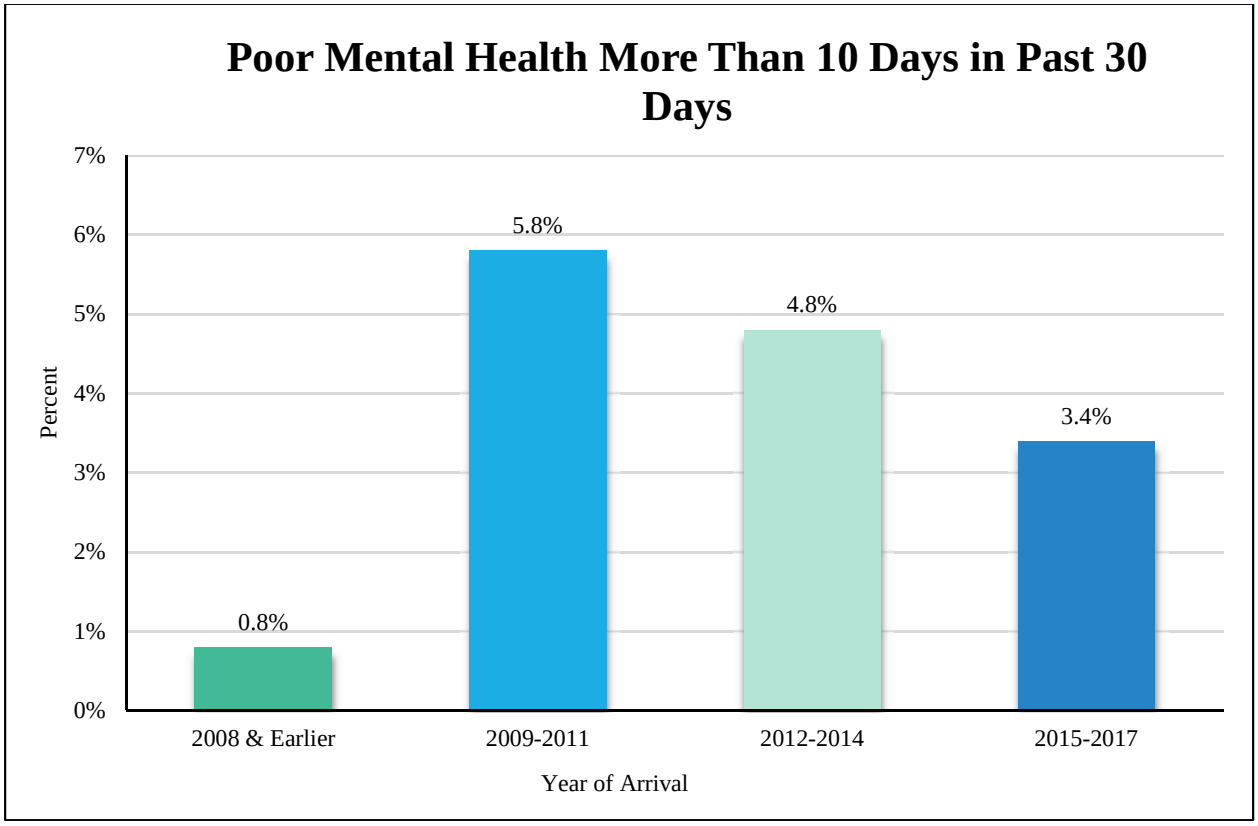


Poor Mental Health More Than 10 Days

The below chart represents the proportion of Omaha refugees who reported that their mental health was not good on 10 or more of the past 30 days.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 (5.8%) were most likely to report poor mental health on 10 or more of the past 30 days, followed by refugees arriving in 2012-2014 (4.8%).
- Refugees arriving in 2008 and earlier (0.8%) were least likely to report having poor mental health on 10 or more of the past 30 days.



Depressive Disorder

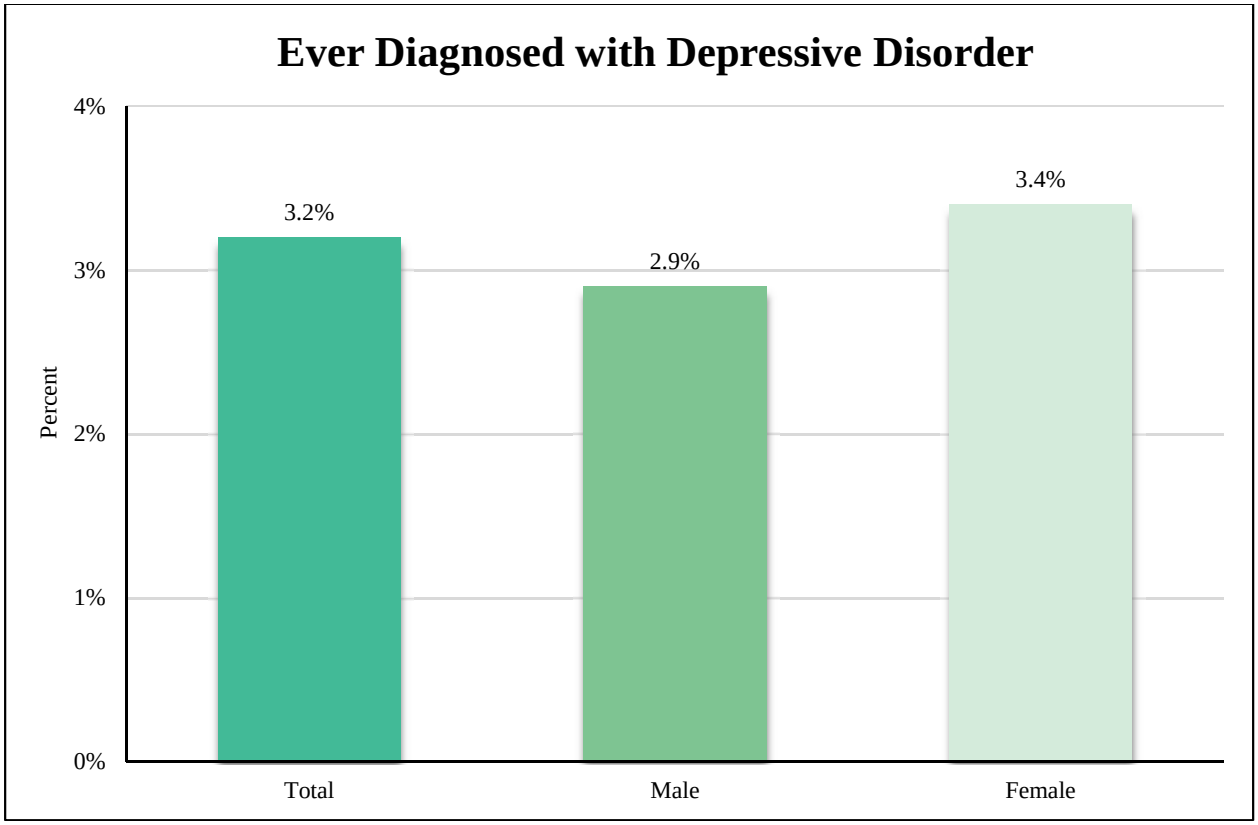
Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?

Depression is a major cause of illness and injury worldwide. If not treated, individuals with depression face a higher risk of suicide, heart disease, and other mental disorders.[52]

The below chart represents the proportion of Omaha refugees who reported having ever been diagnosed with a depressive disorder.

By Gender

- Approximately 3% of Omaha refugees (3.2%) reported having ever been diagnosed with a depressive disorder.
- Female refugees (3.4%) were slightly more likely than male refugees (2.9%) to report having ever been diagnosed with a depressive disorder.



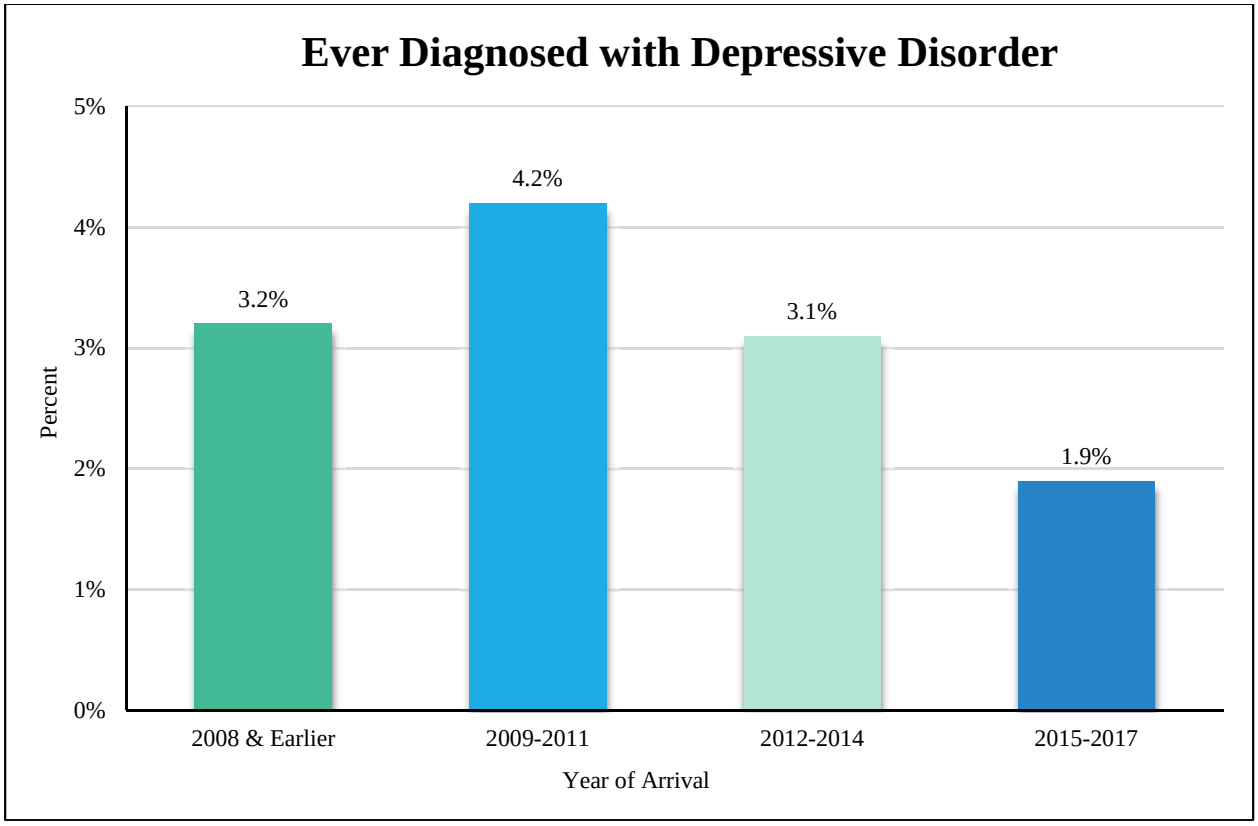
[52] Centers for Disease Control and Prevention. (2016). Depression. Retrieved from www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm

Depressive Disorder

The below chart represents the proportion of Omaha refugees who reported having ever been diagnosed with a depressive disorder.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 (4.2%) were most likely to report having ever been diagnosed with a depressive disorder. This percentage was more than twice that of refugees arriving in 2015-2017 (1.9%).
- Omaha refugees arriving in 2008 and earlier (3.2%) reported having ever been diagnosed with a depressive disorder, followed by Omaha refugees arriving in 2012-2014 (3.1%).



Difficulty Concentrating

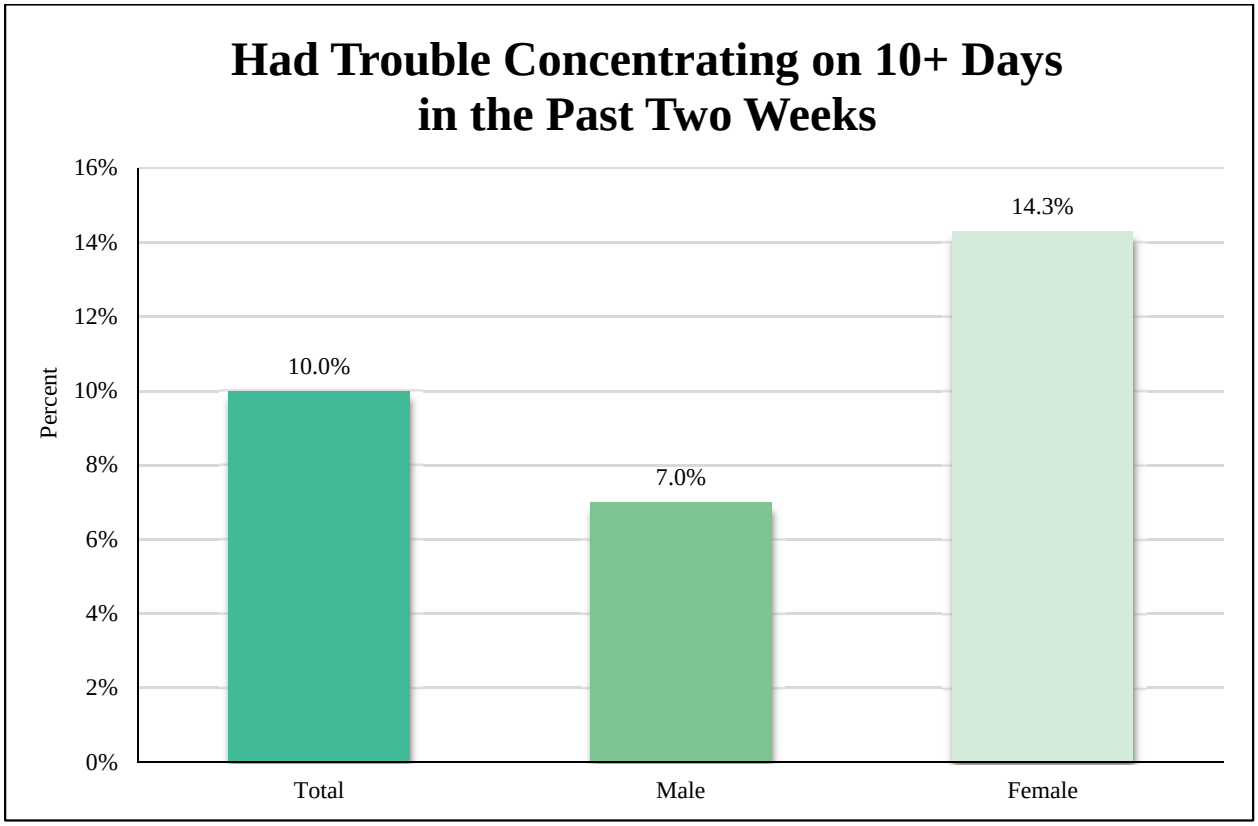
Over the last two weeks, how many days have you had trouble concentrating on things, such as reading the newspaper or watching TV?

Many individuals have difficulty concentrating occasionally, which is generally no cause for concern. However, difficulty concentrating an excessive amount during the day can be a symptom of stress or depression.

The below chart represents the proportion of Omaha refugees who reported having difficulty concentrating on 10 or more days in the past two weeks.

By Gender

- One-tenth Omaha refugees (10.0%) reported having difficulty concentrating on 10 or more days in the past two weeks.
- Female refugees (14.3%) were twice as likely as male refugees (7.0%) to report having difficulty concentrating on 10 or more days in the past two weeks.

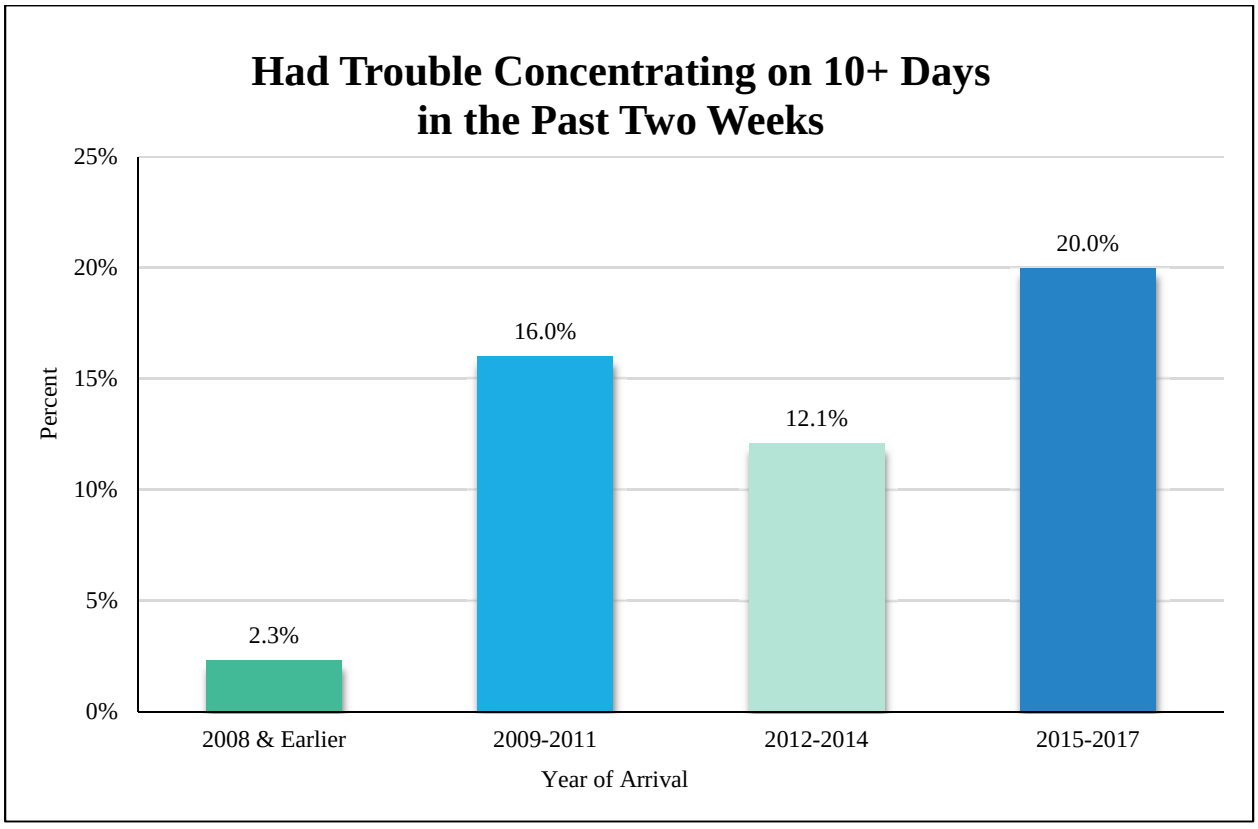


Difficulty Concentrating

The below chart represents the proportion of Omaha refugees who reported having difficulty concentrating on 10 or more days in the past two weeks.

By Year of Arrival

- One-fifth of Omaha Refugees arriving in 2015-2017 (20.0%) were most likely to report having ever been diagnosed with a depressive disorder, followed by refugees arriving in 2009-2011 (16%).
- Refugees arriving in 2008 and earlier were least likely to report having ever been diagnosed with a depressive disorder at 2.3%.
- Omaha refugees arriving in 2012-2014 reported having difficulty concentrating on 10 or more days in the past two weeks at 12.1%.



Health Behaviors and Risk Factors for Illness

Health behaviors refer to an individual's actions regarding their health and well-being. Positive health behaviors include getting adequate exercise, never smoking, consuming alcohol in moderation, maintaining a healthy body weight, and eating nutritious foods. Promoting positive health behaviors stresses individual responsibility in maintaining health and preventing illness through various activities and prevention measures.

Limited research has been conducted on refugee health behaviors, including how they may transform and develop over the course of resettlement in the United States. Even prior to becoming a refugee, cultural beliefs surrounding health may cause certain populations to be less likely to get routine screenings or follow preventative guidelines. Upon becoming a refugee, the effects of the refugee experience coupled with adjusting to the health environment in the United States can contribute to unhealthy practices, which have the potential to lead to chronic disease.

As part of the process of acculturation, refugees may adopt certain negative health behaviors after resettlement in the United States. This is particularly evident when looking at the consumption of nutritious foods among refugees. One study, following Dinka and Nuer refugees from Sudan in Nebraska, found that refugees were unfamiliar with U.S. foods and food preparation, which led them to consume more convenience foods and sugary beverages.[53] Lack of knowledge of new foods and preparation methods, transportation, and high costs may prevent refugees from accessing nutritious foods.

Upon arrival in the United States, many refugees are underweight and often gain needed weight after resettlement. However, research has shown that acculturation may cause unhealthy weight gain among refugees. In these cases, refugees often rapidly gain more weight than needed. One study found that the body mass index (BMI) among refugees from Southeast Asia and Africa had significant weight gain over a two-year period. The study suggested food insecurity, acculturation, and environmental factors as possible causes.[54]

The following chapter provides an overview of the prevalence of certain health behaviors reported by Nebraska's refugee populations. This research is a step towards identifying refugee health behaviors over time after resettlement, which can help to identify gaps in knowledge and inform interventions. Ensuring positive health behaviors among Nebraska's refugee populations will play an important role in the prevention and early detection of chronic diseases.

[53] Willis, M. S. & Buck, J. S. (2007). From Sudan to Nebraska: Dinka and Nuer refugee diet dilemmas. *Journal of Nutrition Education and Behavior, 39*(5), 273-280.

[54] Careyva, B., Mills, G., LaNoue, M., Bangura, M., de la Paz, A., Gee, A., & Patel, N. (2015). The impact of living in the United States on refugee patients' body mass index scores. *Journal of Health Care for the Poor and Underserved, 26*(2), 421-430.

Omaha Refugee Population

Health Behaviors and Risk Factors for Illness

Positive health behaviors, such as routine checkups and taking preventative measures, can help to prevent disease and play an important role in ensuring a healthy life.

53.5% Approximately 54% of Omaha refugees reported having had a routine checkup in the past two years.

25.5% Just over one-fourth of Omaha refugees reported having visited a dentist in the past two years.

36.5% Just approximately 37% of Omaha refugees reported having had a flu shot in the past year.

Healthy Lifestyle

Approximately **60%** of Omaha refugees reported eating fruit less than once daily.

More than **seven in every ten** of Omaha refugees reported eating vegetables less than once daily.

Approximately **half** of Omaha refugees reported getting less than seven hours of sleep daily.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

Routine Checkup

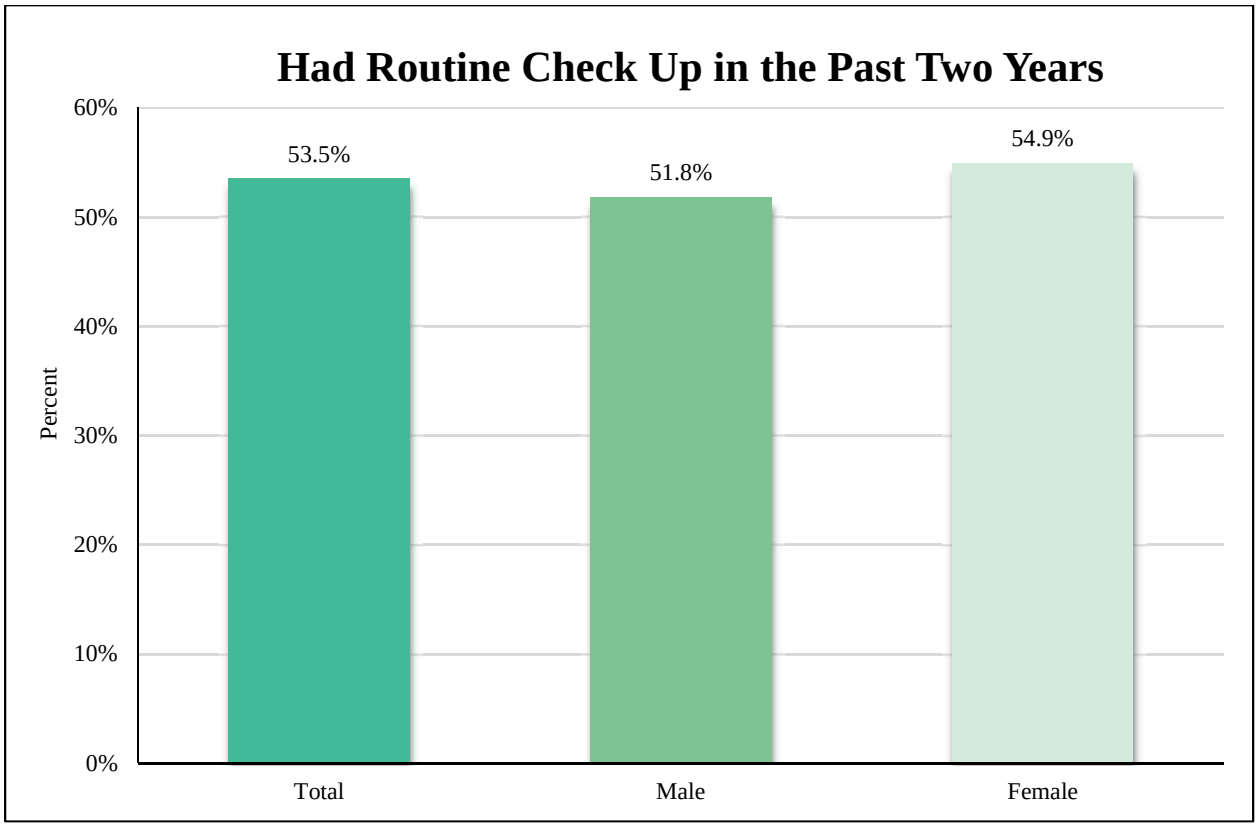
A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?

Routine checkups are helpful in finding problems before they become a cause for concern. Finding problems early makes the chance for treatment better. Scheduling regular checkups with a physician is an important step in maintaining a long, healthy life.

The below chart represents the proportion of Omaha refugees surveyed who reported having had a routine checkup in the past two years.

By Gender

- Over half of Omaha refugees (53.5%) reported having had a routine checkup in the past two years.
- Female refugees (54.9%) were slightly more likely than male refugees (51.8%) to report having had a routine checkup in the past two years.

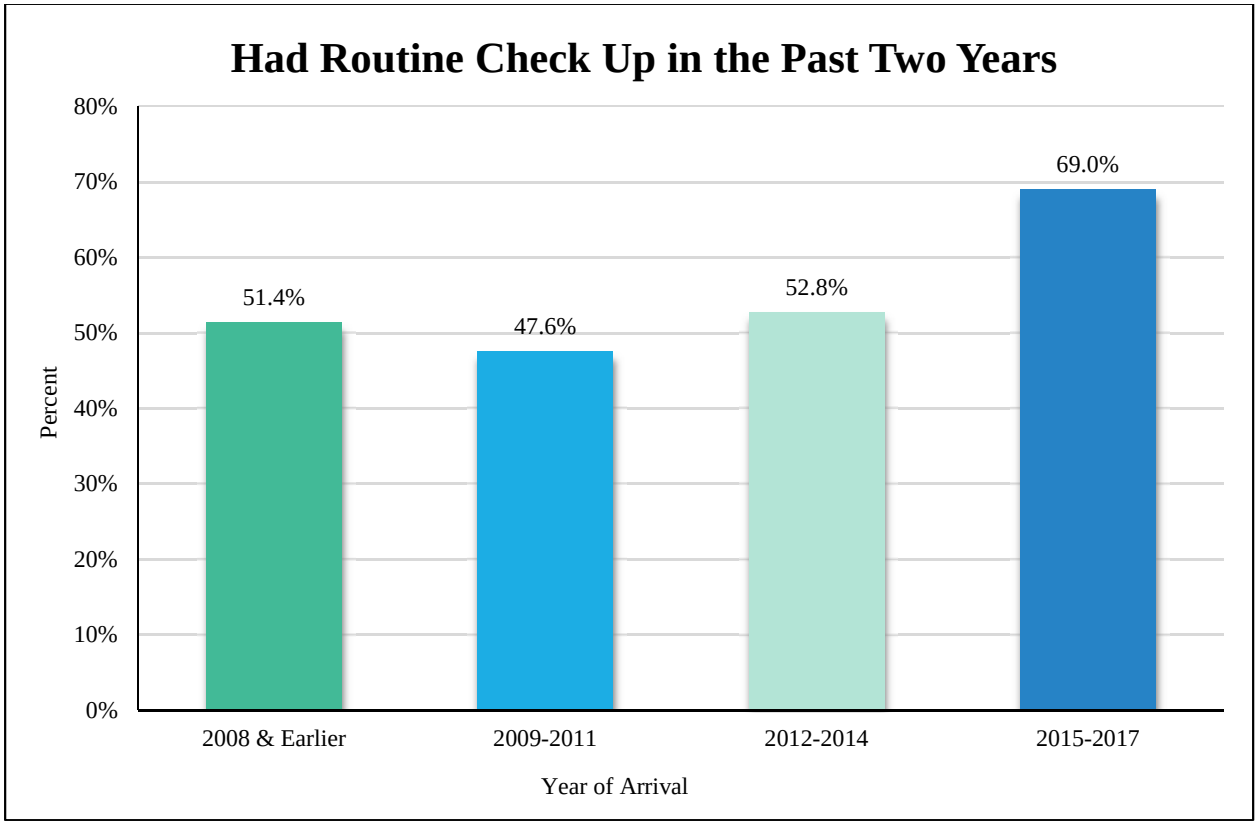


Routine Checkup

The below chart represents the proportion of Omaha refugees who reported having had a routine checkup in the past two years.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (69.0%) were most likely to report having had a routine checkup in the past two years. This percentage was 1.4 times higher than that of those arriving in 2009-2011 (47.6%) who were least likely to report the same.
- Omaha refugees arriving in 2012-2014 reported having had a routine checkup in the past two years at 52.8% and those arriving in 2008 & Earlier at 51.4%.



Oral Health

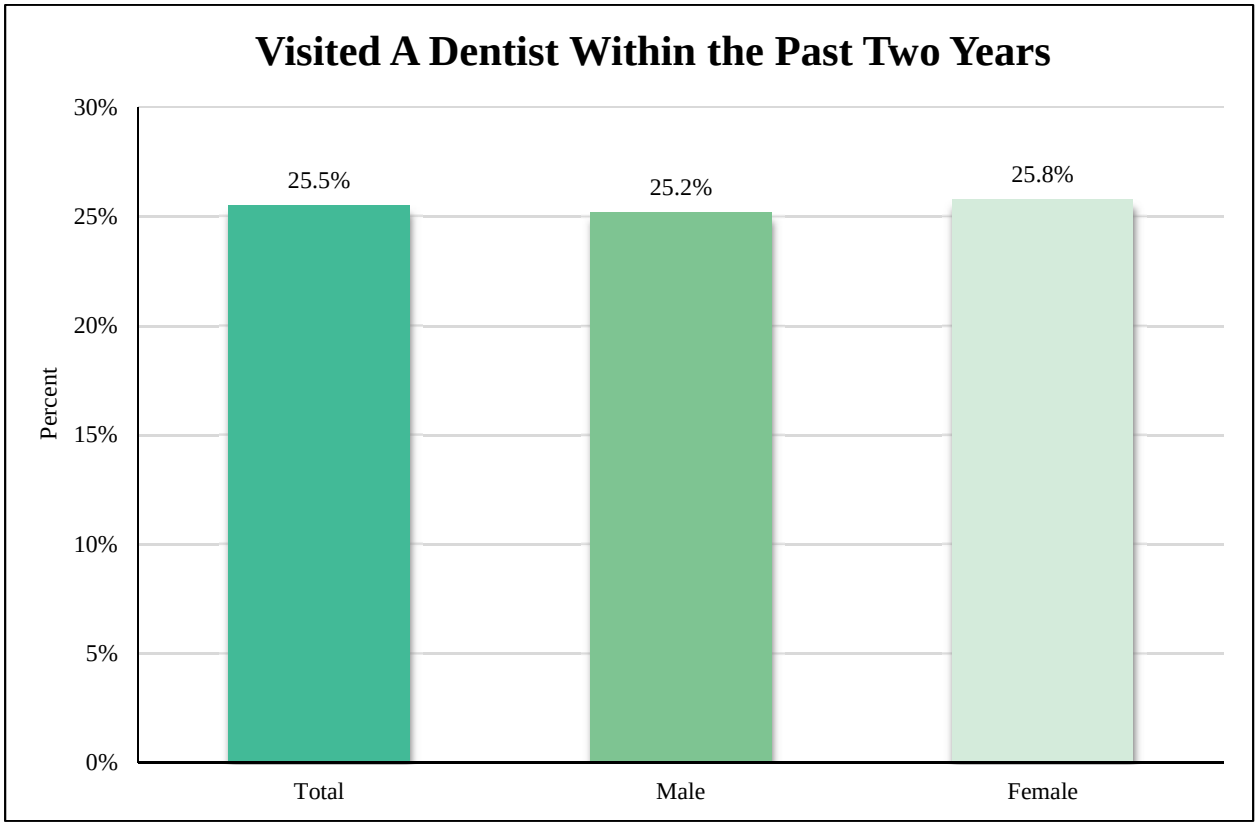
How long has it been since you last visited a dentist or a dental clinic for any reason? Include visits to dental specialists, such as orthodontists.

Regular visits to the dentist are an important part of maintaining good oral health. Several of the most common oral health problems include untreated tooth decay (cavities) and gum disease. In fact, it has been reported that more than one in four adults in the United States has untreated tooth decay.[55]

The below chart represents the proportion of Omaha refugees who reported having visited a dentist in the past two years.

By Gender

- Approximately one-fourth of Omaha refugees (25.5%) reported having visited a dentist in the past two years.
- Female refugees (25.8%) and male refugees (25.2%) reported similar percentages of having visited the dentist in the past two years.



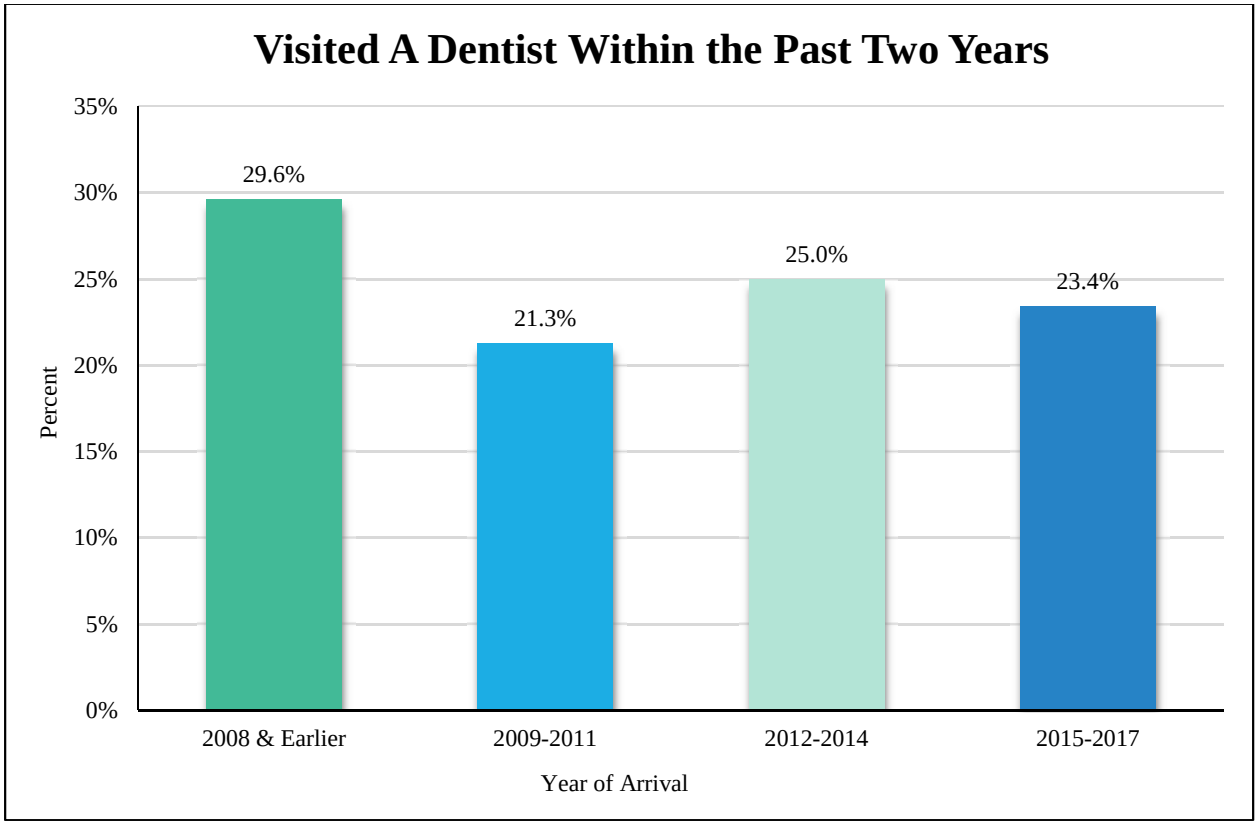
[55] Centers for Disease Control and Prevention. (2015). Dental Caries and Tooth Loss in Adults in the United States, 2011-2012. Retrieved from www.cdc.gov/nchs/data/databriefs/db197.htm

Oral Health

The below chart represents the proportion of Omaha refugees who reported having visited a dentist in the past two years.

By Year of Arrival

- Omaha refugees arriving in 2008 and earlier (29.6%) were most likely to report having visited a dentist in the past two years, followed by refugees arriving in 2012-2014 (25.0%).
- Omaha refugees arriving in 2009-2011 (21.3%) and in 2015-2017 (23.4%) were least likely to report having visited a dentist in the past two years.



Flu Vaccination

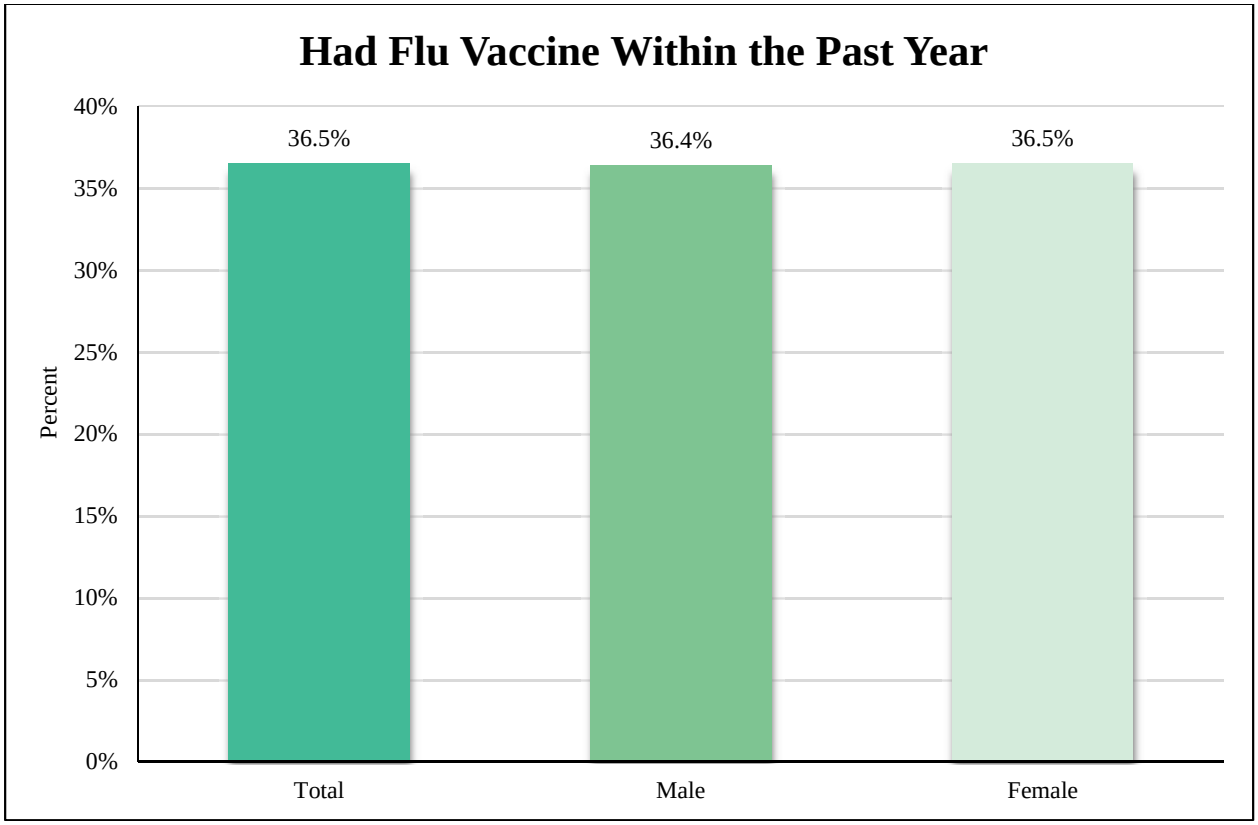
During the past 12 months, have you had either a flu shot or flu vaccine that was sprayed in your nose?

Flu shots protect individuals against the most common influenza viruses and it is recommended that everyone over six months of age get a flu shot every influenza season.[56]

The below chart represents the proportion of Omaha refugees who reported having received a flu shot in the past 12 months.

By Gender

- Over one- third of Omaha refugees (36.5%) reported having had a flu vaccine in the past 12 months.
- Female refugees (36.5%) and male refugees (36.4%) reported similar percentage of having had a flu vaccine in the past 12 months.



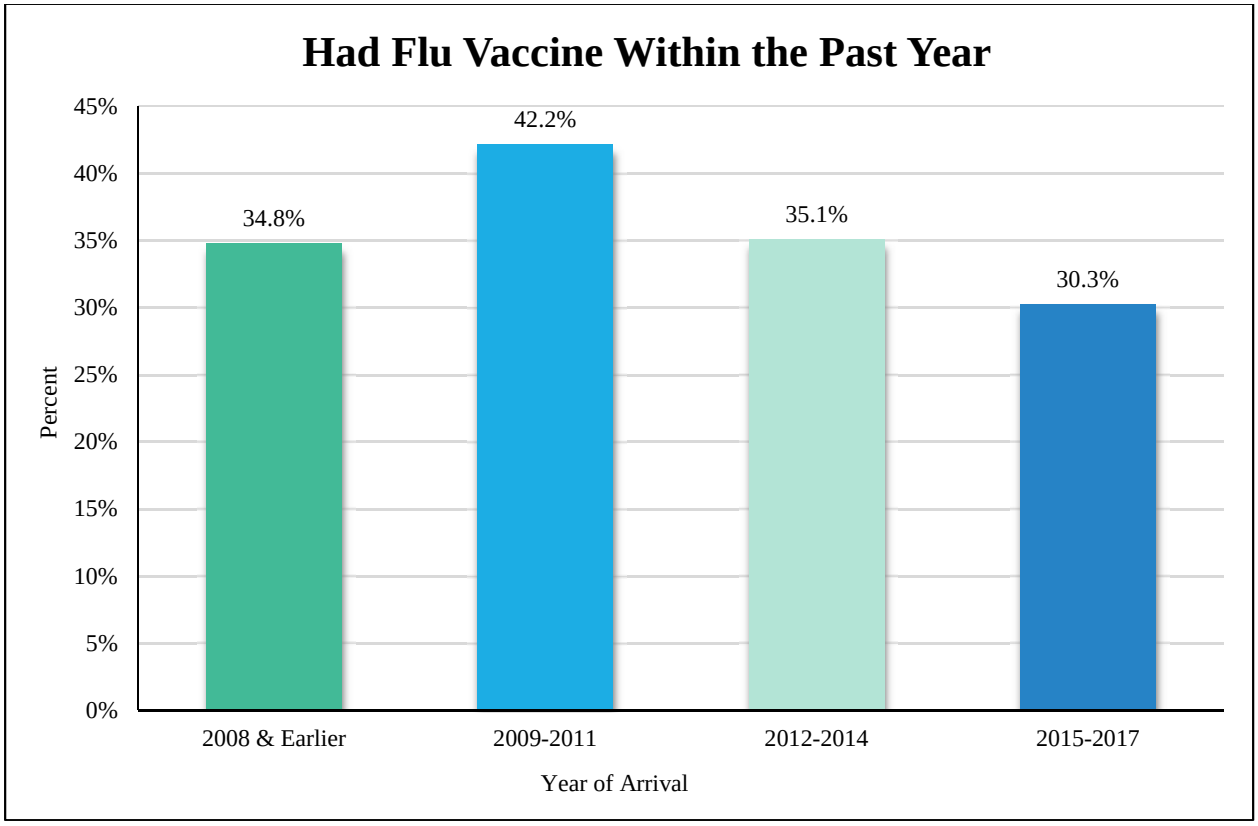
[56] Centers for Disease Control and Prevention. (2016). Key facts about seasonal flu vaccine. Retrieved from www.cdc.gov/flu/protect/keyfacts.htm

Flu Vaccination

The below chart represents the proportion of Omaha refugees who reported having received a flu shot in the past 12 months.

By Year of Arrival

- In Omaha, refugees arriving in 2009-2011 (42.2%) were most likely to have had a flu vaccine in the past 12 months.
- Omaha refugees arriving in 2015-2017 (30.3%) were least likely to have had a flu vaccine in the past 12 months, followed closely by those arriving in 2008 and earlier (34.8%) and 2012-2014 (35.1%).



Flu Vaccination for Age 65 and Older

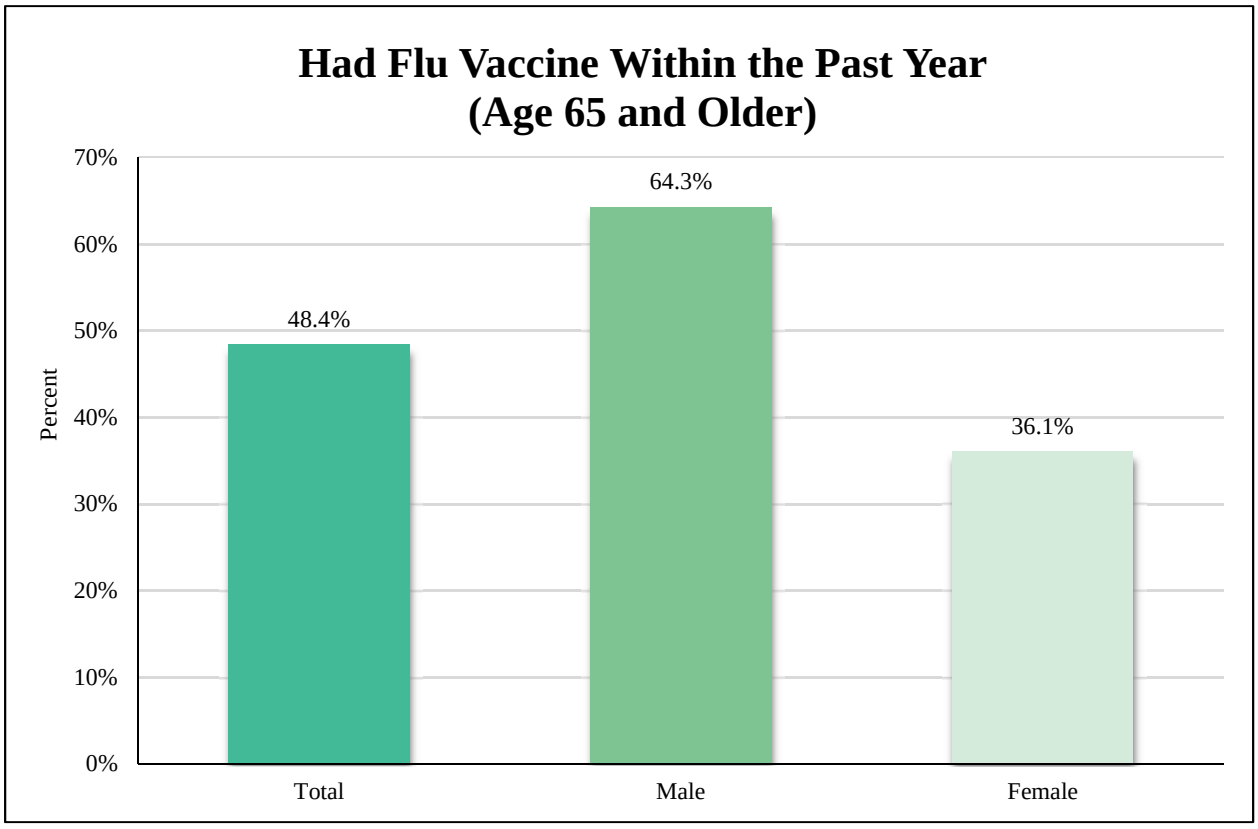
During the past 12 months, have you had either a flu shot or flu vaccine that was sprayed in your nose?

Flu shots protect individuals against the most common influenza viruses, and it is recommended that everyone over six months of age get a flu shot every influenza season.[57]

The below chart represents the proportion of Omaha refugees (age 65 and older) who reported having received a flu shot in the past 12 months.

By Gender

- Under half of Omaha refugees (48.4%) reported having had a flu vaccine in the past 12 months.
- Male refugees (64.3%) were 1.8 times more likely than female refugees (36.1%) to report having had a flu vaccine in the past 12 months.



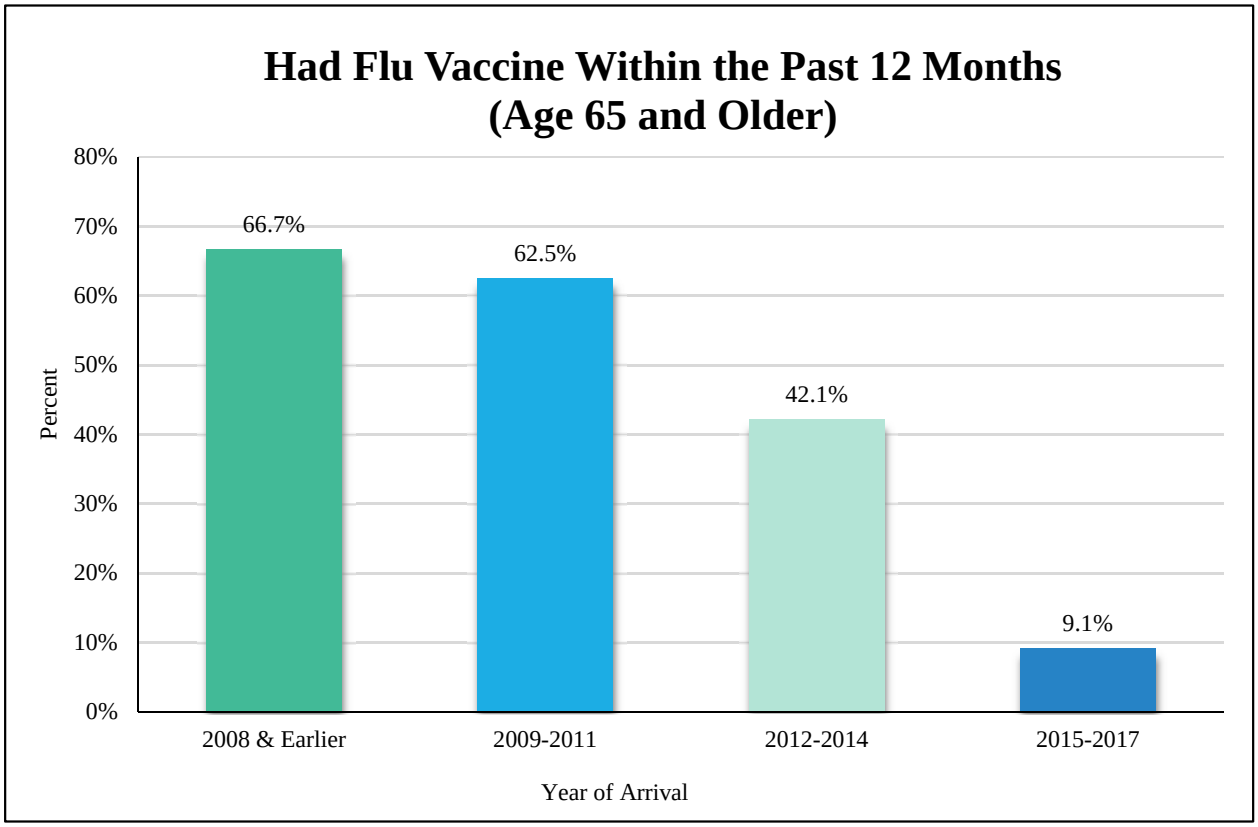
[57] Centers for Disease Control and Prevention. (2016). Key facts about seasonal flu vaccine. Retrieved from www.cdc.gov/flu/protect/keyfacts.htm

Flu Vaccination for Age 65 and Older

The below chart represents the proportion of Omaha refugees (age 65 and older) who reported having received a flu vaccine in the past 12 months.

By Year of Arrival

- The percentage of Omaha refugees who reported having received a flu vaccine in the past 12 months increased with length of stay in the United States.
- Omaha refugees arriving in 2008 and earlier were most likely to report having received a flu vaccine in the past 12 months at 66.7%. This was 7 times higher than those arriving in 2015-2017 (9.1%) who were least likely to report the same.
- Omaha refugees arriving in 2009-2011 reported having received a flu vaccine in the past 12 months at 62.5%, followed by Omaha refugees arriving in 2012-2014 (42.1%).



Pneumonia Vaccination for Age 65 and Older

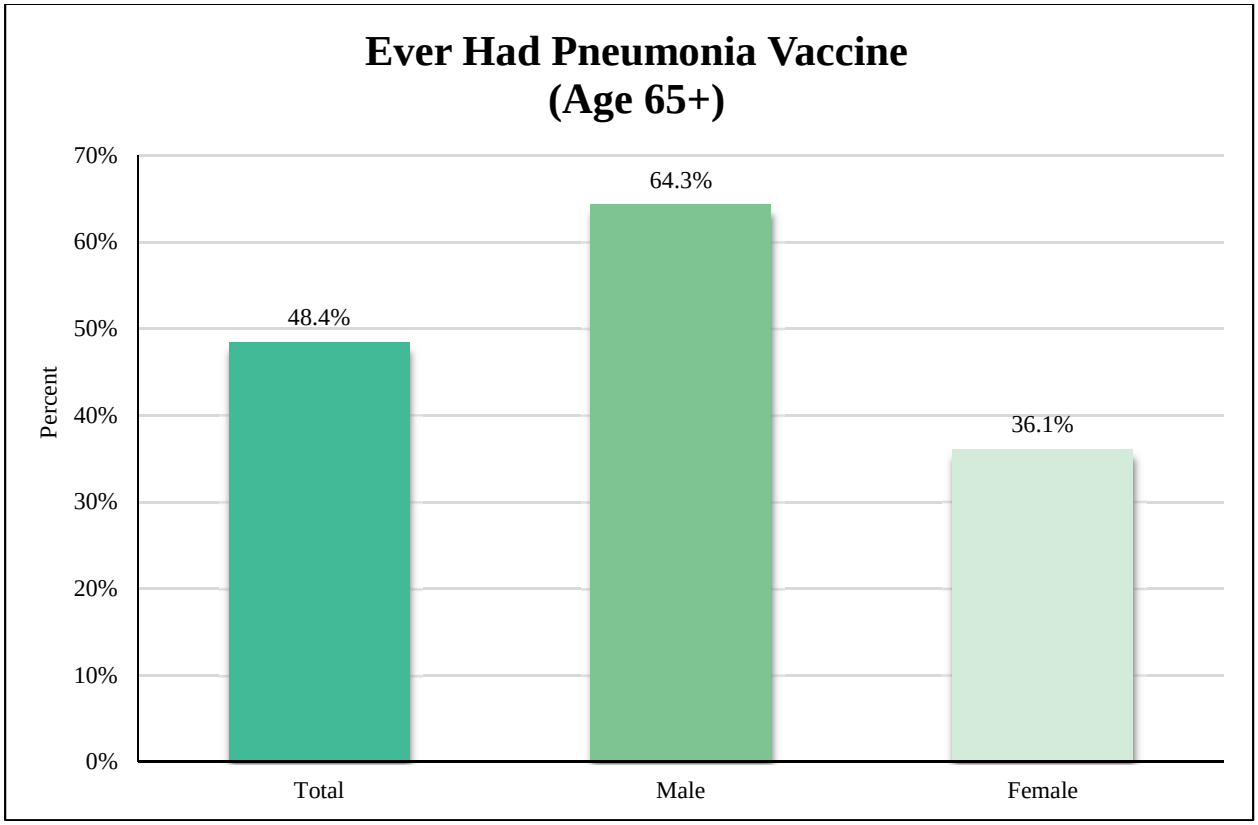
A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

Pneumococcus can cause pneumonia (lung infection), ear infections, sinus infections, and meningitis. While pneumococcal disease is common in young children, adults over the age of 65 face the greatest risk of serious infection.[58]

The below chart represents the proportion of Omaha refugees (age 65 and older) who reported having ever received a pneumonia vaccine.

By Gender

- Approximately half of Omaha refugees (48.4%) reported having ever had a pneumonia vaccine.
- Male refugees (64.3%) were 1.8 times more likely than female refugees (36.1%) to report having ever had a pneumonia vaccine.



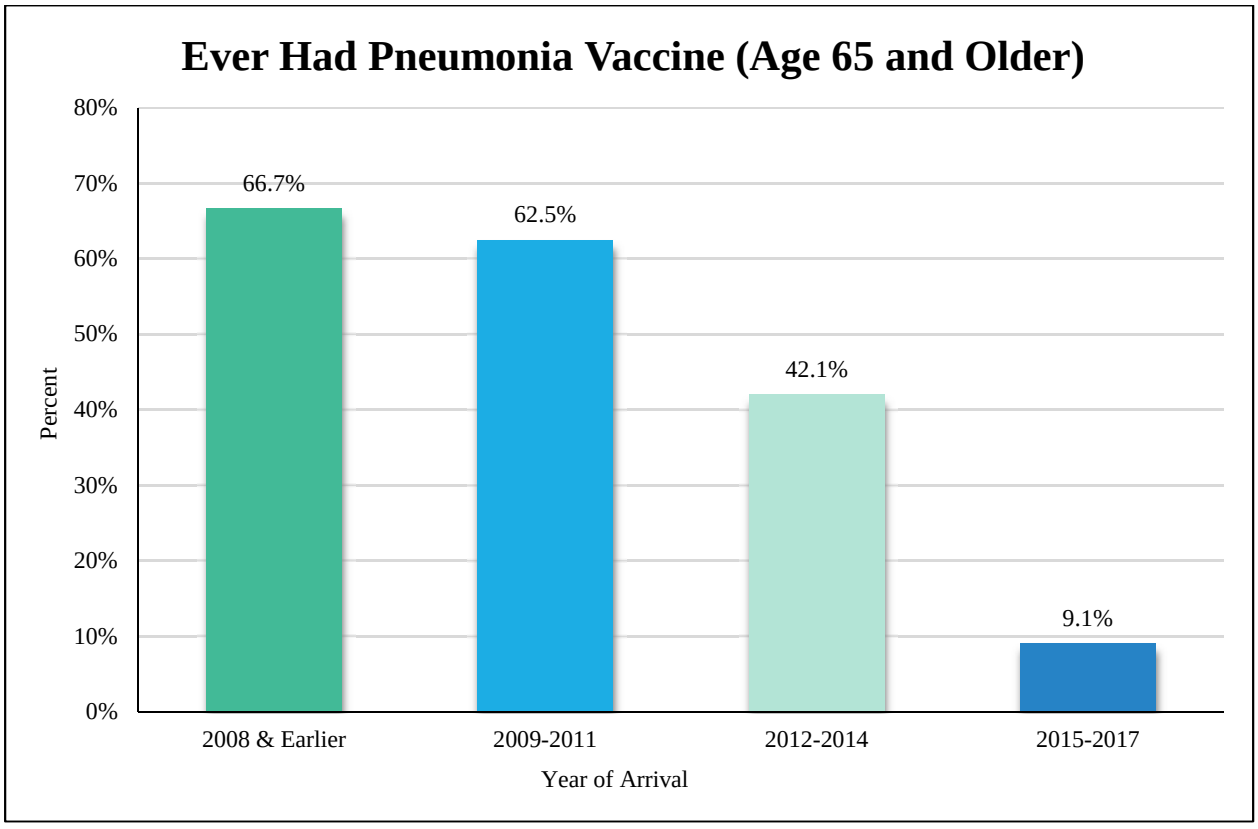
[58] Centers for Disease Control and Prevention. (2016). Pneumococcal vaccination: what everyone should know. Retrieved from www.cdc.gov/vaccines/vpd/pneumo/public/index.html

Pneumonia Vaccination for Age 65 and Older

The below chart represents the proportion of Omaha refugees (age 65 and older) who reported having ever received a pneumonia vaccine.

By Year of Arrival

- The likelihood of refugees reporting having ever had a pneumonia vaccine increased with length of stay in the United States.
- In Omaha, refugees arriving in 2008 and earlier (66.7%) were most likely to report having ever had a pneumonia vaccine, followed by refugees arriving in 2009-2011 (62.5%).
- Omaha refugees arriving in 2015-2017 were by far the least likely arrival group to report having ever had a pneumonia vaccine at 9.1%.



Pneumonia Vaccination for Age 18 and Older

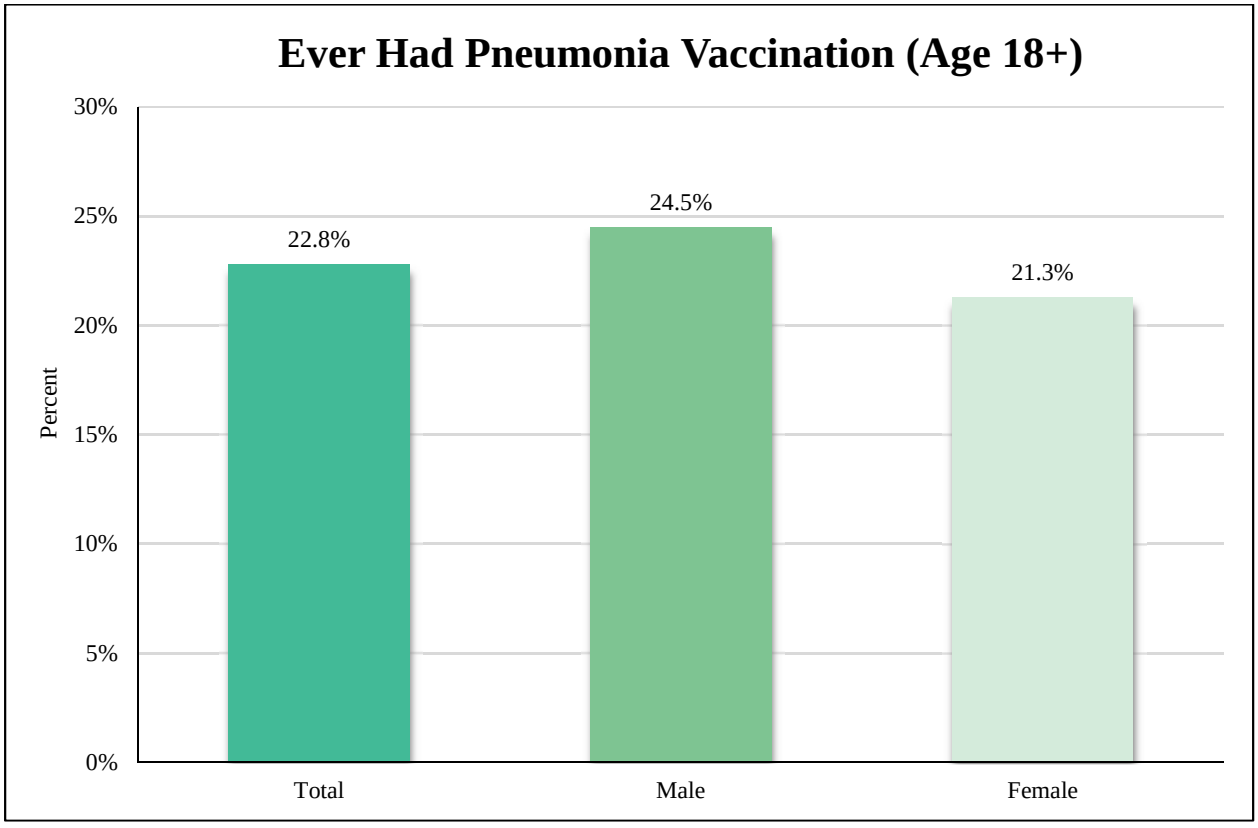
A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot?

Pneumococcus can cause pneumonia (lung infection), ear infections, sinus infections, and meningitis. While pneumococcal disease is common in young children, adults over the age of 65 face the greatest risk of serious infection.[59]

The below chart represents the proportion of Omaha refugees surveyed age 18 and older who reported having ever received a pneumonia vaccine.

By Gender

- Approximately one- fifth of Omaha refugees age 18 and older (22.8%) reported having ever had a pneumonia vaccine.
- Male refugees age 18 and older (24.5%) were more likely than were female refugees age 18 and older (21.3%) to report having ever had a pneumonia vaccine.



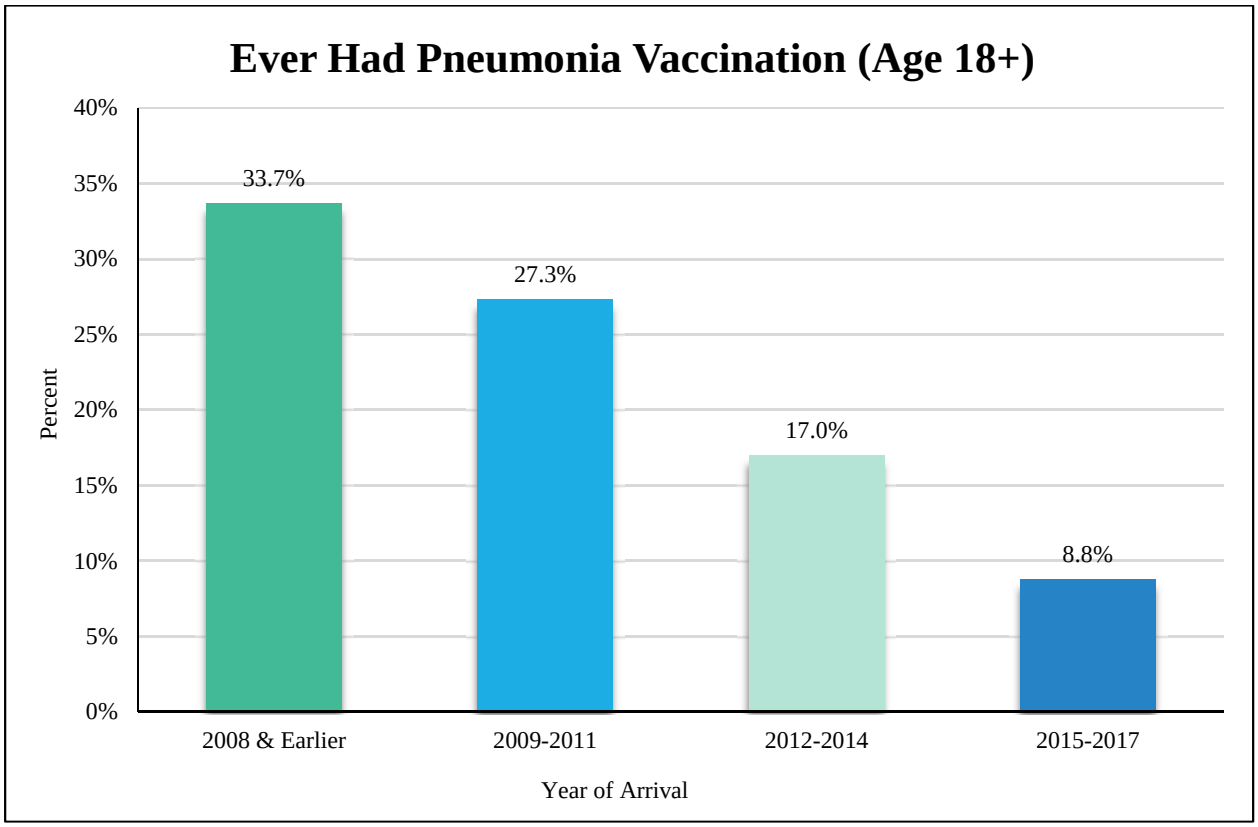
[59] Centers for Disease Control and Prevention. (2016). Pneumococcal vaccination: what everyone should know. Retrieved from www.cdc.gov/vaccines/vpd/pneumo/public/index.html

Pneumonia Vaccination for Age 18 and Older

The below chart represents the proportion of Omaha refugees surveyed age 18 and older who reported having ever received a pneumonia vaccine.

By Year of Arrival

- The percentage of refugees age 18 and older who reported have had a pneumonia vaccine in the past year increased with length of stay in the United States.
- In Omaha, refugees age 18 and older arriving in 2008 and earlier (33.7%) were the most likely population to report having ever had a pneumonia vaccine, followed by refugees arriving in 2009-2011 (27.3%).
- Omaha refugees age 18 and older arriving in 2015-2017 were by far the least likely population to report having ever had a pneumonia vaccine at 8.8%.



HIV Test

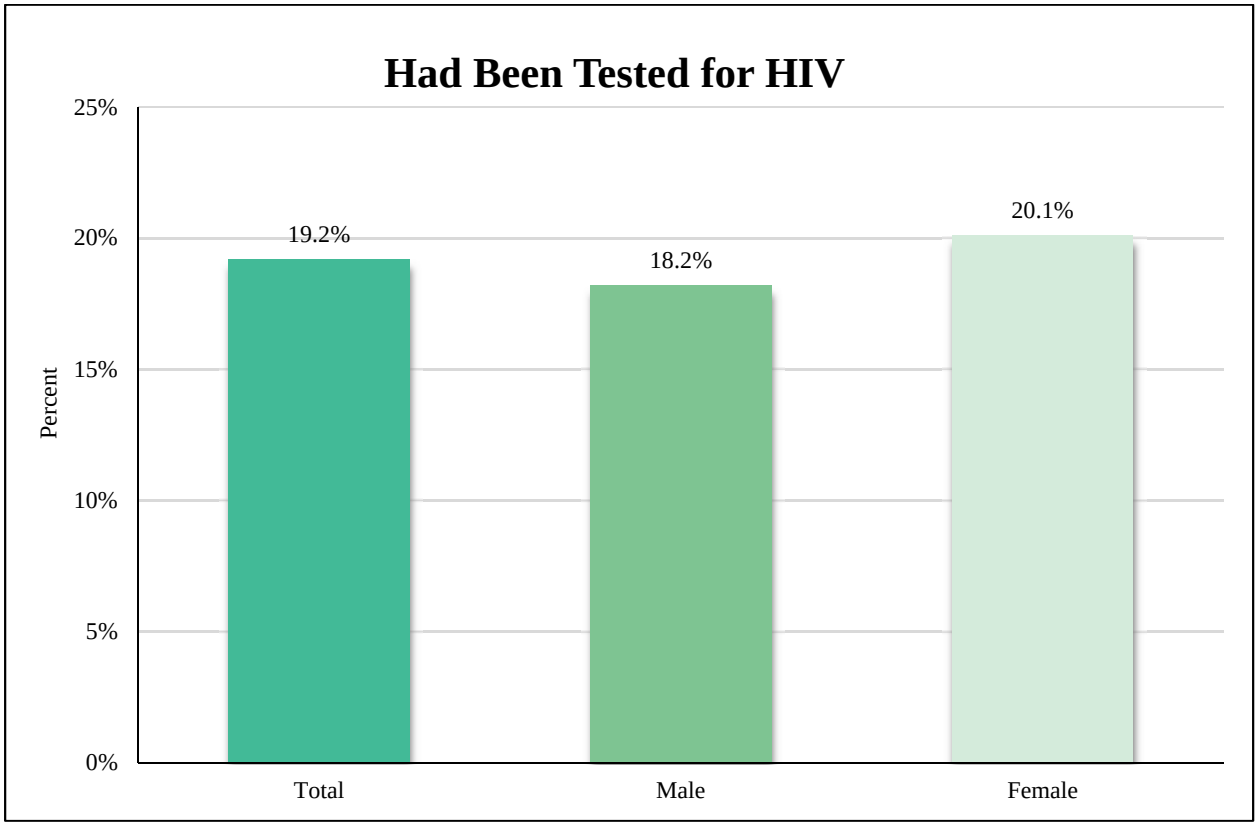
Have you ever been tested for HIV? Do not count tests you may have had as part of a blood donation.

While Human Immunodeficiency Virus (HIV) is quite similar to other viruses, the immune system cannot completely get rid of HIV. Over time, HIV is able to destroy cells that the body needs to fight off infections.[60] If untreated, HIV can lead to acquired immunodeficiency syndrome (AIDS), which leaves the body extremely vulnerable to certain diseases and cancers.

The below chart represents the proportion of Omaha refugees who reported having ever been tested for HIV, excluding blood donations.

By Gender

- Approximately one-fifth of Omaha refugees (19.2%) reported having ever been tested for HIV.
- Female refugees (20.1%) were slightly more likely than were male refugees (18.2%) to report having ever been tested for HIV.



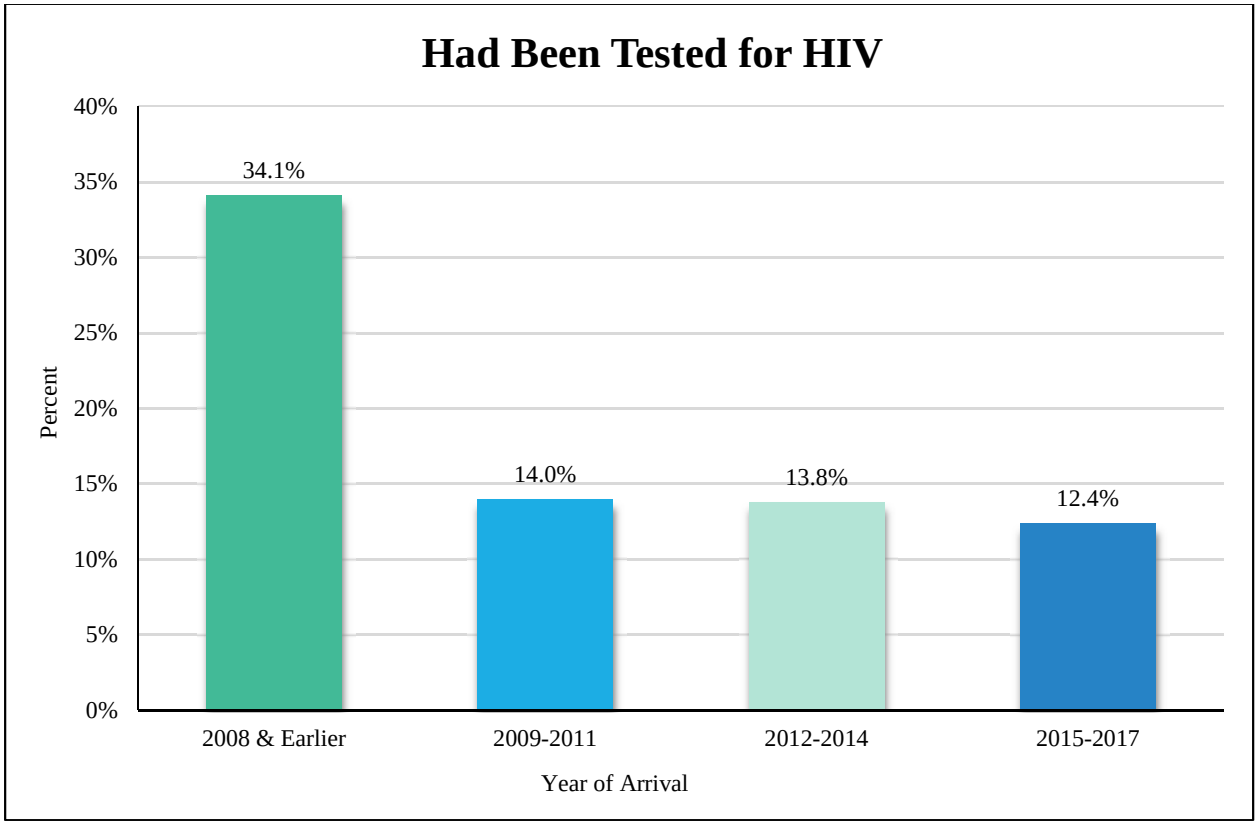
[60] AIDS.gov. (2016). What is HIV/AIDS. Retrieved from www.aids.gov/hiv-aids-basics/hiv-aids-101/what-is-hiv-aids

HIV Test

The below chart represents the proportion of Omaha refugees who reported having ever been tested for HIV, excluding blood donations.

By Year of Arrival

- In Omaha, refugees arriving in 2008 and earlier (34.1%) were the most likely population to have ever been tested for HIV, followed by refugees arriving in 2009-2011 (14.0%) and refugees arriving in 2012-2014 (13.8%).
- Omaha refugees arriving in 2015-2017 (12.4%) were notably less likely than all other arrival populations to report having ever been tested for HIV.



Mammogram

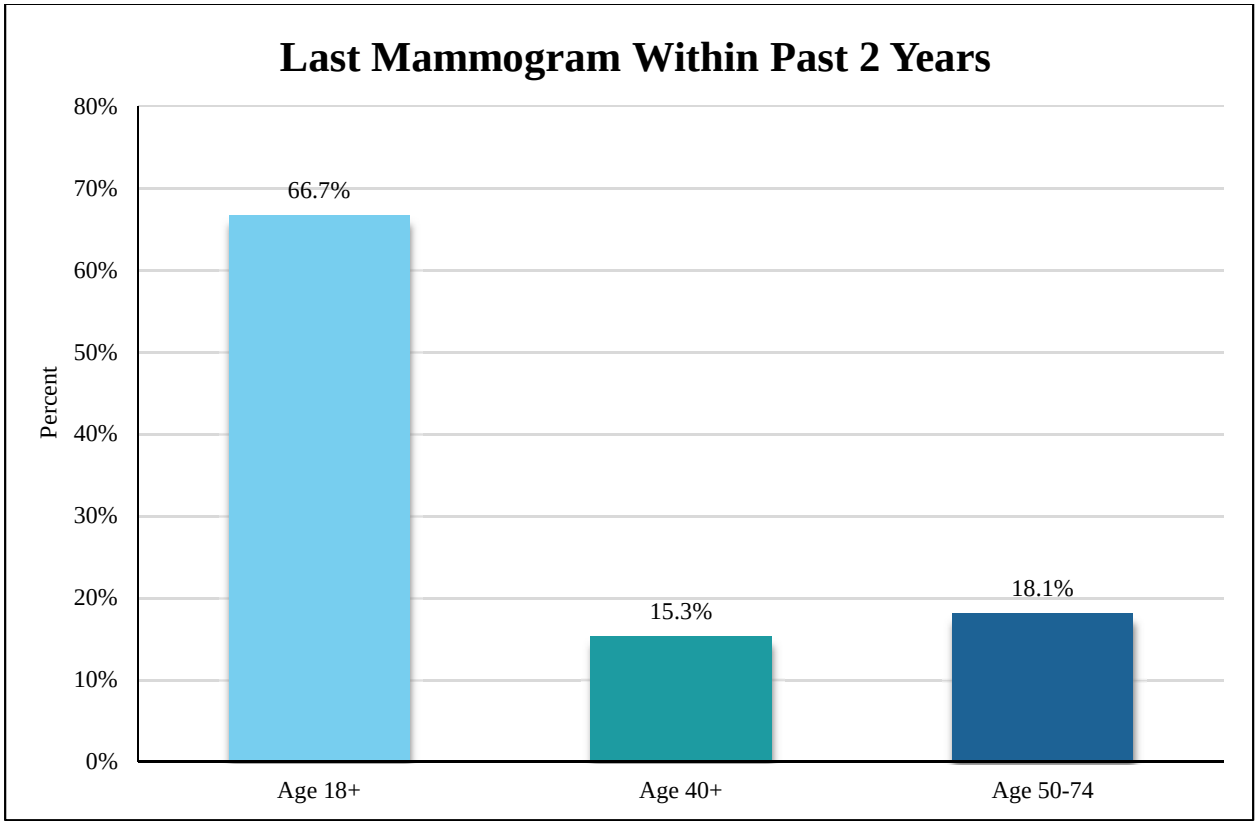
A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram? How long has it been since your last mammogram?

Mammograms are x-ray pictures of the breast used to look for signs of breast cancer. The American Cancer Society recommends women age 45 and older should get mammograms every one or two years and women age 40 to 44 should have the choice to start annual mammograms.[61]

The below chart represents the proportion of Omaha female refugees who reported having had a mammogram in the past two years.

Key Findings

- More than half of female refugees age 18 and older (66.7 %) reported having had a mammogram in the past two years.
- Female refugees age 40 and older (15.3 %) and age 50-74 (18.1%) reported having had a mammogram in the past two years.



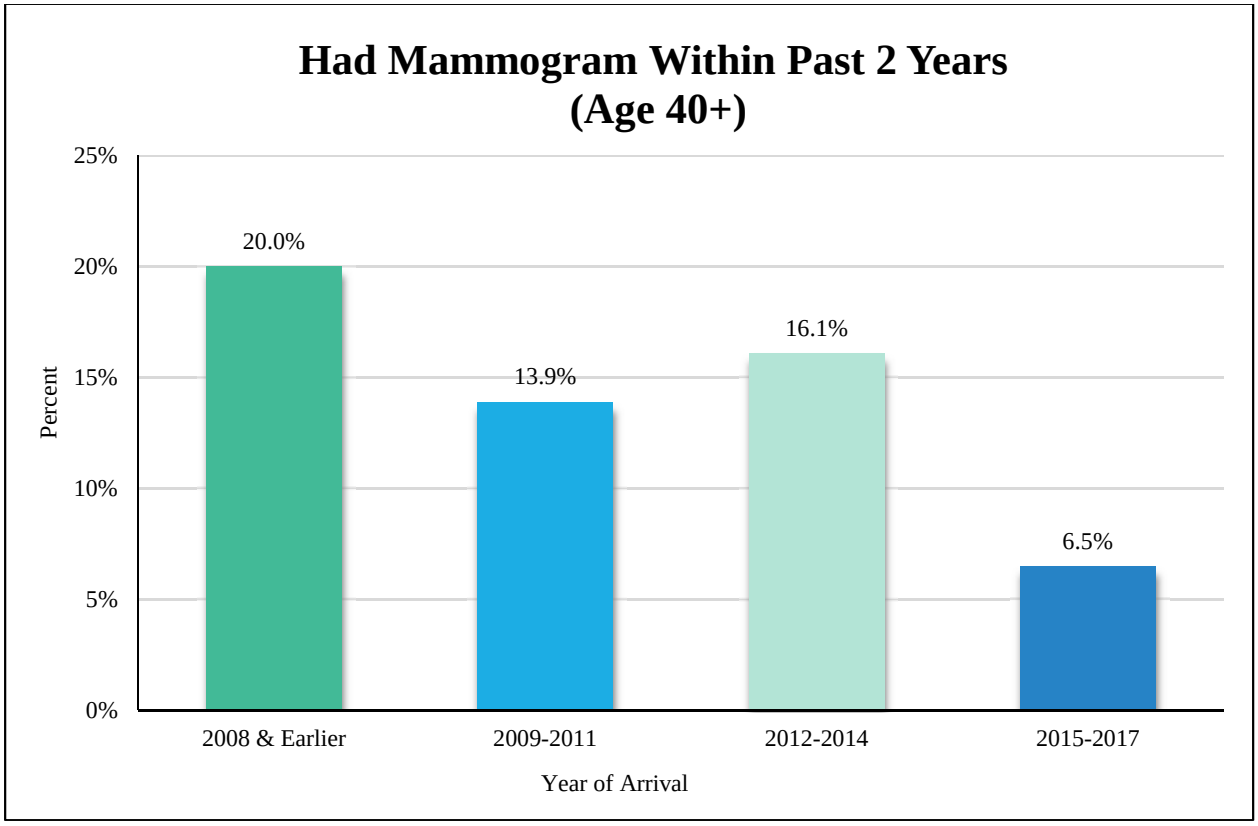
[61] American Cancer Society. (2018). American Cancer Society guidelines for the early detection of cancer. Retrieved from www.cancer.org/healthy/find-cancer-early/cancer-screening-guidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html

Mammogram

The below chart represents the proportion of Omaha female refugees (age 40 and older) who reported having had a mammogram in the past two years.

By Year of Arrival

- Female refugees arriving in 2008 and earlier (20.0%) were most likely to report having had a mammogram in the past two years, followed by refugees arriving in 2012-2014 (16.1%) and refugees arriving in 2009-2011 (13.9%).
- Omaha refugees arriving in 2015-2017 (6.5%) were notably less likely than the other arrival groups to report having had a mammogram in the past two years.



Pap Test

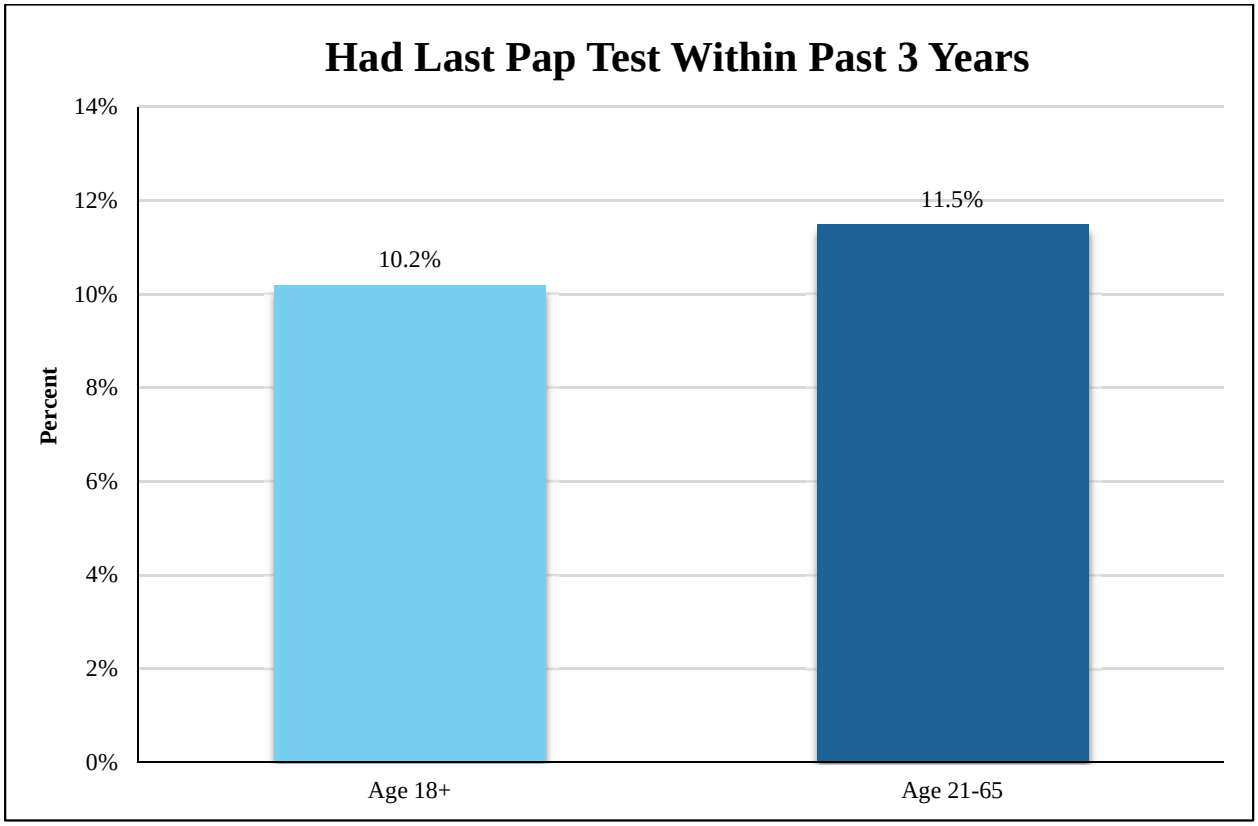
A Pap test is a test for cancer of the cervix. Have you ever had a Pap test? How long has it been since you had your last Pap test?

The American Cancer Society recommends that women begin receiving a Pap test, a screening procedure for cervical cancer, at age 21.[62] Women should continue to get a Pap test every three to five years until age 65.

The below chart represents the proportion of Omaha female refugees (age 21 to 65) who reported having had a Pap test in the past three years.

Key Findings

- Approximately one-tenth of female refugees aged 18 and older (10.2%) reported having had a pap test in the past three years.
- Approximately one-tenth of female refugees aged 21 to 65 (11.5%) reported having had a pap test in the past three years.



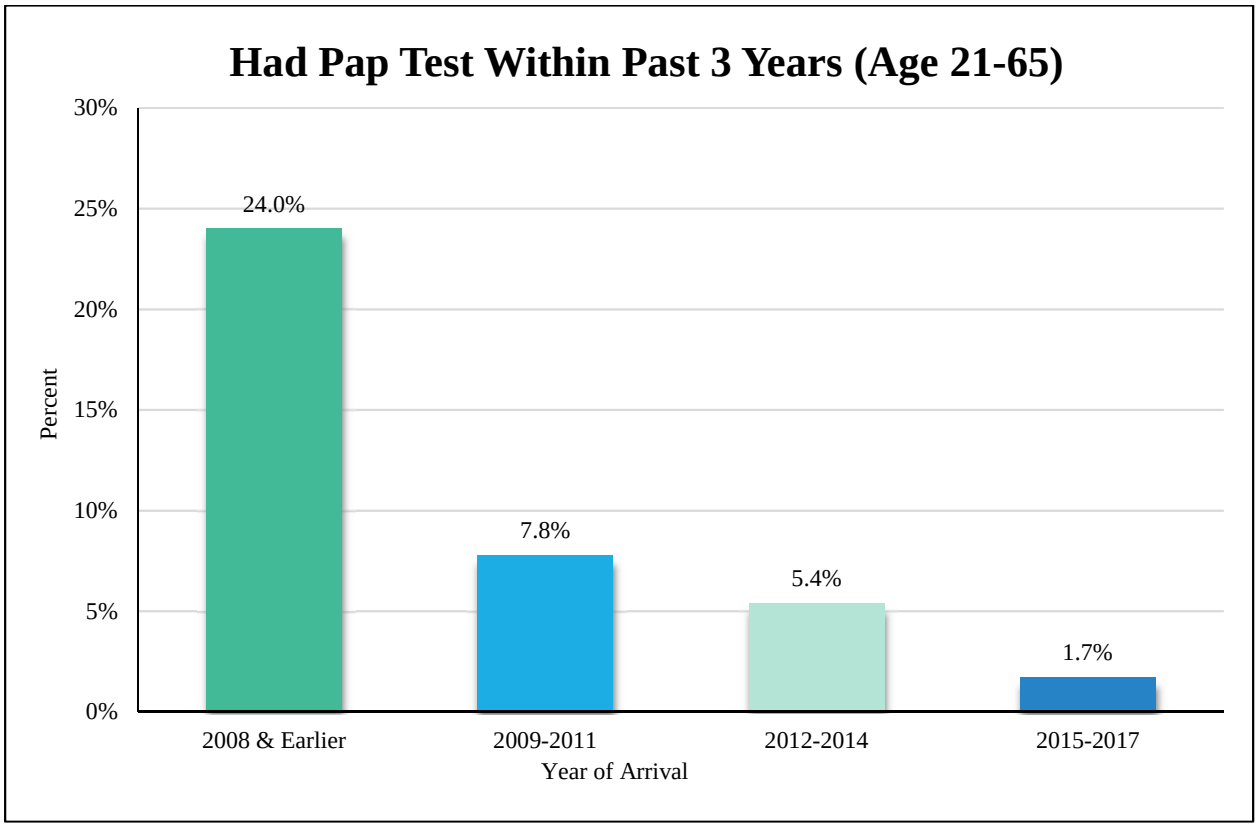
[62] American Cancer Society. (2018). The American Cancer Society guidelines for the prevention and early detection of cervical cancer. Retrieved from www.cancer.org/cancer/cervical-cancer/prevention-and-early-detection/cervical-cancer-screening-guidelines.html

Pap Test

The below chart represents the proportion of Omaha female refugees (age 21 to 65) who reported having had a Pap test in the past three years.

By Year of Arrival

- The percentage of female refugees reporting having had a pap test in the past three years increased with length of stay in the United States.
- Omaha refugees arriving in 2008 and earlier (24.0%) were most likely to report having had a pap test in the past three years. This percentage was 14 times higher than that of refugees arriving in 2015-2017 (1.7%) who were least likely to report the same.
- Similar percentages of Omaha refugees arriving in 2009-2011 (7.8 %) and in 2012-2014 (5.4%) reported having had a pap test in the past three years.



Underweight

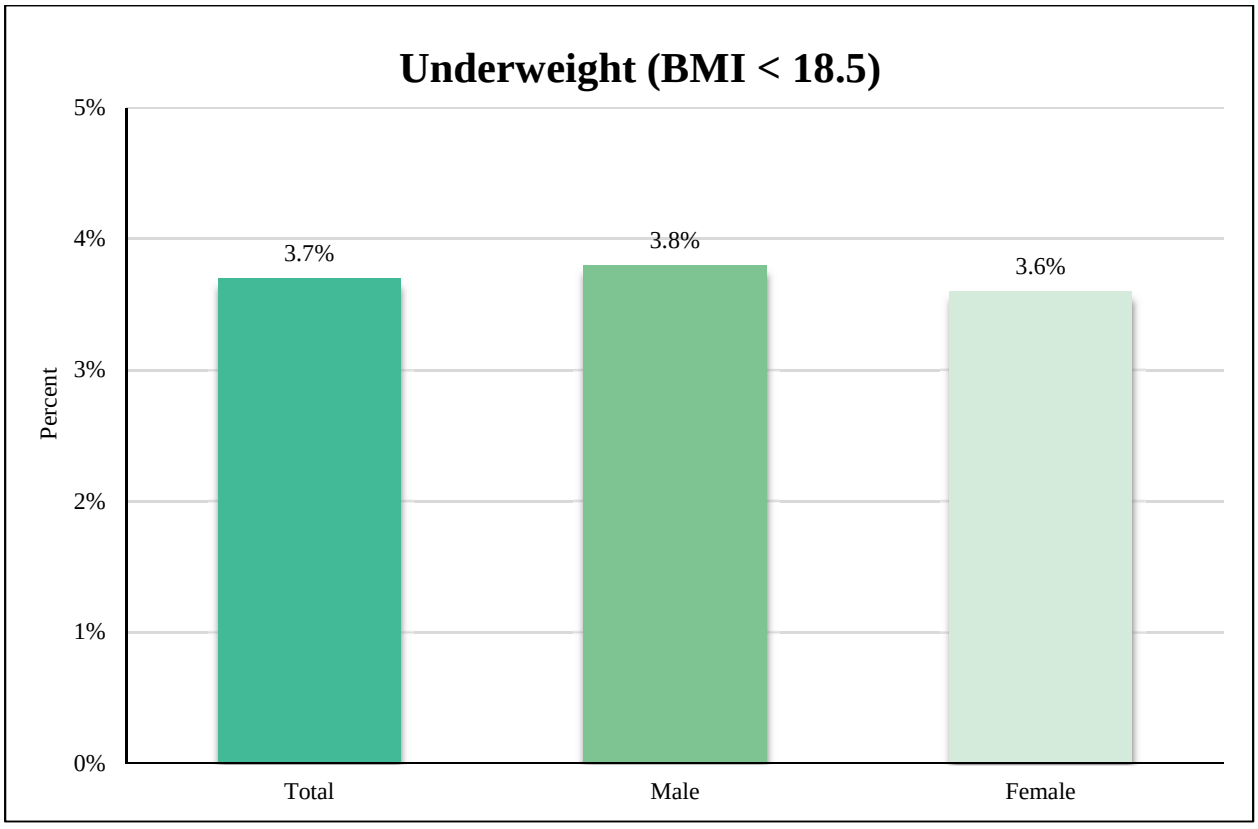
BMI less than 18.5
Calculated using reported height and weight

Body Mass Index (BMI) is an estimated measure of an adult's body fat, which is determined by a ratio of height and weight. Individuals with a BMI lower than 18.5 are considered underweight. Being underweight can put individuals at a higher risk of not getting the amount of nutrients needed for the immune system to function properly.

The below chart represents the proportion of Omaha refugees with a BMI lower than 18.5.

By Gender

- Approximately four percent of Omaha refugees (3.7%) were underweight.
- Male refugees (3.6%) and female refugees (3.8%) reported similar percentages of being underweight.

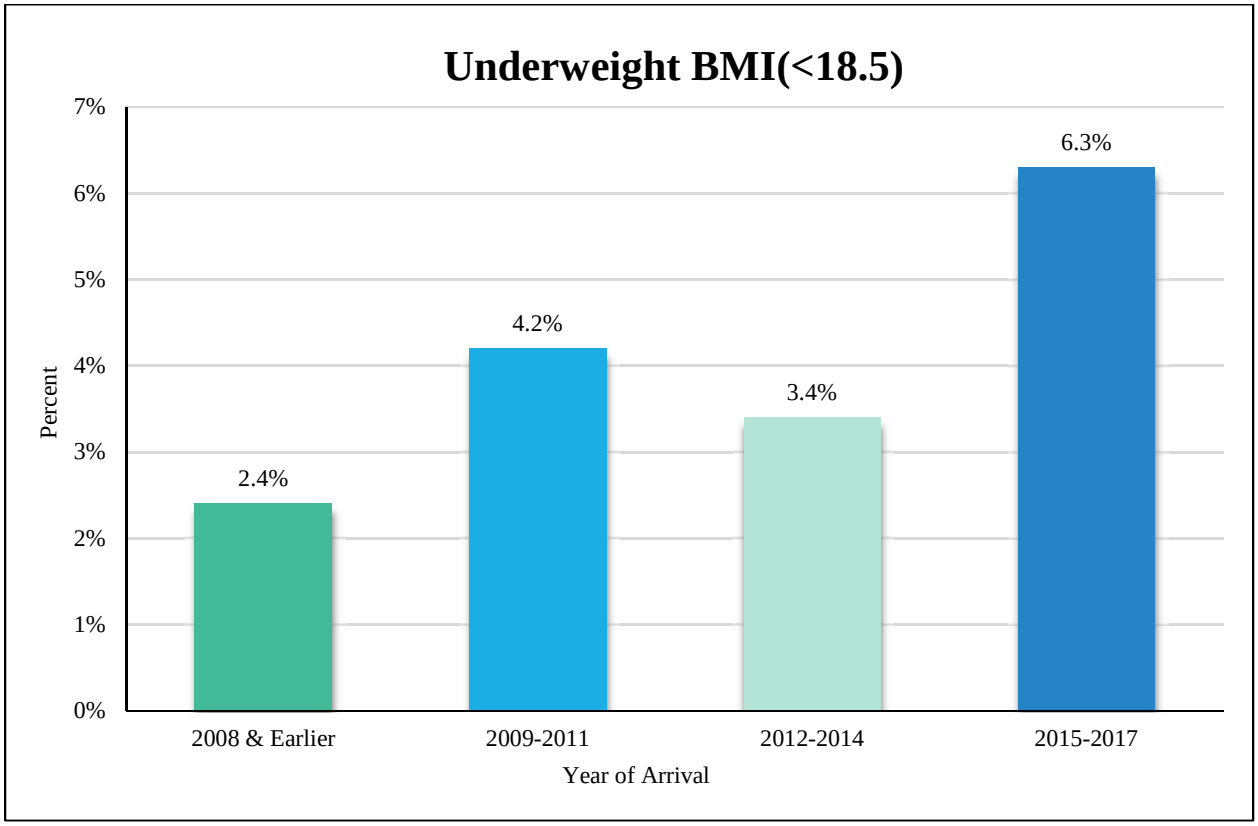


Underweight

The below chart represents the proportion of Omaha refugees with a BMI lower than 18.5.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (6.3%) were most likely to be underweight, followed closely by refugees arriving in 2009-2011 (4.2%).
- Omaha refugees with the longest stay in the United States (2008 and earlier) were least likely to be underweight at 2.4%.



Overweight or Obese

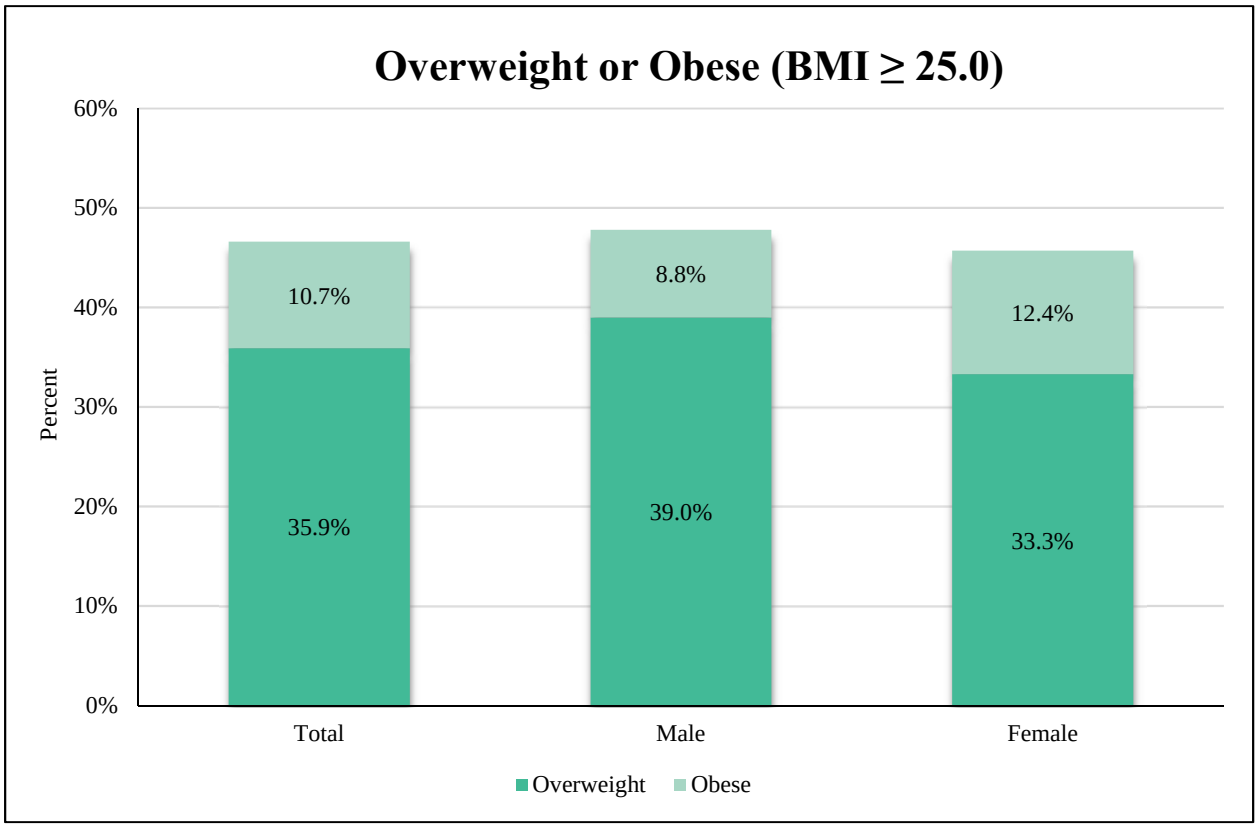
Overweight: BMI of 25 to 29.9 • Obese: BMI of 30 or higher
Calculated using reported height and weight

Higher BMIs can indicate a higher risk of heart disease, high blood pressure, type 2 diabetes, and certain cancers.[63] Individuals with a BMI of 25-29.9 are considered overweight and individuals with a BMI of 30 or higher are considered obese.

The below chart represents the proportion of Omaha refugees with a BMI of greater than or equal to 25.

By Gender

- Approximately one-half of Omaha refugees (46.6%) were overweight or obese, with 35.9% being overweight and approximately 20% being obese.
- Male refugees (47.8%) were slightly more likely than female refugees (45.7%) to be overweight or obese.
- Female refugees (12.4%) were 1.4 times more likely than male refugees (8.8%) to be obese.



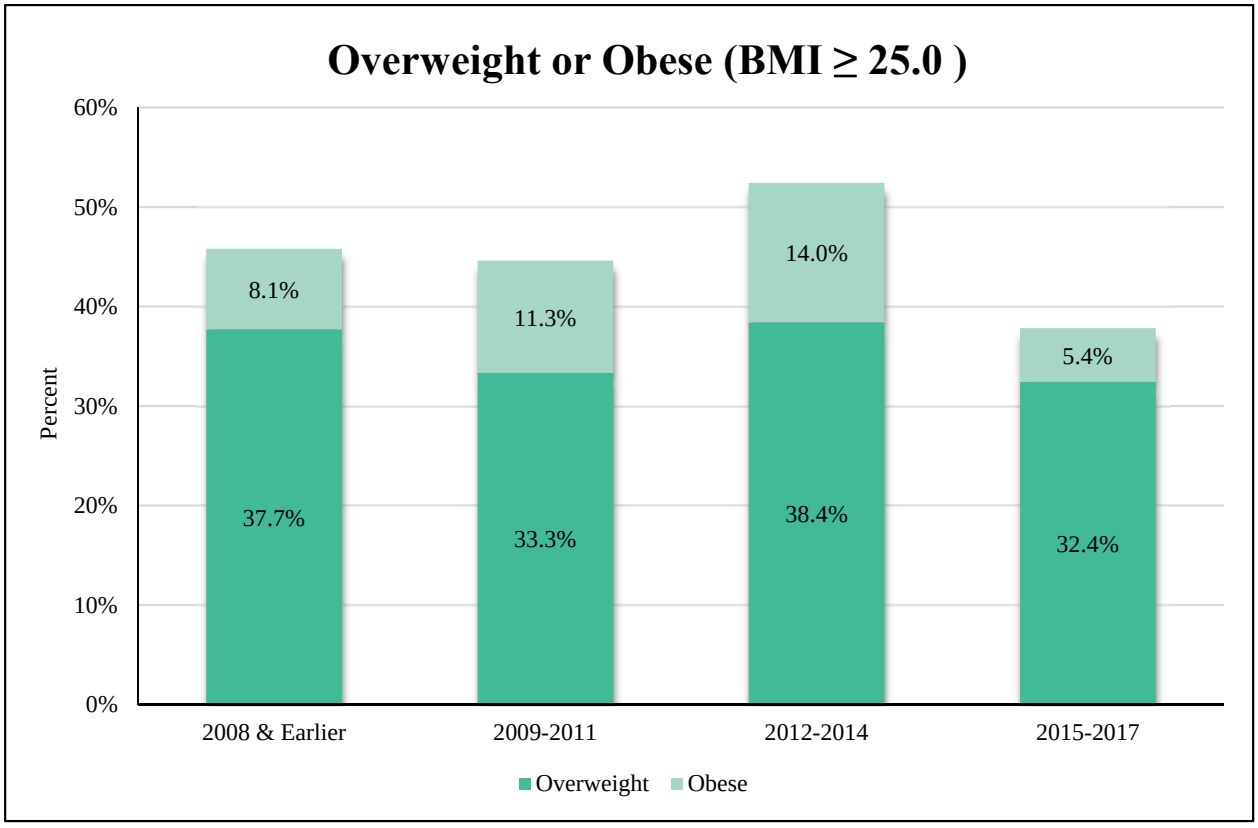
[63] National Institutes of Health. (2016). BMI Tools. Retrieved from www.nhlbi.nih.gov/health/educational/lose_wt/bmitools.htm

Overweight or Obese

The below chart represents the proportion of Omaha refugees with a BMI of greater than or equal to 25.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (37.8%) were least likely to be overweight or obese, followed by refugees arriving in 2009-2011 (44.6%).
- Omaha refugees arriving in 2012-2014 (52.4%) had the highest rate of being overweight or obese.
- Omaha refugees arriving in 2009-2011 (11.3%) had the second highest rate of obesity and those arriving in 2008 and earlier (37.7%) had the second highest rate of being overweight.



Cigarette Smoking

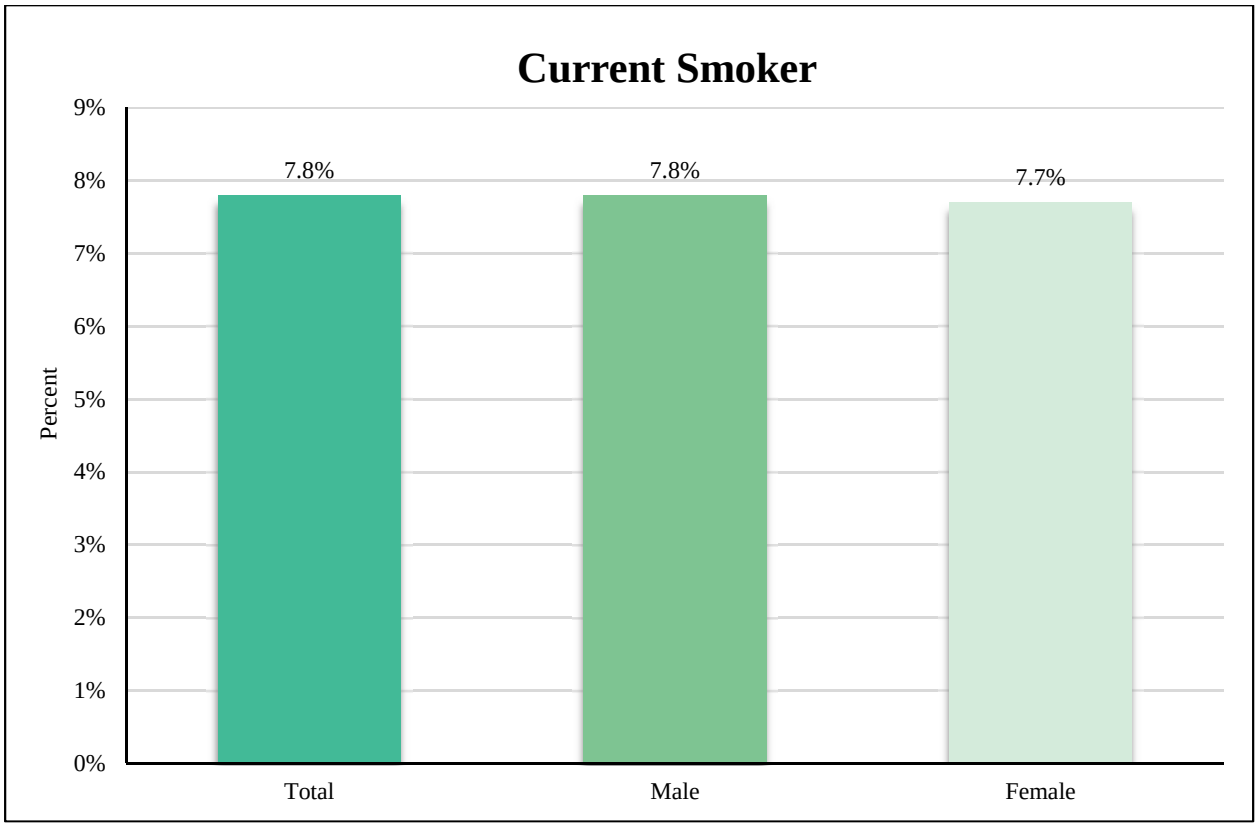
Do you smoke cigarettes every day, some days, or not at all?

Tobacco is the leading cause of preventable death and disease in the United States. Smoking increases the risk of chronic diseases like lung disease, coronary heart disease, stroke, and various cancers.[64] Cigarette smoking causes nearly one in five deaths each year in the United States.[65]

The below chart represents the proportion of Omaha refugees who reported currently smoking cigarettes every day or some days.

By Gender

- Approximately eight percent of Omaha refugees (7.8%) reported being current smokers.
- Similar percentages of female refugees (7.7%) and male refugees (7.8%) reported be current smokers.



[64] Centers for Disease Control and Prevention. (2016). Health effects of cigarette smoking. Retrieved from www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/

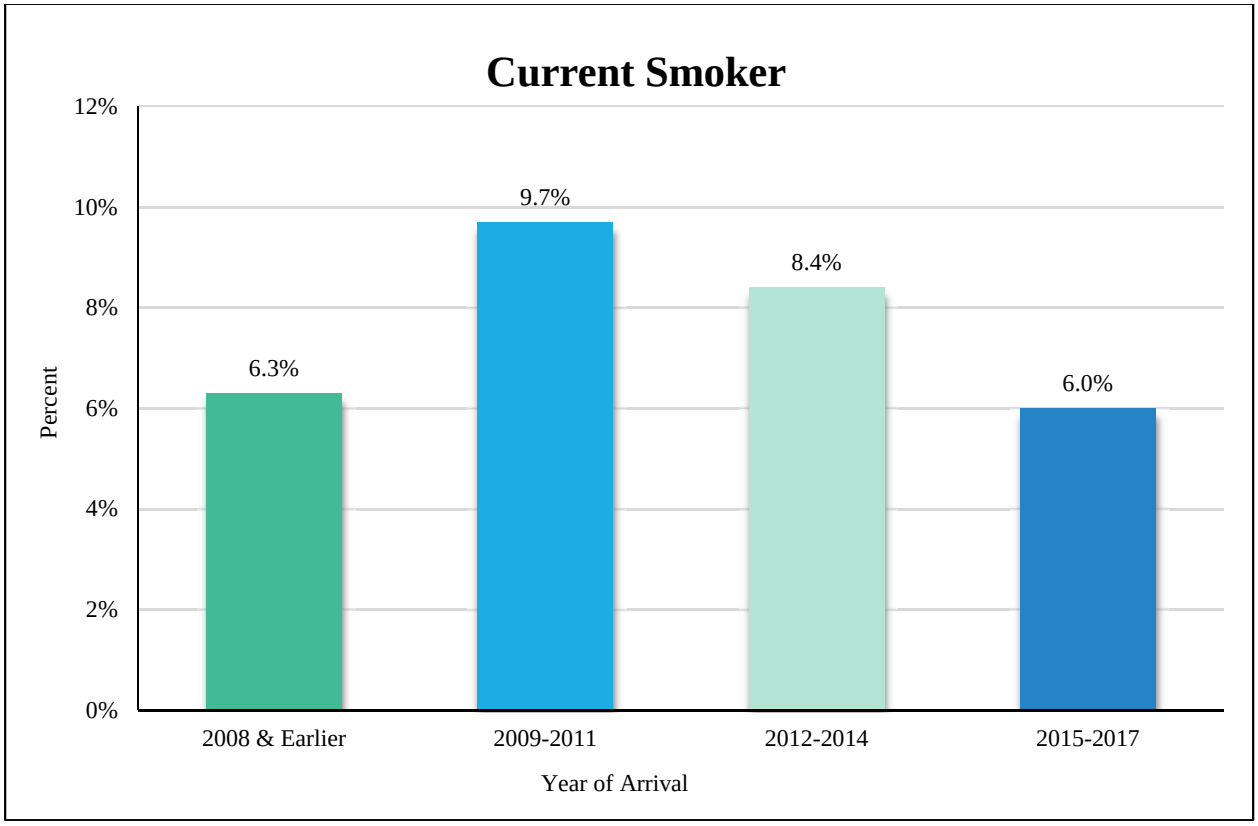
[65] Centers for Disease Control and Prevention. (2013). QuickStats: number of deaths from 10 leading causes. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm6208a8.htm?s_cid=mm6208a8_w

Cigarette Smoking

The below chart represents the proportion of Omaha refugees who reported currently smoking cigarettes every day or some days.

By Year of Arrival

- Omaha refugees arriving in 2009-2011 were most likely to report being current cigarette smokers at 9.7%. This percentage was 1.6 times that of the arrival group least likely to report being current smokers – refugees arriving in 2015-2017 at 6.0%.
- Omaha refugees arriving in 2008 and earlier reported being current cigarette smokers at 6.3%, followed by Omaha refugees arriving in 2012-2014 (8.4%).



E-Cigarette Smoking

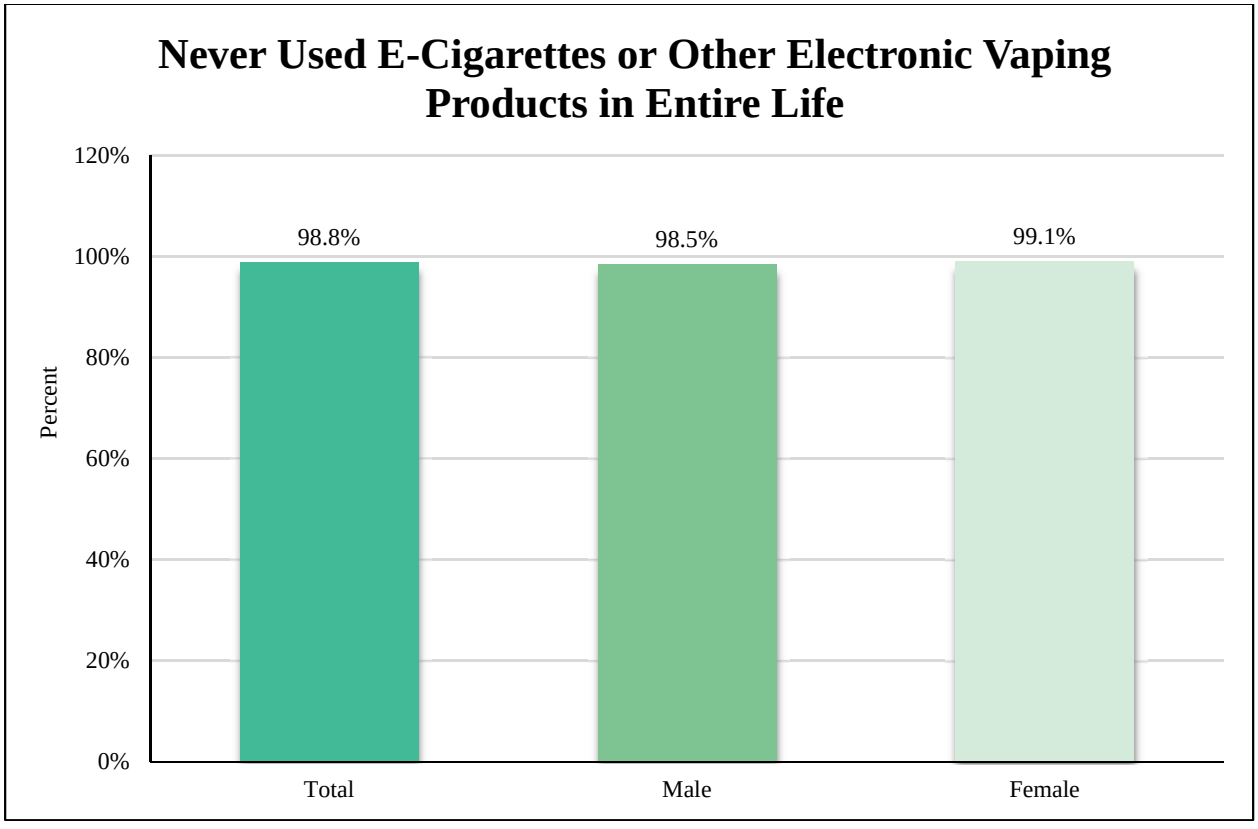
Have you ever used an e-cigarette and other electronic vaping product, ever just one time, in your entire life?

E-cigarettes are sometimes called “e-cigs,” “vapes,” “e-hookahs,” “vape pens,” and “electronic nicotine delivery systems (ENDS).” Some e-cigarettes look like regular cigarettes, cigars, or pipes. Some look like USB flash drives, pens, and other everyday items. Using e-cigarettes causes health risks. It concluded that e-cigarettes both contain and emit a number of potentially toxic substances.

The below chart represents the proportion of Omaha refugees who reported E-cigarettes using or other electronic vaping products in their entire life.

By Gender

- Almost all
- Omaha refugees (98.8%) reported had never used E-cigarettes or other electronic vaping products in their entire life.
- Male refugees (98.5%) and female refugees (99.1%) had similar rates of never using E-cigarettes or other electronic vaping products in their entire life.

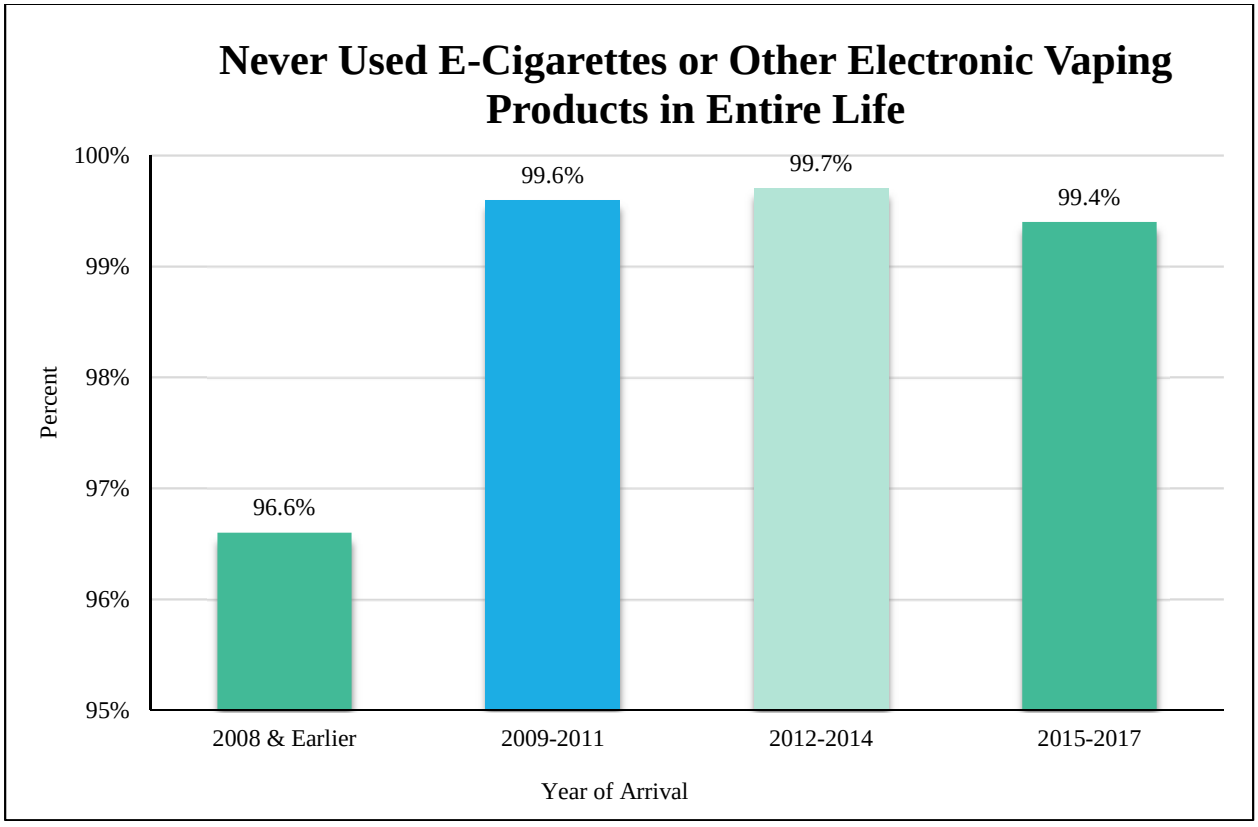


E-Cigarette Smoking

The below chart represents the proportion of Omaha refugees who reported E-cigarettes using or other electronic vaping products in their entire life.

By Year of Arrival

- Omaha refugees arriving in 2012-2014 were most likely to report never using an E-cigarettes or other electronic vaping products in their entire life at 99.7%, followed closely by refugees arriving in 2009-2011 (99.6%) and refugees arriving in 2015-2017 (99.4%).
- Omaha refugees arriving in 2008 and earlier were least likely to report never using an E-cigarettes or other electronic vaping product in their entire life at 96.6%.



Binge Drinking

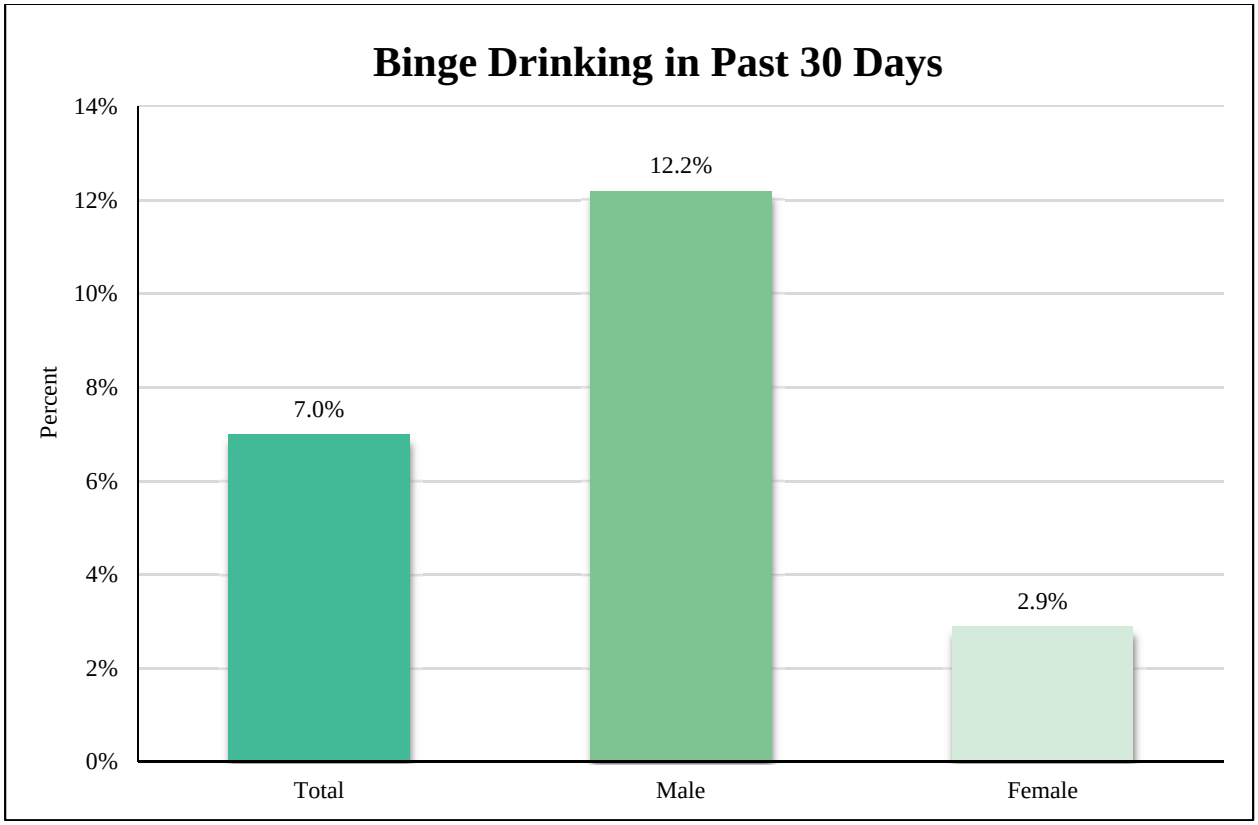
During the past 30 days, what is the largest number of drinks you had on any one occasion?

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines binge drinking as drinking five or more alcoholic beverages on any one occasion for men and drinking four or more alcoholic beverages on any one occasion for women.[66]

The below chart represents the proportion of Omaha refugees who reported having four or more drinks (for women) or five or more drinks (for men) on any one occasion in the past month.

By Gender

- Seven percent of Omaha refugees reported binge drinking in the past 30 days.
- Male refugees (12.2%) were four times more likely than female refugees (2.9%) to report binge drinking in the past 30 days.



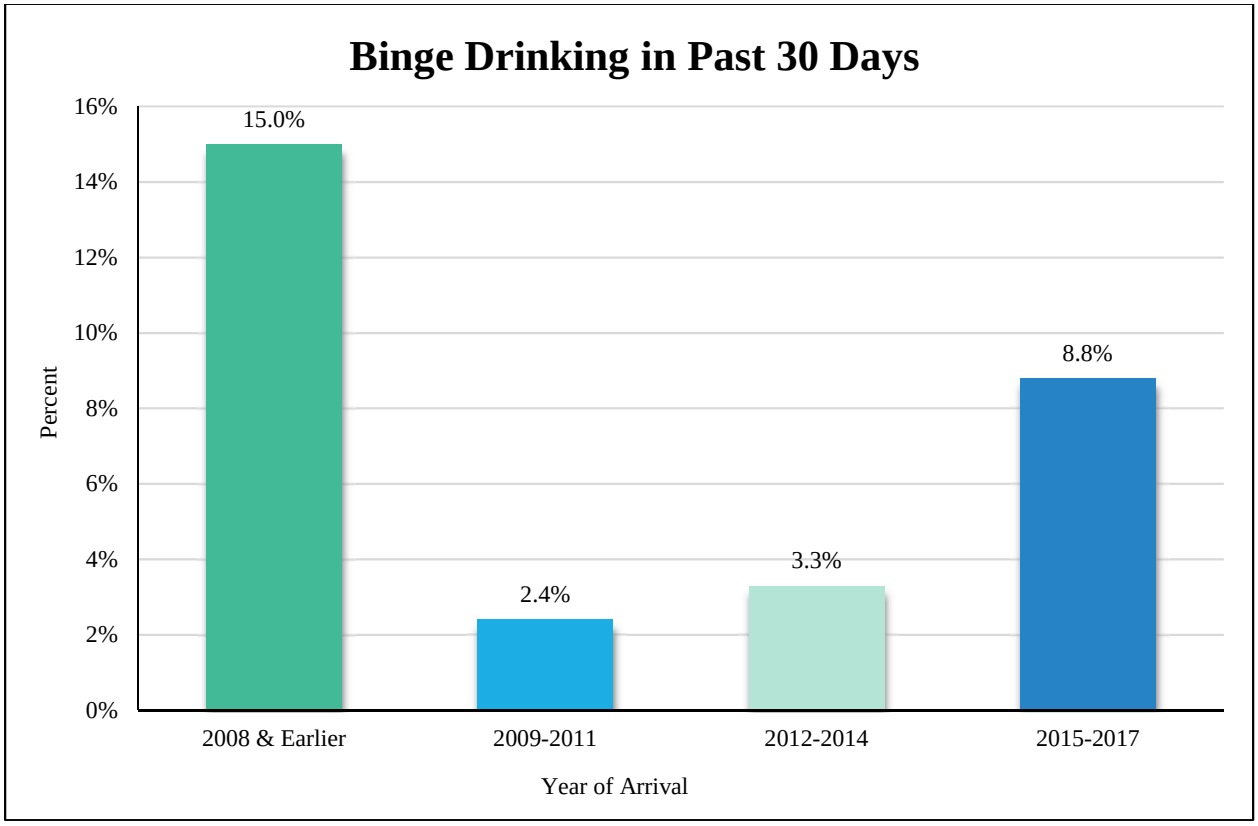
[66] National Institutes of Health. (2016). Drinking levels defined. Retrieved from www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking

Binge Drinking

The below chart represents the proportion of Omaha refugees who reported having four or more drinks (for women) or five or more drinks (for men) on any one occasion in the past month.

By Year of Arrival

- Omaha refugees arriving in 2008 & earlier (15.0%) were most likely to report binge drinking in the past 30 days, followed by refugees arriving in 2015-2017 (8.8%).
- Omaha refugees arriving in 2009-2011 (2.4%) and refugees arriving in 2012-2014 (3.3%) were notably less likely than other arrival groups to report binge drinking in the past 30 days.



Fruit Consumption

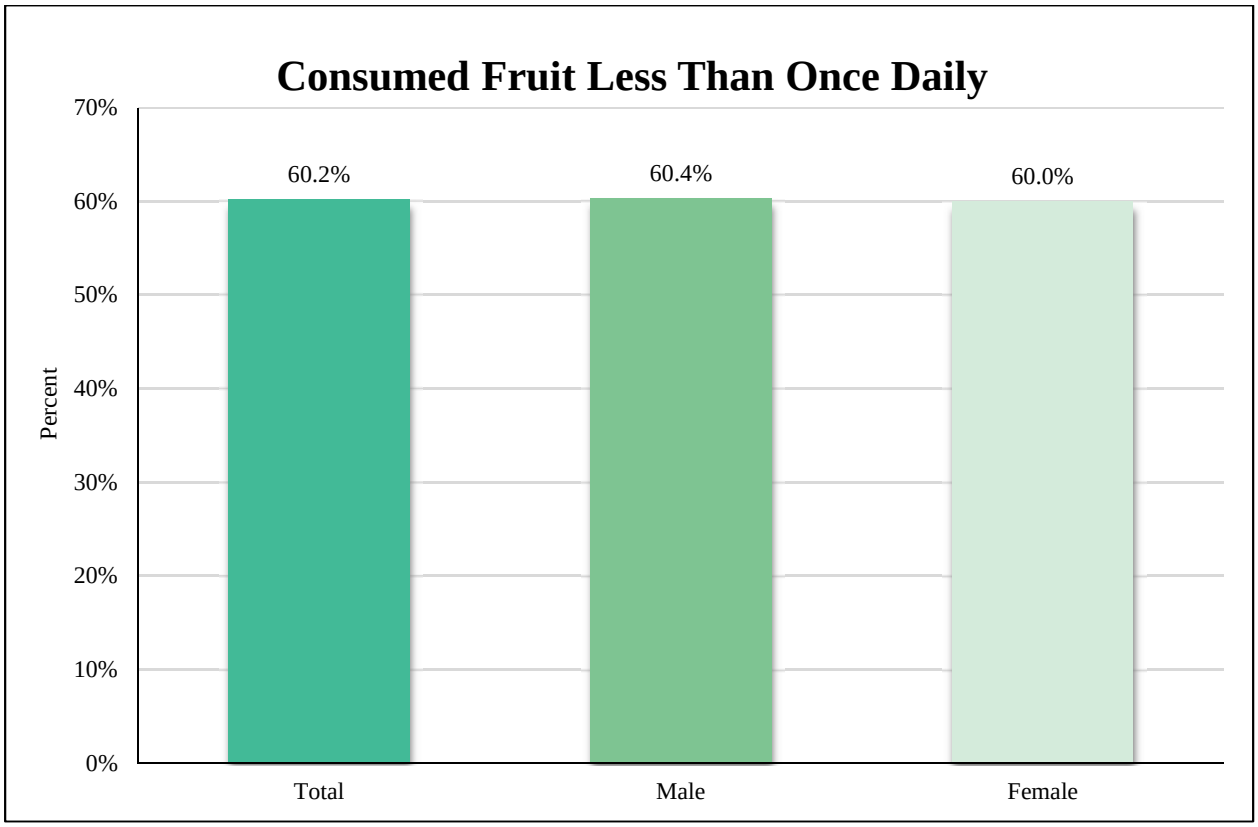
Not including juices, how often did you eat fruit in the past 30 days, including meals and snacks?

Diets high in fruits and vegetables can reduce the risk for cancer and chronic disease.[67] Fruits and vegetables are a good source of essential vitamins and minerals. They also provide fiber, while remaining low in fat and calories. Half of one's dinner plate should consist of fruits and vegetables.

The below chart represents the proportion of Omaha refugees who reported eating fruit less than once daily.

By Gender

- Approximately 60% of Omaha refugees (60.2%) reported consuming fruit less than once daily.
- Male refugees (60.4%) and female refugees (60.0%) had similar rates of consuming fruit less than once daily.



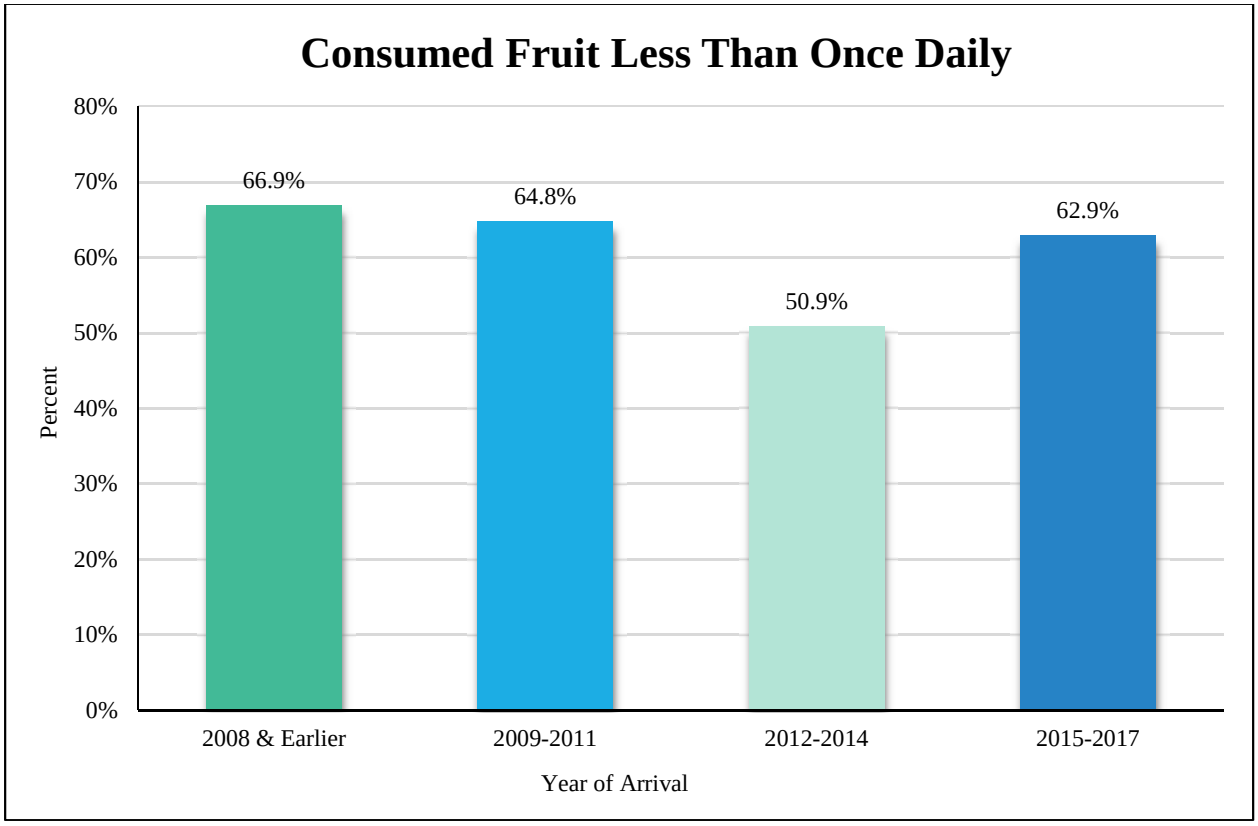
[67] Centers for Disease Control and Prevention. (2015). Adults meeting fruit and vegetable intake recommendations. Retrieved from www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a1.htm

Fruit Consumption

The below chart represents the proportion of Omaha refugees who reported eating fruit less than once daily.

By Year of Arrival

- Omaha refugees with the longest stay in the United States (2008 & earlier) were most likely to report consuming fruit less than once daily at 66.9%, followed by refugees arriving in 2009-2011 (64.8%) and refugees arriving in 2015-2017 (62.9%).
- Omaha refugees arriving in 2012-2014 were least likely to report consuming fruit less than once daily at 50.9%.



Vegetable Consumption

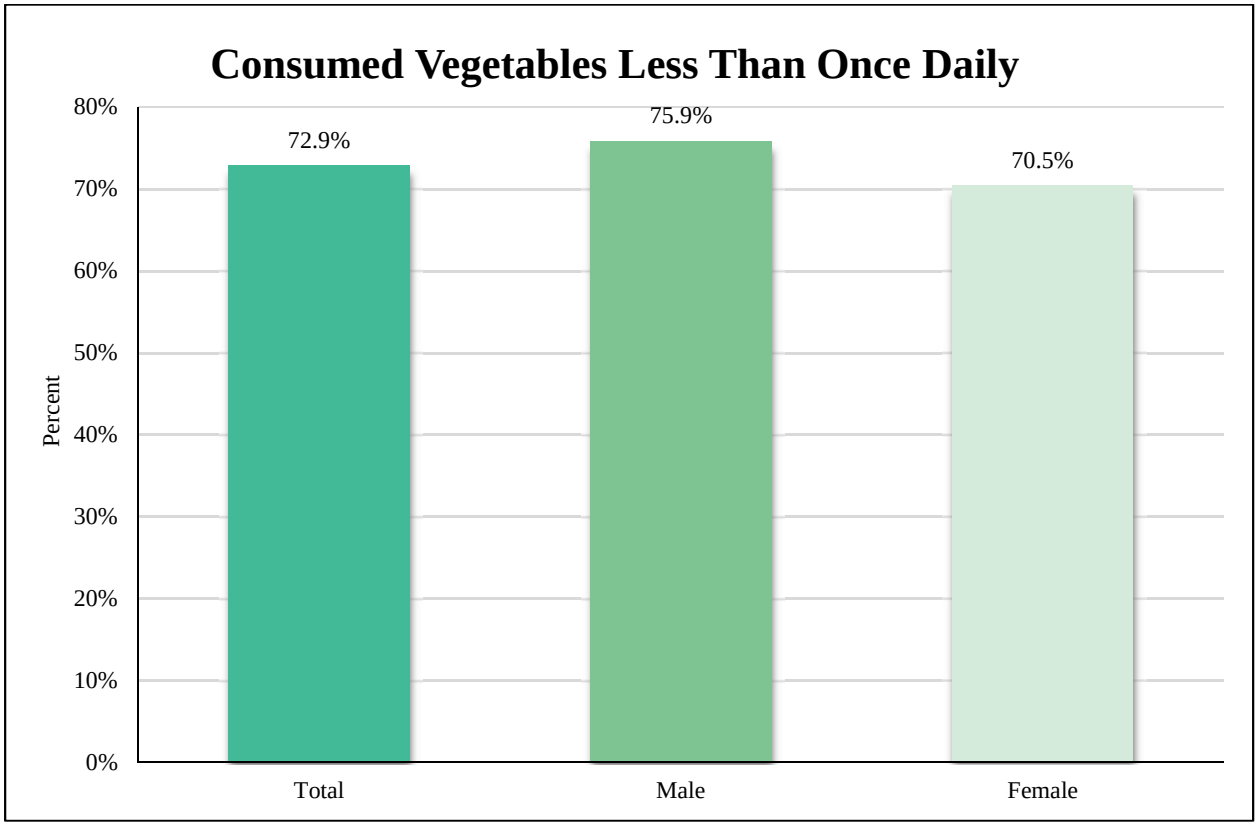
How often did you eat a green leafy or lettuce salad, with or without other vegetables? Not including lettuce salads and potatoes, how often did you eat other vegetables?

In the United States, only 9.3% of adults meet the recommendation for daily vegetable intake.[68] This number is much higher among refugees.

The below chart represents the proportion of Omaha refugees who reported eating vegetables less than once daily.

By Gender

- Over 70% of Omaha refugees (72.9%) reported consuming vegetables less than once daily.
- Male refugees (75.9%) were more likely than female refugees (70.5%) to report consuming vegetables less than once daily.



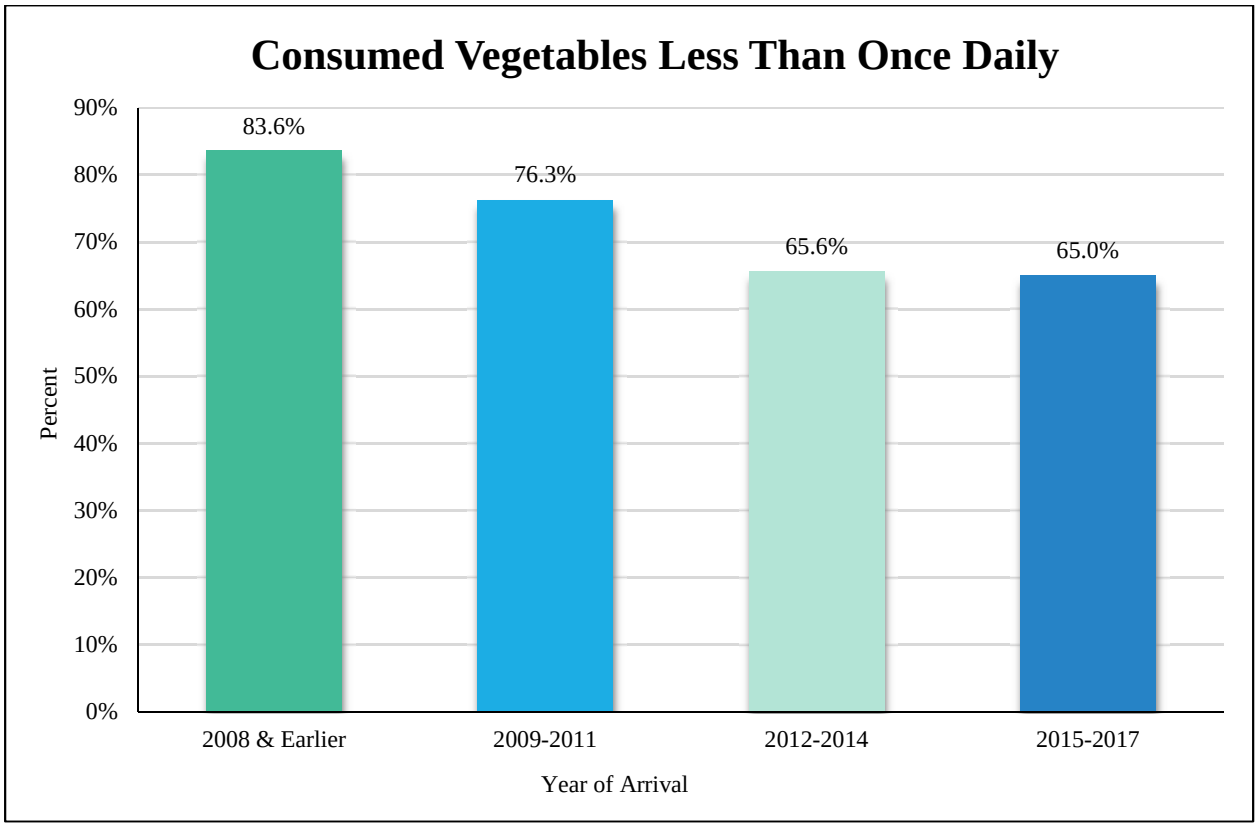
[68] Centers for Disease Control and Prevention. (2018). State indicator report on fruits and vegetables. Retrieved from www.cdc.gov/nutrition/downloads/fruits-vegetables/2018/2018-fruit-vegetable-report-508.pdf

Vegetable Consumption

The below chart represents the proportion of Omaha refugees who reported eating vegetables less than once daily.

By Year of Arrival

- The percentage of Omaha refugees who reported eating vegetables less than once daily increased with length of stay in the U. S.
- Omaha refugees arriving in 2008 and earlier (83.6%) were most likely to report consuming vegetables less than once daily, followed by those arriving in 2009-2011 (76.3%).
- Omaha refugees arriving in 2012-2014 (65.6%) and 2015-2017 (65.0%) were least likely to report consuming vegetables less than once daily.



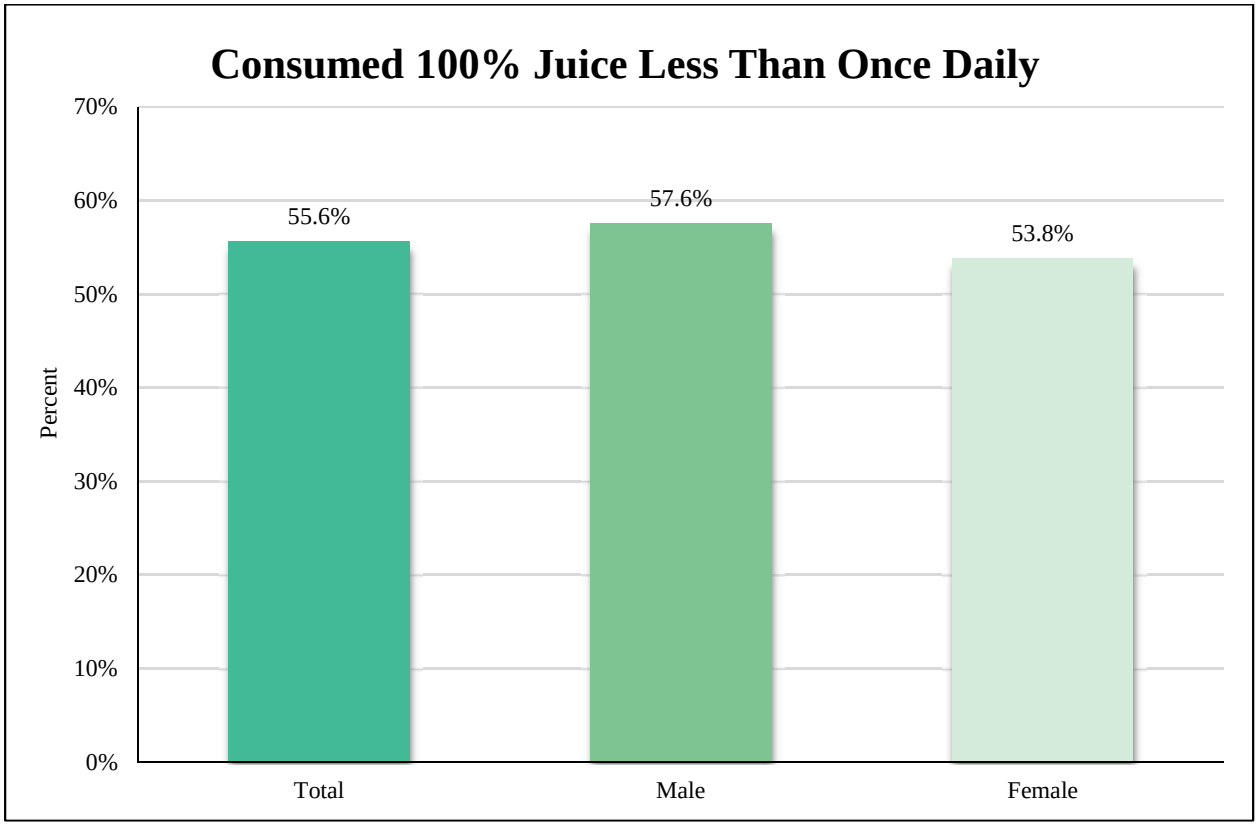
100% Fruit Juice Consumption

Not including fruit-flavored drinks or fruit juices with added sugar, how often did you drink 100% fruit juice such as apple or orange juice?

The below chart represents the proportion of Omaha refugees who reported consuming 100% fruit juice less than once daily.

By Gender

- Over half of Omaha refugees (55.6%) reported consuming 100% fruit juice less than once daily.
- Male refugees (57.6%) were more likely than female refugees (53.8%) to report consuming 100% fruit juice less than once daily.

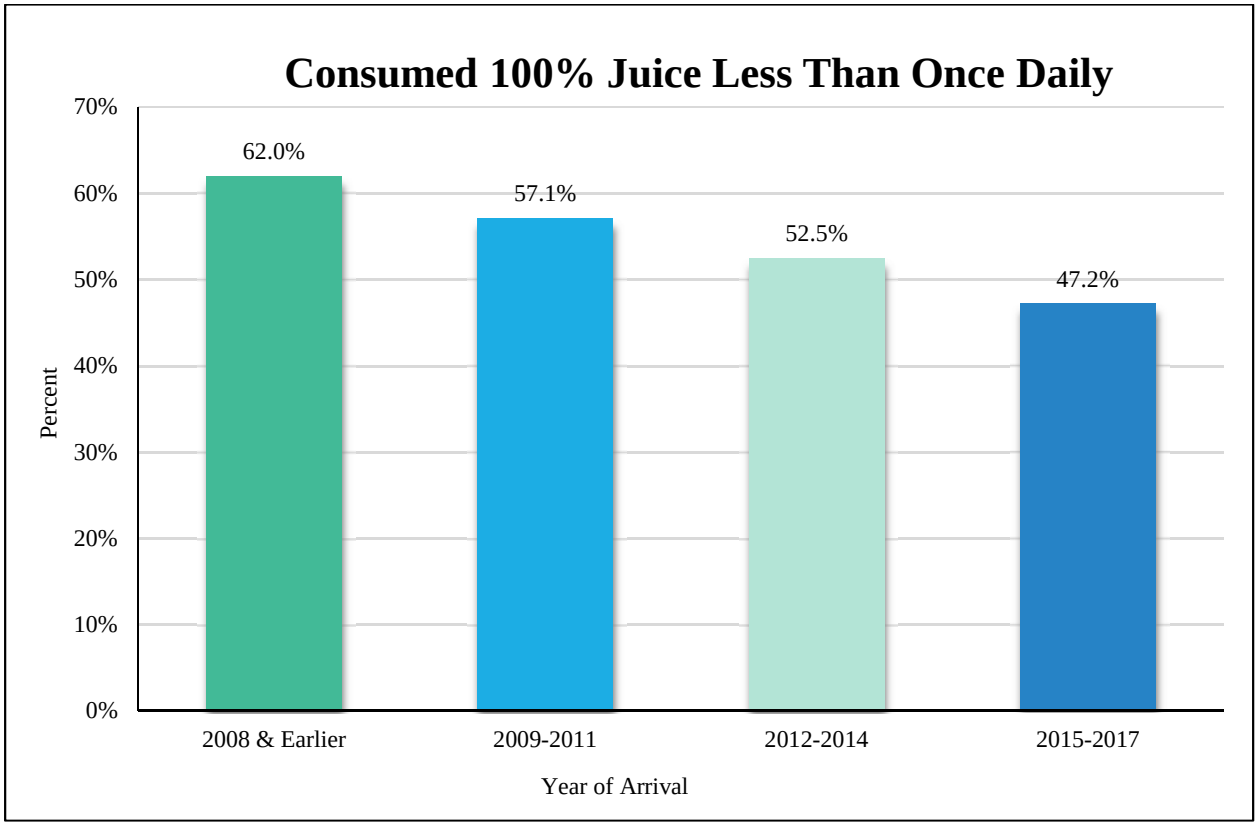


100% Fruit Juice Consumption

The below chart represents the proportion of Omaha refugees who reported consuming 100% fruit juice less than once daily.

By Year of Arrival

- The percentage of Omaha refugees reported 100% fruit juice less than once daily increased gradually with length of stay in the U.S.
- Omaha refugees arriving in 2008 and earlier (62.0%) were most likely to report consuming vegetables less than once daily, followed by those arriving in 2009-2011 (57.1%).
- Omaha refugees arriving in 2012-2014 (52.5%) and 2015-2017 (47.2%) were least likely to report consuming 100% fruit juice less than once daily.



Physical Activity

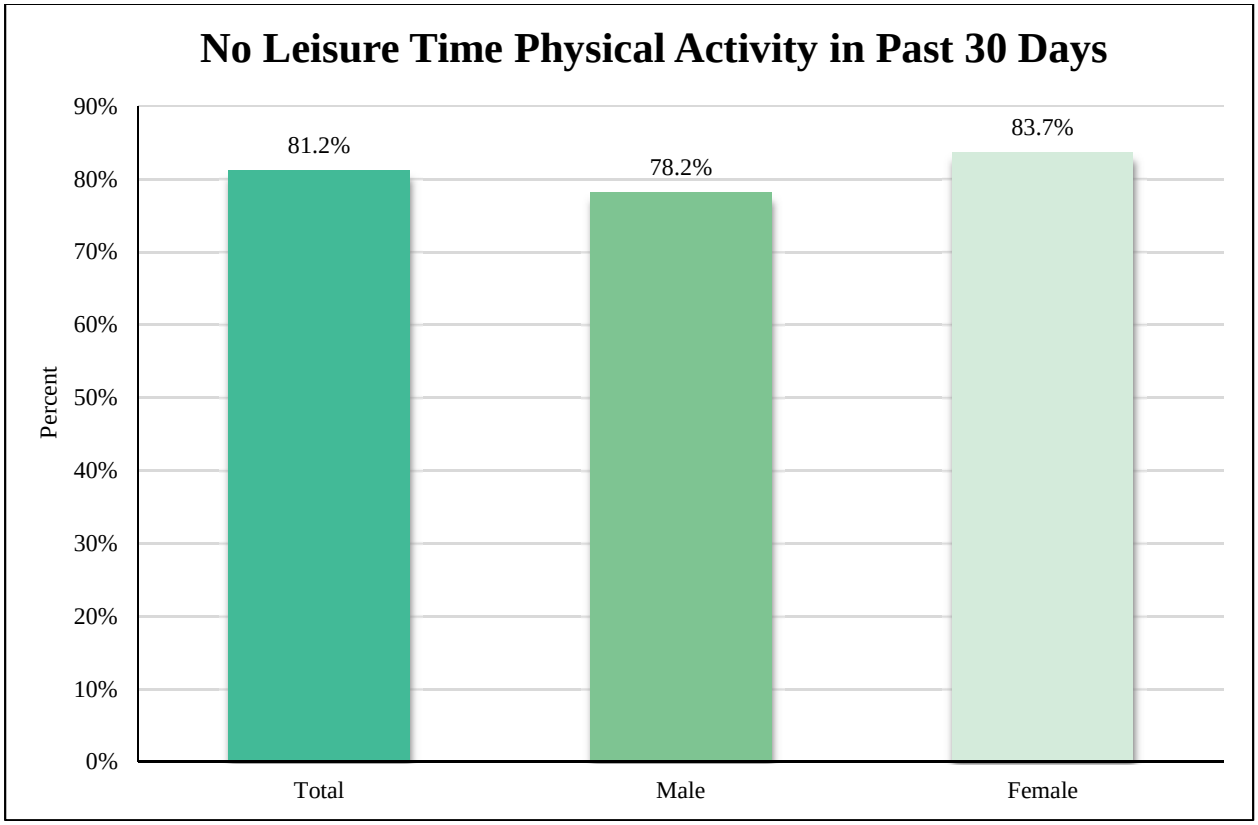
During the past month, other than your regular job, did you participate any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

Getting regular physical activity is an important factor in maintaining overall health. Individuals who are active are more likely to live longer and less likely to have chronic diseases.[69]

The below chart represents the proportion of Omaha refugees who reported not having leisure time physical activity in the past 30 days.

By Gender

- Approximately 80% of Omaha refugees (81.2%) reported not having leisure time physical activity in the past 30 days.
- Female refugees (83.7%) were more likely than male refugees (78.2%) to report not having leisure time physical activity in the past 30 days.



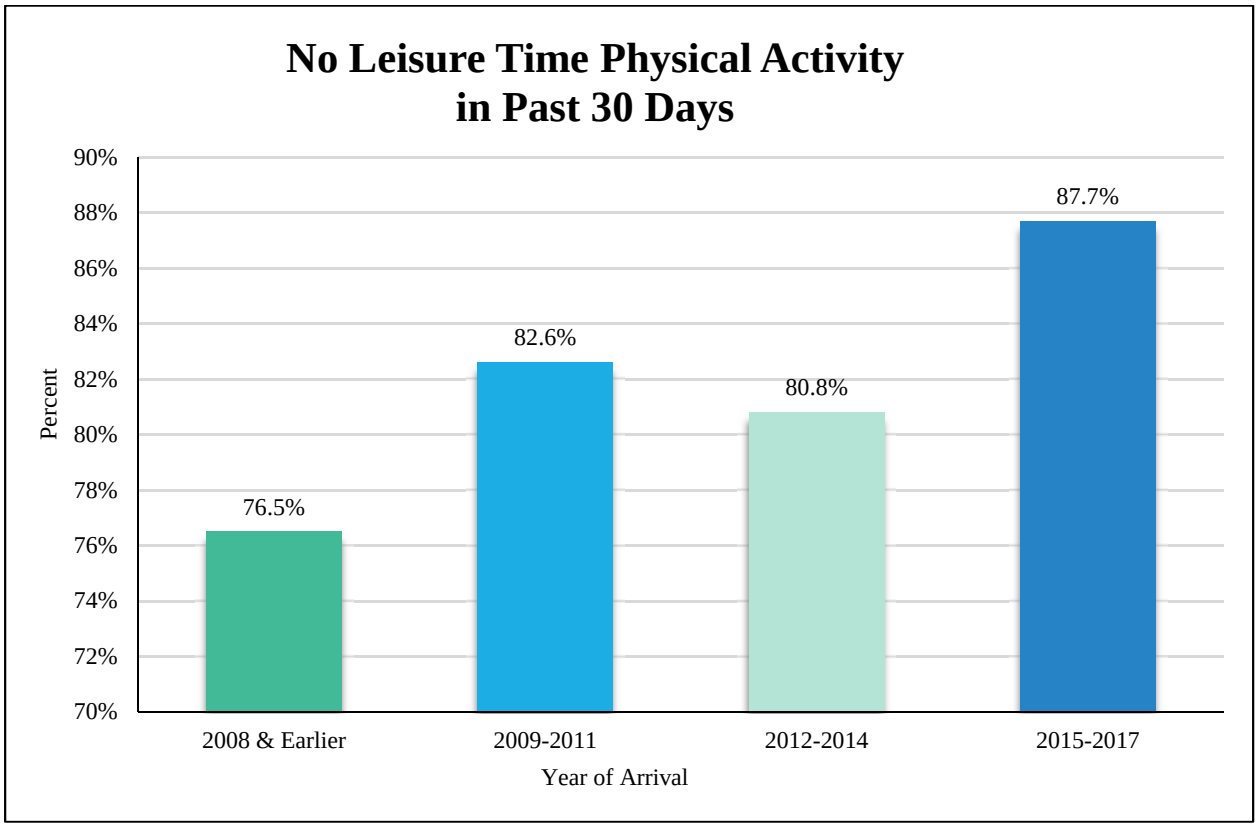
[69] Centers for Disease Control and Prevention. (2010). About physical activity. Retrieved from www.cdc.gov/physicalactivity/about-physical-activity/index.html

Physical Activity

The below chart represents the proportion of Omaha refugees who reported having no leisure time physical activity in the past 30 days.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (87.7%) were most likely to report not having leisure time physical activity in the past 30 days.
- Omaha refugees arriving in 2008 & earlier (76.5%) were least likely to report not having leisure time physical activity in the past 30 days.



Insufficient Sleep

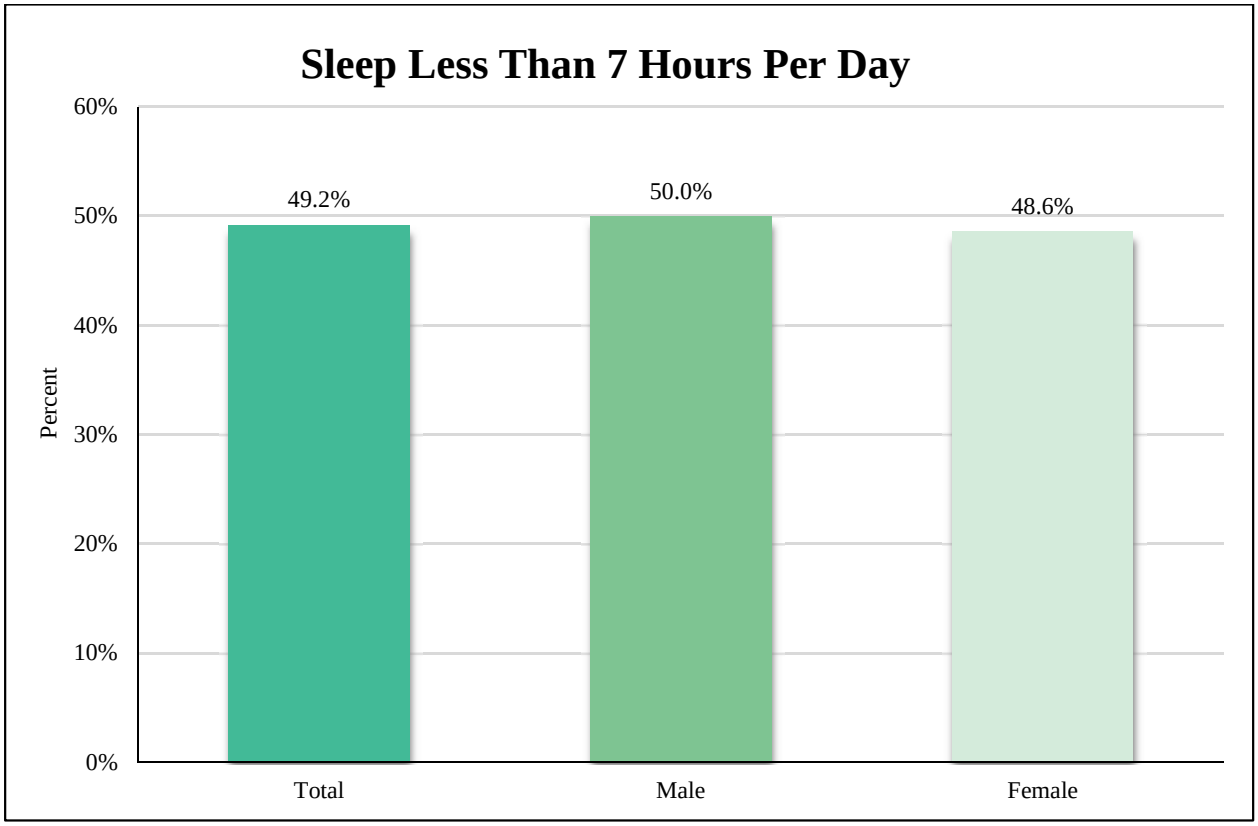
On average, how many hours of sleep do you get in a 24-hour period?

Insufficient sleep has been linked to numerous chronic diseases, including diabetes, obesity, depression, and cardiovascular disease.[70] Additionally, insufficient sleep can be responsible for motor vehicle crashes, causing considerable injury each year.

The below chart represents the proportion of Omaha refugees who reported sleeping less than seven hours daily.

By Gender

- Approximately half of Omaha refugees (49.2%) reported sleeping less than seven hours daily.
- Male refugees (50.0%) were slightly more likely than female refugees (48.6%) to report sleeping less than seven hours daily.



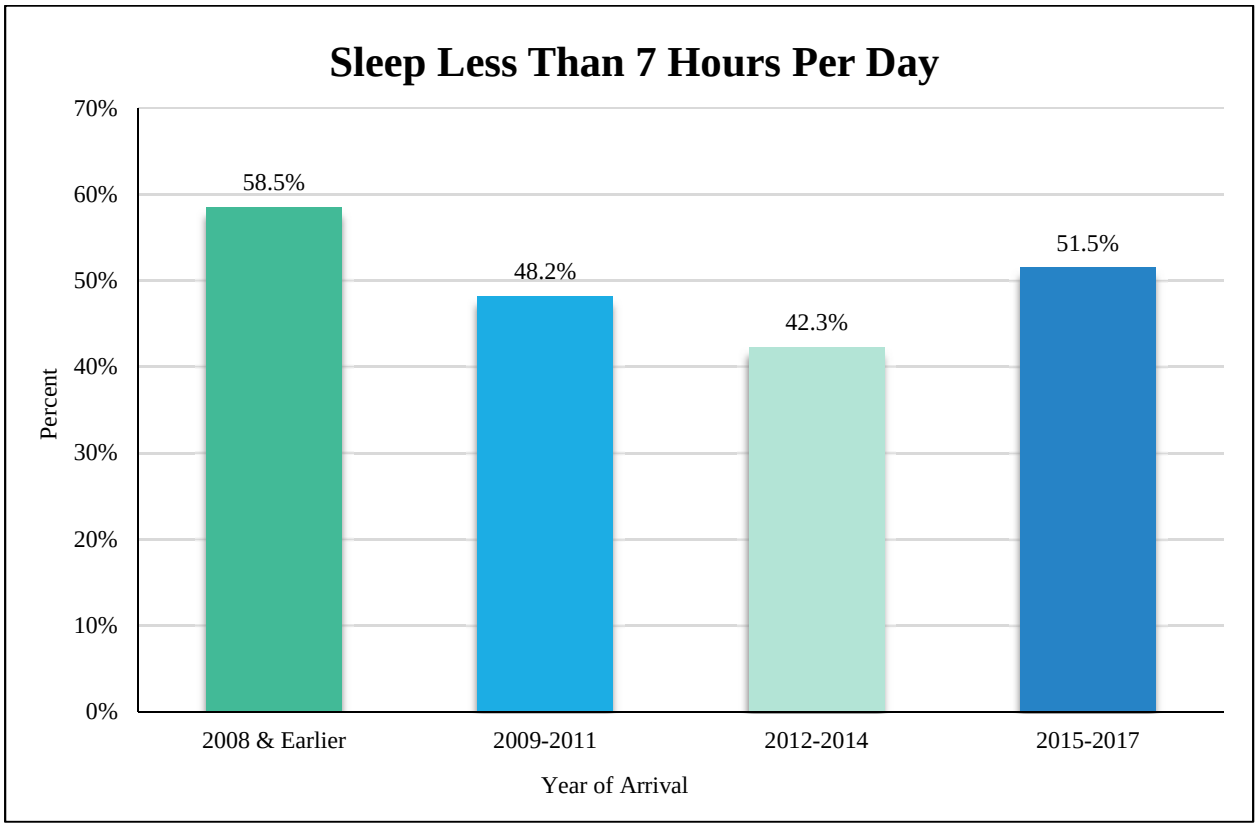
[70] Centers for Disease Control and Prevention. (2016). Sleep and sleep disorders. Retrieved from www.cdc.gov/sleep/index.html

Insufficient Sleep

The below chart represents the proportion of Omaha refugees who reported sleeping less than seven hours daily.

By Year of Arrival

- Omaha refugees arriving in 2008 and earlier (58.5%) were most likely to report sleeping less than seven hours daily.
- Omaha refugees arriving in 2012-2014 (42.3%) and 2009-2011 (48.2%) were least likely to report sleeping less than seven hours daily.



Omaha Refugee Population

Reactions to Refugee Status

Perceived Treatment at Work

4.6% Approximately 5% of Omaha refugees reported feeling treated worse than non-refugees at work.

2.2x Male refugees (6.4%) were twice as likely than female refugees (2.9%) to report feeling treated worse than non-refugees at work.

Experience Seeking Health Care

7.0% Seven percent of Omaha refugees felt their experience seeking health care was worse than non-refugees.

1.3x Male refugees (7.8%) were slightly more likely than female refugees (6.2%) to report that their experience seeking health care was worse than non-refugees.

Refugees arriving in 2008 & Earlier (6.4%) were the most likely to report feeling that their experience seeking health care was worse than non-refugees.

Office of Health Disparities and Health Equity
Division of Public Health
Nebraska Department of Health and Human Services
Source: Nebraska 2017 Refugee BRFSS Survey

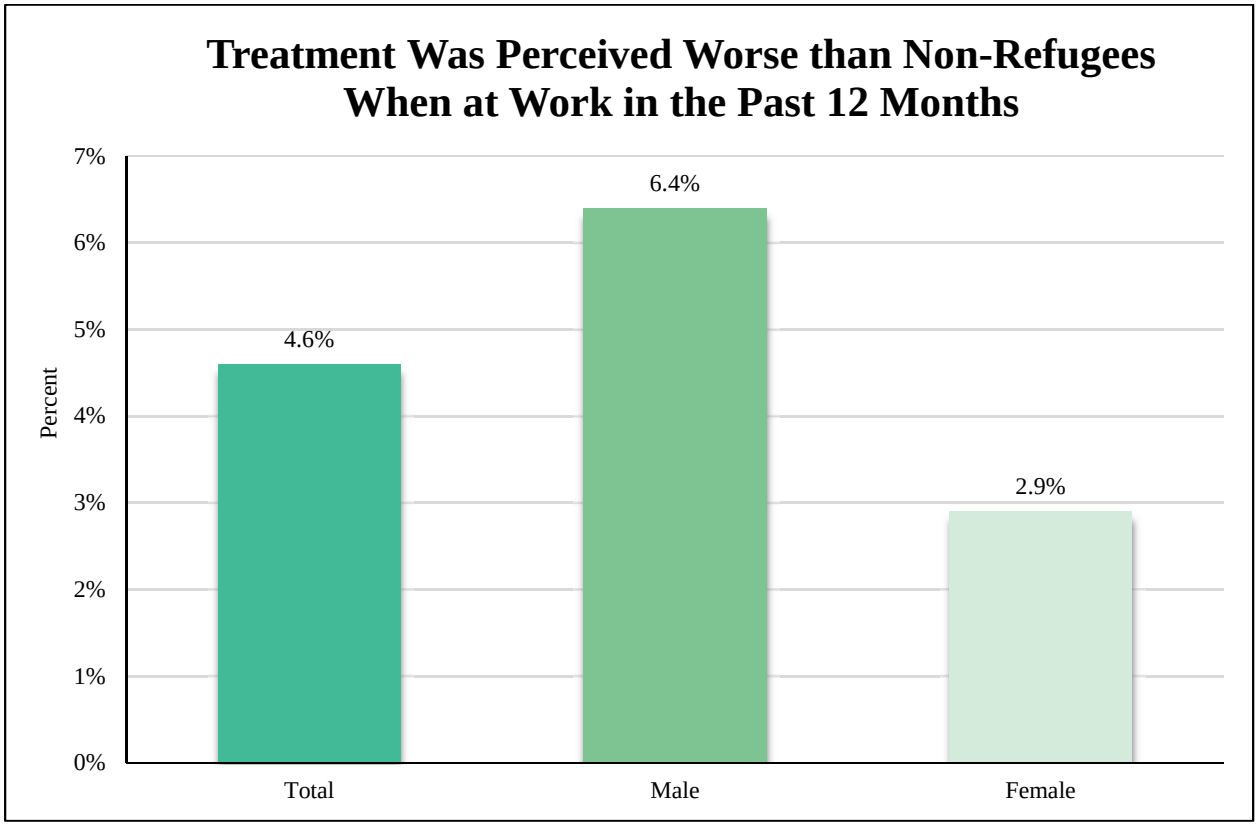
Work Experiences

Within the past 12 months at work, do you feel you were treated worse than, the same as, or better than non-refugees?

The below chart represents the proportion of Omaha refugees who felt they were treated worse than non-refugees at work during the past 12 months.

By Gender

- Approximately 5% of Omaha refugees (4.6%) perceived being treated worse than non-refugees at work in the past 12 months.
- Male refugees (6.4%) were twice as likely as female refugees (2.9%) to perceive being treated worse than non-refugees at work in the past 12 months.

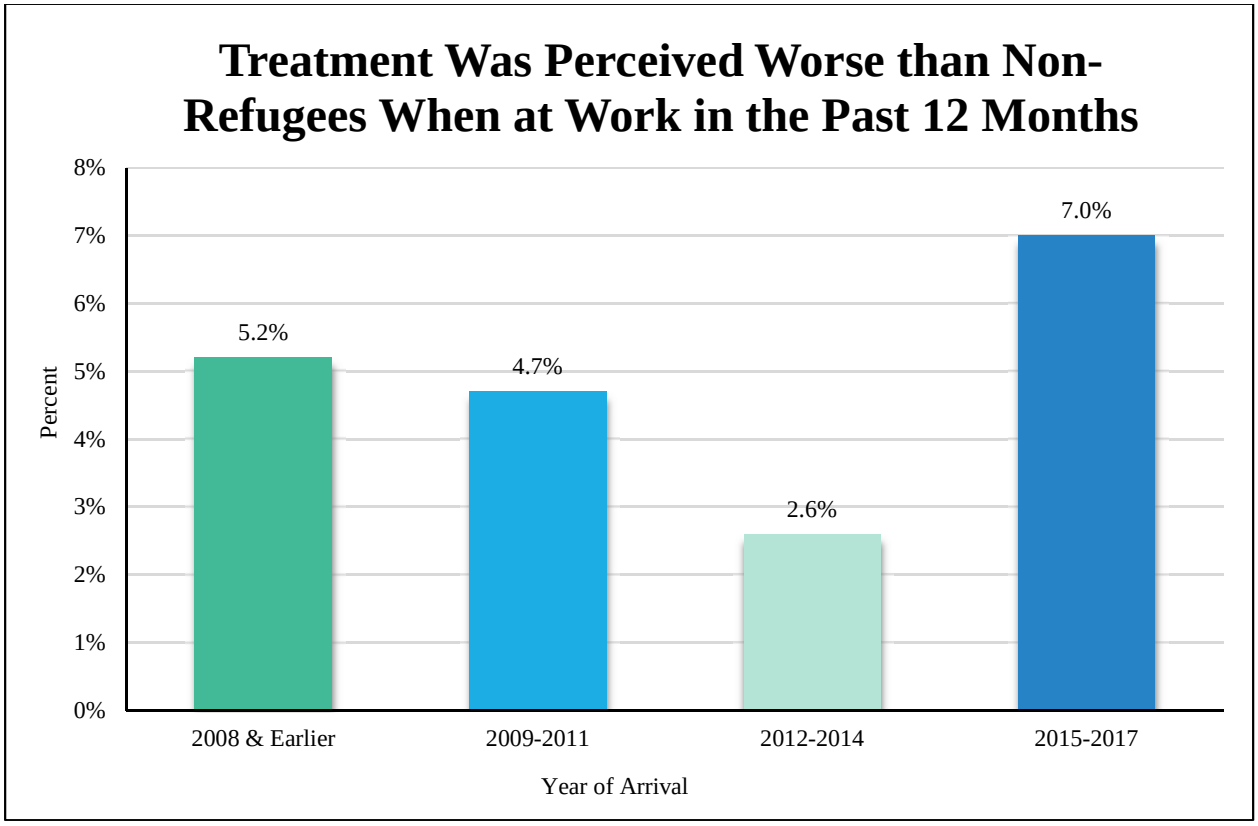


Work Experiences

The below chart represents the proportion of Omaha refugees who felt they were treated worse than non-refugees at work during the past 12 months.

By Year of Arrival

- Omaha refugees arriving in 2015-2017 (7.0%) and 2008 and earlier (5.2%) were most likely to perceive being treated worse than non-refugees at work in the past 12 months.
- Omaha refugees arriving in 2009-2011 (4.7%) were least likely to perceive being treated worse than non-refugees at work in the past 12 months, followed by those arriving in 2012-2014 (2.6%).



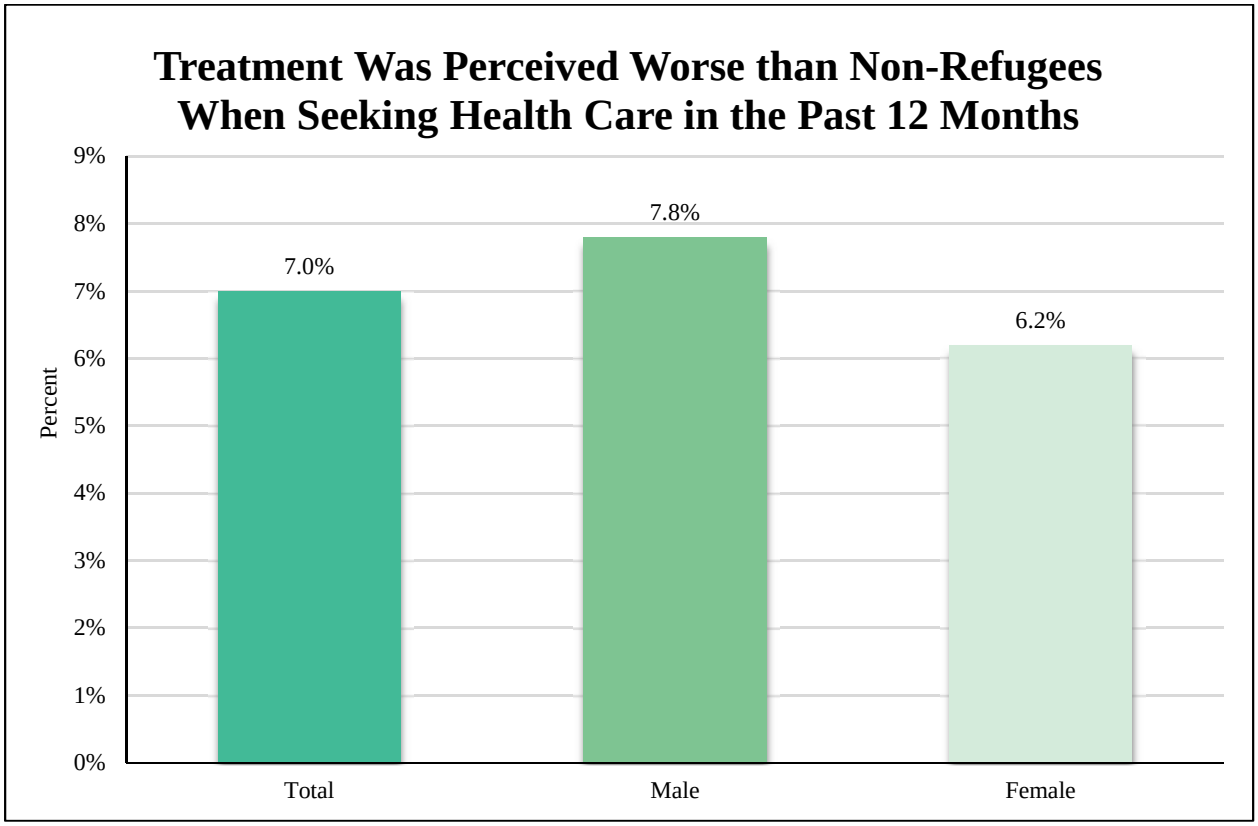
Health Care Experiences

Within the past 12 months, when seeking health care, do you feel you were treated worse than, the same as, or better than non-refugees?

The below chart represents the proportion of Omaha refugees who felt they were treated worse than non-refugees when seeking health care during the past 12 months.

By Gender

- Seven percent of Omaha refugees perceived being treated worse than non-refugees when seeking health care in the past 12 months.
- Male refugees (7.8%) were more likely than female refugees (6.2%) to perceive being treated worse than non-refugees when seeking health care in the past 12 months.

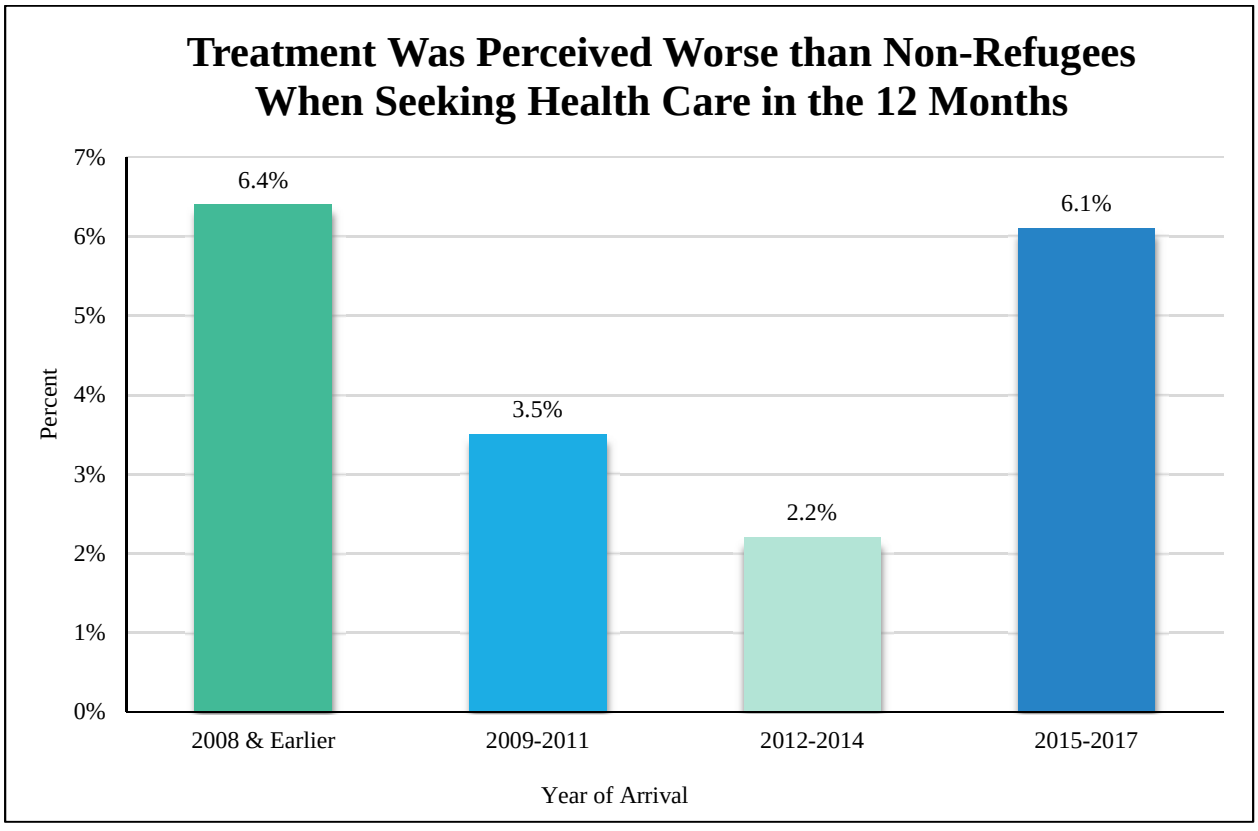


Health Care Experiences

The below chart represents the proportion of Omaha refugees who felt they were treated worse than non-refugees when seeking health care during the past 12 months.

By Year of Arrival

- Omaha refugees arriving in 2008 and earlier (6.4%) were most likely population to perceive being treated worse than non-refugees when seeking health care in the past 12 months. This percentage was 2.9 times that of those arriving in 2012-2014 (2.2%) who were least likely to report the same.
- Omaha refugees arriving in 2015-2017 (7.2%) also were likely to perceive being treated worse than non-refugees when seeking health care in the past 12 months, followed by those arriving in 2009-2011 (3.5%).



Conclusion

The total sample size of this survey is 1132. Omaha refugees surveyed came from primarily three areas – Burma, Bhutan, and Somalia. The largest age groups for the Omaha refugees surveyed were ages 18-24 and ages 25-34. The top languages spoken included Karen, Nepali, Somali and Nuer. Approximately half of those surveyed came from the Karen community.

Refugees face unique challenges upon arriving in the United States. As this report shows, health care, education, financial, were identified as the top three most urgent needs for Omaha refugees. Approximately 40% of Omaha refugees reported health care was the most urgent need and 25% reported education as the next urgent need. Approximately 30% of Omaha refugees reported having no education or having only attended kindergarten and only 0.6% of Omaha refugees most recently arriving to the U.S. (2015-2017) reported being college graduates.

Language barriers were overwhelming the biggest challenge reported by Omaha refugees. Approximately three-fourths of the Omaha refugee population reported limited English proficiency, which makes practically all aspects of navigating and integrating into the community immensely difficult. In Omaha, female refugees were more likely than male refugees to report languages barriers as their biggest challenge. Refugees arriving in 2015-2017 (79.3%) reported the highest percentage of those who felt language barriers were their biggest challenge. With respect to language barriers in health care, one-half of Omaha refugees reported that it was very difficult to understand verbal information from health professionals and very difficult to understand written health information. Even if medical interpretation is provided at an appointment, navigating the health care system, making an appointment, or trying to arrange payment for health services can be exceedingly difficult without English proficiency.

While language barriers play a role in an individual's ability to access health services, the significant lack of health insurance among Omaha refugees also affects the frequency with which individuals seek health care or preventative exams. Medicare and Medicaid enrollments were the most important predictor of health care utilization. Approximately one-quarter of Omaha refugees reported Medicaid as their primary source of health care coverage. The likelihood of Medicaid coverage decreased with length of stay in the U.S with 19.6% of refugees arriving in 2008 & earlier reporting such compared to 36.6% of those arriving in 2015-2017. However, there was still about half of Omaha refugees reporting not having health coverage of any kind. It is not surprising that over one-fifth of Omaha refugees reported being unable to see a physician due to cost in the past year. Moreover, approximately 80% of Omaha refugees regardless of year of arrival reported they were unable to see a physician due to cost. The most recently arrived group of refugees (2015-2017) were most likely to not have health care coverage at 62.1%. Even for Omaha refugees age 65 and older, 15% reported not having health care coverage. Financial barriers are one of the main obstacles to accessing appropriate health services. Two out of every

ten Omaha refugees had a household income of $10,000 or less annually, which can change a decision to seek healthcare a financial choice rather than a medical one.

Marital status and changes in marital status can have implications for an individual's health. In general, married individuals are in better health and have lower mortality rates than those who are single. Omaha refugees arriving in 2015-2017 reported the highest divorce and separated rate than all other arrival groups. The divorce rate is more than three times and the separated rate is about six times than all other arrival groups.

When it comes to the overall health status of a population, perceived health status is one of the most common indicators employed. To measure perceived health status, participants are asked to rate their overall health as excellent, very good, good, fair, or poor. More than one-quarter of Omaha refugees perceived their health status to be fair or poor. The percentage of Omaha refugees reporting their health status as fair or poor increased grad ually with length of stay in the U.S. Female refugees were twice as likely as male refugees to report their physical health was poor and had difficulty concentrating. However, female Omaha refugees reported lower rates of heart attack, coronary heart disease, stroke, asthma, COPD, kidney disease, and high blood cholesterol.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. When talking about the overall health of a population, it is important to consider mental health in addition to physical health. Research has shown that poor mental health is a major source of distress, disability, and social burden. Furthermore, poor mental health can interfere with social functioning and negatively impact physical well-being as well as the practice of health-promoting behaviors. Approximately 4% of Omaha refugees reported having poor mental health on 14 or more days in the past 30 days. Approximately 3% of Omaha refugees reported having ever had a depressive order.

Barriers to accessing health care not only limit an individual's ability to seek treatment for medical issues as they arise, but also deter individuals from scheduling preventative care appointments, such as routine checkups. Only one-fourth of Omaha refugees had visited the dentist in the past two years and only half of Omaha refugees had a routine checkup in the past two years.

Clinical preventive services, such as routine disease screenings or tests and scheduled immunizations, are key to reducing death and disability and improving the nation's health. However, just over one-third of Omaha refugees reported having had a flu vaccine in the past year and only 22% reported ever having had a pneumonia vaccine. The percentage of Omaha refugees who reported ever having had a pneumonia vaccine decreased dramatically from 66.7% in 2008 and earlier to 9.1% in 2015-2017. Only one-third of Omaha female refugees (age 40 and above) reported having had a mammogram in the past two years and 1.7% refugees reported having had a pap test in the past three years for refugees who arrived in 2015-2017.

To improve the rate of chronic disease and other medical issues, it is often necessary to first look at indicators related to health behaviors. Part of leading a healthy lifestyle includes eating nutritious foods and being physically active. Omaha refugees reported particularly high rates of individuals who ate fruits and vegetables and consumed 100% fruit juice less than once daily. Additionally, approximately 80% of the Omaha refugee population reported not getting leisure-time physical activity in the past 30 days. Half of Omaha refugees reported sleeping less than seven hours daily.

All of these indicators show a need for integrated support across state and local agencies, refugee communities, and the organizations that serve them to better address the health barriers and needs of the Omaha refugee population.

Recommendations:

Based on the findings from this study, we recommend health care providers, refugee resettlement agencies, policymakers, refugee communities, and other stakeholder organizations work together to:

1. Increase availability and time-flexibility of English language classes and raise awareness about these classes among refugees.

2. Work closely with employers in Omaha to provide job training and employment opportunities for the local refugee population.

3. Provide information and resources for health insurance coverage purchase and enrollment among refugees.

4. Promote health literacy and patient navigation among refugees through trained community health workers recruited from the refugee community.

5. Mobilize the needed resources and partnerships to provide the health services refugees reported they were most interested in. Such as the provision of flu shots, exercise facilities, health fairs, healthy eating education, and women's health services.

6. Equip health care providers with the language support they need when serving refugees with no or limited English proficiency

7. Provide the legal support they need.

University of Nebraska Medical Center (2017). Refugee Health Needs Assessment in Omaha, Nebraska. Retrieved from https://www.unmc.edu/publichealth/crhd/about/Refugee-Health-Needs-Assessment-in-Omaha,-Nebraska-Report-2017.pdf