

Care of the Immigrant Child

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EDUCATION GAP

Because 3% to 4% of children in the United States are foreign-born, it is highly likely that most pediatric providers will encounter these children in their practice, and thus, important for all clinicians to understand best practice guidelines for their care. Immigrant health curricula are not standardized across US pediatric health professional training programs, leading to variable levels of competency in currently practicing providers.

OBJECTIVES *After completing this article, readers should be able to:*

1. Describe national guidelines for the care of the immigrant child.
2. Use concepts from the national guidelines to implement practical improvements in clinical service delivery for immigrant children, at both the facility and individual levels.
3. Offer solutions for personal and professional obstacles that can arise when caring for immigrant children.

INTRODUCTION

There are approximately 2.5 million immigrant children in the United States, (1) defined by the American Academy of Pediatrics (AAP) as “those born outside the United States to non-US citizen parents.” (2) This heterogeneous group includes children from countries all around the world, with the top 4 countries of origin being Mexico (18%), India (8%), China (5%), and the Philippines (3%). (3) Most immigrant children come to the United States with 1 or both parents for 1 or more of a myriad of reasons, including economic opportunity, educational attainment, family reunification, and/or safe haven from violence or persecution. In general, immigrants to the United States tend to be healthier than their US-born counterparts (known as the healthy immigrant paradox), but this advantage tends to decrease over time. (4)(5) Although the exact reasons for this are unknown, the effects of poverty (25% of immigrant children live below the federal poverty level) (3) and lack of health insurance coverage (18%–33% of foreign-born children are uninsured, depending on immigration status) (6) likely play a large role. To mitigate this health decline and provide immigrant children

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ABBREVIATIONS

AAP American Academy of Pediatrics
 CDC Centers for Disease Control and Prevention
 HEADSS Home, education, activities, drugs, suicidality/homicidality, sex
 IOM International Organization for Migration
 ORR Office of Refugee Resettlement
 UIC unaccompanied immigrant child

with the highest quality of care possible, the AAP recommends specific core competencies for all pediatric health-care providers. (2) This paper offers practical advice to achieve these standards for all foreign-born children and concludes with helpful tips for caring for special immigrant subpopulations as well as immigrant child health practitioners themselves.

CONSTRUCTING THE MILIEU

Practice Environment

To create a practice environment that is welcoming to all patients, it is helpful to have a visual reflection of diversity. For example, employing staff members and providers who come from the varying communities served by your practice can help a family feel more comfortable. In addition, any people depicted in artwork should represent a variety of different backgrounds, and signage should, when possible, include the most common languages spoken in the local community. Language services, either through a phone/video line or in person, should be available at all visits. Furthermore, offering regular trainings for providers and staff on cultural humility and implicit bias can help everyone work together to create a positive experience for every patient.

Services Offered

The gold standard for any pediatric primary care practice is to be a “medical home,” where children and families can receive comprehensive services and care coordination. (7)(8)(9) As such, it is helpful to have a holistic view of health and employ staff who can support patients accordingly. Depending on the population served, recommended resources could be social work, referral coordination, nutrition, and/or financial counseling. For the uninsured population with limited income, having a sliding scale discount or charity care program would also be beneficial. Although these options are most often found at Federally Qualified Health Centers or other low-cost clinics, private practices could help expand access for uninsured children by developing similar programs for a subset of their patients. Complementary services such as behavioral health, dentistry, optometry, and pharmacy should be co-located with primary care providers or, if not available within the clinic, efficient referral pathways should be created to ensure that patients are able to easily access these services at neighborhood organizations.

Community

In the same way that health services providers should work together to ensure a holistic approach, pediatric practices should also collaborate with nonmedical community organizations that serve children. Schools, child care centers, community centers, social service organizations, and places of worship can be invaluable partners in the mission to protect children’s health. This partnership should be bidirectional, with medical practices sharing public health information that community organizations can use to educate their beneficiaries and community organizations helping to identify children without a medical home and directing them to medical practices.

TAKING THE HISTORY

Language and Communication

At the start of the encounter, it is important for the provider to establish which language(s) the caregiver and child are most comfortable speaking (this can differ between the two). If the provider is not fluent in the preferred language of the caregiver and/or child, a certified medical interpreter should be used (ie, not a family member, a friend, or the child). Best practices for working with an interpreter include 1) maintaining eye contact with the caregiver or patient while talking, 2) pausing every 1 to 2 sentences to allow the interpreter to translate, 3) positioning the interpreter next to the provider, and 4) speaking directly to the caregiver or patient (eg, saying to the caregiver, “Your child is growing well” instead of telling the interpreter, “Please tell the caregiver that their child is growing well”). (10)(11)

Preface

With any new patient, introducing oneself and the involved clinical staff properly is key to establishing rapport. It is also beneficial to describe the flow of the visit so that families know what to expect. This can be particularly important for children new to the United States because many countries around the world do not use a similar preventive care approach (eg, apart from receiving vaccines, children in developing countries might go to a health facility only when they are ill). Normalizing (eg, saying, “These are questions I ask all new patients”) and framing (eg, stating, “I only ask these questions because it helps me understand how to better care for your child”) are 2 techniques that can help the caregiver and patient feel more comfortable. (12)(13) In addition, providers should let families know that the information obtained remains only in the medical record (which is not shared with government

authorities), and they can choose not to answer a question at any time without experiencing negative repercussions.

Medical Record Review

Caregivers often possess medical records for the child but might not offer to share them unless asked. Therefore, inquiring whether families brought any past medical paperwork with them (including vaccination records) should be done early in the visit. Children who are new to the United States might have important health information from their home country, countries through which they passed on their journey, predeparture medical visits (eg, through the International Organization for Migration [IOM], US Embassy, or US Department of State), or another health facility in the United States (eg, clinic, urgent care, hospital, immigration facility/shelter, or health department).

Questions

One of the first questions for all new patients, regardless of background, should be, “Where was the child born?” Whether the child was born outside of the United States will determine whether an immigrant-focused framework should be applied to the visit. If the child was born in the United States, a typical history should be conducted according to AAP and individual practice guidelines. If the child was born outside of the United States, specific questions should be covered in addition to the typical history (Table 1). (14)

Screening

Through the Bright Futures periodicity schedule, the AAP sets forth guidelines for when to screen children for developmental delay, psychosocial/behavioral concerns, substance use, and depression (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). (16) As appropriate for age, screening of immigrant children should be initiated at the first available opportunity. Foreign-born children should also be asked about trauma exposure, if not already part of routine practice, because they experience higher rates of trauma than native-born children. (17) Immigrant adolescents should be screened for depression, anxiety, and posttraumatic stress disorder in addition to a HEADSS (Home, Education, Activities [including employment], Drugs, Suicidality/homicidality, Sex [including questions about menstrual history, consensual sex, sexual abuse, and child marriage]) assessment that covers their experience in previous countries and the United States. Tools to assist with screening for mental health concerns

that are recommended for use in the foreign-born population can be found through the National Child Traumatic Stress Network (<https://www.nctsn.org/resources/measures-are-appropriate-refugee-children-and-families>). (18) All children should also be screened for social determinants of health, including (but not limited to) housing, environmental exposures (eg, cigarette smoke, firearms, and pets), interpersonal violence, food insecurity, and caregiver employment. (19)(20)(21)

CONDUCTING THE PHYSICAL EXAMINATION

Routine Measurements

Vital signs and anthropometric measurements, as well as hearing and vision testing, should be completed as recommended in the AAP Bright Futures guidelines. (16) Furthermore, children younger than 3 years who never received newborn screening—and for whom there is parental or provider concern for hearing loss—should be referred to audiology. For foreign-born children 3 years and older, vision and hearing testing should be conducted at the first opportunity, regardless of whether they are currently the age at which screening is typically conducted in the practice.

Expectation Setting

While the patient is still clothed, it is important to explain to the caregiver and patient what the physical examination entails and how it will proceed. This might be the first time that the child has been fully assessed in the standard manner for US healthcare. Specifically, the caregiver and patient should be informed that the routine health maintenance visit in the United States includes an examination of the external genital area. Many children from developing countries have never had a complete “head to toe” examination by a medical professional because any visits to health facilities might have focused only on the presenting concern. If the caregiver or patient is not comfortable with this full physical review and has no specific concerns about the genital area, this portion of the examination can be deferred until the second visit. However, this should be considered an option only if follow-up can be ensured (due to the potential for missing conditions such as imperforate hymen or undescended testes, among other congenital or acquired conditions).

Physical Examination

The patient should change into a gown for the physical examination. As the examination is conducted, the provider should talk through every aspect with the patient

Table 1. Special Considerations While Taking the History of Immigrant Children

Birth history	In what type of facility (hospital, clinic, home) was the child born? Did the mother undergo any laboratory testing while pregnant? If so, are the results available? Did the child undergo any laboratory testing or other screening in the newborn period? If so, are the results available?
Medical/surgical history	Did the child have a blood transfusion? Do they have any tattoos or traditional scarification? Was the male child circumcised? If so, in what setting? Did the female child have any procedures to alter the genital area, such as female genital mutilation or cutting? (15)
Family history	Is there any history of human immunodeficiency virus, hepatitis B, hepatitis C, tuberculosis, or hemoglobinopathies in the family?
Exposure history	What type of work did the child's caregiver(s) do before coming to the United States? What type of work does he or she perform in the United States?
Social history	With whom was the child living in their home country? With whom did they travel to the United States? By what mode of transportation did they travel to the United States? Through what countries did they pass? When did they arrive in the United States? Were they ever separated from their caregiver? Were they ever detained? How long was the journey to the United States? ^a
Nutrition history	What was the child's typical diet before coming to the United States? What is the child's typical diet now? Was there a time in the child's life that the caregiver worried that there would not be enough food for the child? If so, does the caregiver still worry about that?
Education history	What was schooling (if any) like before coming to the United States? Did the child have any learning challenges when being taught in his or her preferred language? If so, what were they?

^aThe questions related to immigration are asked solely for the purpose of eliciting historical details that might require further follow-up, such as a need for particular infectious disease testing based on regional exposure or more detailed assessments for sequelae of trauma; they are not asked to determine immigration status. A child's immigration status should generally not be written in the medical record, especially if the child is undocumented. However, clinics that focus specifically on the care of newly arrived children might have the expertise to accurately denote the designation of an immigrant child with legal status, as might a provider working with an immigration attorney for a particular child.

and caregiver to help them feel as comfortable as possible. The provider should approach the physical examination as he or she would a newborn examination, as if no medical provider has ever fully evaluated the child before. There might be unaddressed or undiagnosed abnormalities found on examination that, with proper intervention or follow-up, can be prevented from causing problems in the future. In addition to the standard physical examination recommendations for all children, special attention should

be given to certain areas for immigrant children (Table 2). (14)

LABORATORY TESTING

Children who are born in other countries often do not receive the same laboratory screenings that US-born children receive as neonates and throughout childhood, and neither do their mothers during the prenatal period. If the mothers and/or children were tested, it is unlikely that

Table 2. Special Considerations During the Physical Examination of Immigrant Children

EXAMINATION TYPE	ASSESSMENT FOR
Eyes	Strabismus, coloboma, ptosis, nystagmus, cataracts, conjunctival pallor
Teeth	Visible caries, significant malalignment
Neck	Goiter
Heart	Murmurs/gallops/rubs while seated and supine
Skin	Birthmarks, nevi, scars, tattoos
Skeleton	Bony deformities, scoliosis, polydactyly, clubfoot, evidence of rickets (genu varum/valgum, rachitic rosary, frontal bossing/delayed closure of fontanelle, and flared wrists/ankles)
External genitalia	Tanner stage, female genital mutilation or cutting, imperforate hymen, undescended testes, inguinal hernias
General	Wasting, stunting

the results are available or easily attainable. One notable exception is the case of children who enter the United States through the Refugee Resettlement Program. Most receive all the recommended laboratory tests within the first 90 days of arrival in the United States, and the results should be available on request. In addition, a review of their overseas medical examination paperwork might reveal that they were given presumptive treatment for certain conditions immediately before departure and thus do not require additional screening or presumptive treatment (see the Refugees subsection later herein). In the absence of medical records that contain these results, screening laboratory studies should be considered for all asymptomatic foreign-born children, especially those from Africa, the Middle East, Asia, Latin America, and the Caribbean (Table 3).

Asymptomatic

Routine screening tests should be added by age as recommended in the AAP Bright Futures guidelines for all children

residing in the United States, (16) as well as targeted testing based on concerns arising during the history and physical examination, such as dietary deficiencies, abnormal physical findings, or risk factors for infectious disease. In addition, providers can consider screening for conditions such as sickle cell trait and glucose-6-dehydrogenase deficiency, depending on family history and region of origin. Further recommendations for screening can be found in the AAP Immigrant Child Health Toolkit (<https://www.aap.org/en-us/advocacy-and-xpolicy/aap-health-initiatives/Immigrant-Child-Health-Toolkit/Pages/Immigrant-Child-Health-Toolkit.aspx>) and the Centers for Disease Control and Prevention (CDC) Domestic Refugee Guidelines (<https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-domestic-guidelines.html>). (14)(22)

Symptomatic

Symptomatic children should receive testing and treatment for their presenting condition either before or at the same time as their screening is conducted, whichever is medically appropriate. For children who present with fever

Table 3. Recommended Laboratory Testing of Asymptomatic Immigrant Children

Baseline laboratory tests for all children	<ul style="list-style-type: none"> • Complete blood cell count with differential count (focus on anemia, eosinophilia) • Lead (age 0–16 y, pregnant or breastfeeding females at any age)^a • Interferon-γ release assay (first-line at any age: interferon-γ release assay, second-line: tuberculin skin test)^a • HIV (antibody test for age \geq18 mo, RNA test for age <18 mo) • Syphilis (EIA, VDRL test, or RPR test at any age or FTA-ABS test if \geq12 mo old) • Hepatitis B surface antigen • Hepatitis C antibody (if positive, would need confirmatory RNA test if age <18 mo) • Strongyloides serology (IgG) (see Table 4 for optional presumptive treatment) • Ova and parasite stool test, 2–3 samples collected on 2–3 different days (although presumptive treatment is preferred over testing, if possible [see Table 4])
If <12 mo of age, add:	<ul style="list-style-type: none"> • Newborn screen
If <6 y of age, ^b add:	<ul style="list-style-type: none"> • Thyrotropin thyroid stimulating hormone (TSH) • Free thyroxine (T4)
If adolescent, add:	<ul style="list-style-type: none"> • Pregnancy test for females (urine beta hCG) • Gonorrhea/chlamydia for males and females (urine nucleic amplification test)
If lived in sub-Saharan Africa (excluding Lesotho), add:	<ul style="list-style-type: none"> • Schistosoma serology (IgG) (see Table 4 for optional presumptive treatment)
If lived in Latin America and received a blood transfusion or organ transplant while there, are pregnant, are immunosuppressed, or mother has a known diagnosis of Chagas disease, add:	<ul style="list-style-type: none"> • Chagas serology (IgG for <i>Trypanosoma cruzi</i>)

EIA=enzyme immunoassay, FTA-ABS=fluorescent treponemal antibody absorption, hCG=human chorionic gonadotropin, HIV=human immunodeficiency virus, IgG=immunoglobulin G, RPR=rapid plasma reagin, VDRL, venereal disease research laboratory test.

^aConsider repeating at the follow-up visit (see the Laboratory Testing subsection under the Follow-up Visit section), even if initially normal and no known exposures since the previous test. Other repeated testing to be determined by new exposures.

^bUnpublished consensus guidelines from Andrew Bauer, MD, The Thyroid Center, Division of Endocrinology and Diabetes, Perelman School of Medicine, University of Pennsylvania; Jennifer Barker, MD, Sharon Travers, MD, Philip Zeitler, MD, Maggie Chan, MD, University of Colorado School of Medicine, Children's Hospital Colorado, Department of Pediatric Endocrinology; Janine Young, MD, Division of General Pediatrics, Denver Health, University of Colorado School of Medicine.

within the first 4 months of arrival in the United States from a malaria-endemic area, malaria testing should be performed as part of the evaluation. After 4 months, malaria should remain on the differential diagnosis but testing performed only if indicated by the presence or absence of other symptoms (eg, fever plus headache or fever plus vomiting and diarrhea would be more consistent with malaria, whereas fever plus cough or rhinorrhea is less likely related to malaria).

TREATMENT

Medications

Aside from medicine needed to treat identified concerns, a multivitamin with iron should be considered for all children, especially those between 6 months and 6 years of age. (14) Newly arrived children might not have had access to a wide variety of nutritious foods before coming to the United States and can benefit from supplementation.

In addition, presumptive treatment should be given to all children older than 12 months for soil-transmitted helminths (Table 4). This is preferable because stool tests for ova and parasites have poor sensitivity and the medications are generally well tolerated. However, if treatment is contraindicated, stool for ova and parasites should be analyzed with 2 to 3 stool samples from different days. Stool testing is not an effective screen for strongyloidiasis and schistosomiasis, so either serum testing should be performed or presumptive

treatment given for these conditions (Table 4).(14)(22) For children who are uninsured or underinsured, discount pricing might be available for medications through prescription assistance programs.

Vaccinations

Vaccinations given in other countries can be accepted if the dates are written in ink (or typed) on an official immunization form, the timing of administration and vaccine type are acceptable per CDC guidelines, (23)(24) and the record contains the patient's correct name and date of birth. If the child's previous immunization record meets all the preceding criteria, they will require only any catch-up vaccinations not already administered (can test for immunity before going directly to administering vaccines, if possible and desired). If the child does not have an attainable immunization record or the record is not acceptable, there are 2 options: 1) serum testing can be performed to assess for immunity (available for hepatitis A, hepatitis B, measles, mumps, rubella, and varicella) and vaccines given only if not immune or for diseases for which serologic evidence of immunity is not possible; or 2) all vaccinations can be administered as if the child has never received any immunizations, per the CDC catch-up schedule. The latter option might be the most practical for situations in which the child is uninsured because the laboratory cost might be prohibitive, the vaccines can be given without charge through the Vaccines for Children

Table 4. Presumptive Treatment Options for Immigrant Children

DISEASE	AGE/WEIGHT RECOMMENDATIONS (IF NO OTHER CONTRAINDICATIONS)	MEDICATION AND DOSAGE	CONTRAINDICATIONS
Soil-transmitted helminth infection: first line	≥12 mo of age	Albendazole: 12–23 mo of age: 200 mg po once; ≥24 mo of age: 400 mg po once	Pregnancy, allergy to albendazole, known cysticercosis or neurocysticercosis, seizures of unknown etiology
Soil-transmitted helminth infection: second line	≥2 y of age	Pyrantel pamoate: 11 mg/kg po of pyrantel base daily × 3 d; maximum 1,000 mg/dose	Allergy to pyrantel pamoate
Strongyloidiasis	≥15 kg in weight	Ivermectin: 0.2 mg/kg po daily × 2 d	Pregnancy, breastfeeding an infant <1 wk old, allergy to ivermectin, from a <i>Loa loa</i> -endemic country, known cysticercosis or neurocysticercosis, seizures or neurologic disorders of unknown etiology
Schistosomiasis	≥4 y of age	Praziquantel: 40 mg/kg po divided into 2 doses × 1 d	Allergy to praziquantel, known cysticercosis or neurocysticercosis, seizures or neurologic disorders of unknown etiology

po=by mouth.

Table 5. Select Immigrant-Focused Organizations in the United States

Organization	Website
American Immigration Council	https://www.americanimmigrationcouncil.org
International Refugee Assistance Project	https://refugeerights.org
Migration Policy Institute	https://www.migrationpolicy.org
National Immigration Law Center	https://www.nilc.org
Protecting Immigrant Families	https://www.protectingimmigrantfamilies.org
RAICES: The Refugee and Immigrant Center for Education and Legal Services	https://www.raicestexas.org
United We Dream	https://unitedwedream.org
Young Center for Immigrant Children's Rights	https://www.theyoungcenter.org

program, (25) and the benefits to ensuring coverage for vaccine-preventable illnesses greatly outweigh the minimal risk to the child of receiving vaccinations.

RECOMMENDATIONS AND REFERRALS

Families who are new to the United States would benefit from anticipatory guidance on how the health care system works, including explanations about primary care providers, the concept of a medical home, preventive care, the referral process, and appropriate use of urgent care as well as emergency departments and 9-1-1. They should also be connected to services to meet their comprehensive health needs, either within the same facility or as an external referral. For example, any child 12 months and older should be linked to a dentist. Referrals should also be made for children with behavioral health, optometry, or other subspecialty concerns. Finally, families should be informed of resources for which they are eligible that can alleviate health risks caused by social circumstances. These resources can include federal supports such as the Special Supplemental Nutrition Program for Women, Infants, and Children (aka WIC; open to all children <5 years of age whose families meet income requirements) and the Supplemental Nutrition Assistance Program (aka SNAP; open only to lawful permanent residents, US citizens, and grantees of humanitarian relief whose families meet income requirements) as well as local resources, including food banks, legal organizations, housing support, domestic violence hotlines, utility and rental assistance, recreation/community centers, English-language classes, and job training. Immigrant-specific, nationwide, nongovernmental organizations can also offer resources and/or information for providers and families (Table 5).

FOLLOW-UP VISIT

Timing

Immigrant children should be seen on the same routine preventive care schedule as children who were born in the

United States, with the exception of the visit immediately after their establishment of care. If the next routine visit would be more than 6 months after the initial visit, a follow-up should be scheduled for 1 to 6 months in the future. This visit is necessary to check on referrals or issues from the first visit, review any medical records that have been received in the interim, do additional laboratory testing and vaccinations (as needed), and identify new concerns.

History and Screening

This time should be used to discuss how the child is adjusting to American culture, review how he or she is doing in school (if applicable), reassess the social determinants of health (see the Screening section previously herein), and ask about any new issues. Screening for mental health and trauma should also be repeated because it can capture new concerns or yield previously unrevealed information that the patient is now more comfortable sharing. A second HEADSS assessment should be completed for adolescents as well.

Physical Examination

A focused physical examination should be conducted to follow up on any abnormalities noted at the first visit or to evaluate new concerns revealed in the history. If the external genital examination was normal at the first visit, there are no current, related complaints, and the child is at least 3 years old, this region does not need to be addressed and can be examined on a once yearly schedule. If, however, all 3 conditions are not met, the genital area should be examined at this follow-up visit. Weight and height/length should also be checked to determine whether the child is growing well. On the other side of the spectrum from undernutrition and failure to thrive, some newly arrived children who initially present with a body mass index within normal limits experience rapid weight gain due to overindulgence in

the typical American diet. It is important to identify these children and discuss interventions (eg, how to select healthier foods and beverages, recommendations for exercise, and limiting screen time) with their caregivers before the children develop weight-related health problems.

Laboratory Testing

For children up to 6 years of age, a second lead level should be measured 3 to 6 months after the first visit (even if the first level was normal). The reason for repeated testing is to assess the current environmental exposure because the first level can reflect the previous living environment in newly arrived children. If a child of any age was experiencing severe stress, malnutrition, parasitic infection, or untreated human immunodeficiency virus infection at the initial visit, a repeated tuberculosis test should be performed. It is recommended to do an interferon- γ release assay if at all possible, although a tuberculin skin test can be used if the interferon- γ release assay is not feasible. (26)(27)(28) Other tests might be warranted, as well, depending on specific disease processes and new risk factors (eg, testing for sexually transmitted infections might be needed if sexual activity or abuse has occurred or been revealed since the original visit).

Treatment

If presumptive treatment was prescribed for parasites, the provider should ensure that it was taken. In addition, the efficacy of any ongoing medications should be assessed and refills prescribed, as needed. The multivitamin recommended at the first visit can be either continued or stopped after 6 months of treatment, depending on the diet of the child. Catch-up or routine vaccinations should be given per the CDC timetable.

If there are no issues identified or continuing vaccination delays that necessitate more frequent follow-up, the child can then be scheduled for his or her next preventive care visit per the routine Bright Futures guidelines. (16)

SPECIAL CIRCUMSTANCES

Refugees

Children who arrive in the United States as refugees are generally with a parent or guardian, although a small subset are “unaccompanied refugee minors” and placed with foster families. Refugees in the United States have been predetermined—through months to years of

extensive vetting abroad—to have a well-founded fear of persecution or harm if they were to return to their countries of origin. Before arrival in the United States, refugees receive predeparture medical examinations, usually by the IOM. The US Refugee Resettlement Program is the formal process by which they come to the United States and are resettled into communities by local agencies. (29) Refugee children are typically able to receive Medicaid and have case managers who assist their families with finding health services, among other supports. Furthermore, refugees generally receive their first set of postarrival laboratory screenings and vaccinations at a health department, community health center, or academically affiliated clinic within their first 90 days in the United States. Records from this visit should be requested (if not immediately available) to avoid repeating laboratory tests and vaccinations unnecessarily. In addition, previous records from countries of origin or transit should be reviewed—such as the medical information from the predeparture examination conducted by the IOM—to look for any laboratory and radiology results as well as any presumptive treatment and vaccinations given.

Unaccompanied Immigrant Children

Most children without a parent or legal guardian who arrive in the United States and do not have a previously approved form of admittance are transferred to the custody of the Office of Refugee Resettlement (ORR). Although unaccompanied immigrant children (UIC) are not considered refugees, the ORR (under the Department of Health and Human Services) is the branch of the US government tasked with covering the basic needs of these children while the government assesses potential “sponsors” (usually parents or other family members) to assume guardianship. Within the first 24 hours of entry into ORR care in a shelter (where most UICs are placed) or foster home, every child receives a psychological evaluation and, within 48 hours of entry, an initial medical examination. Typically, ORR-affiliated shelters contract with external pediatric-trained practitioners to come into the shelter to provide preventive and acute care, although some hire full-time, in-house providers and others take the UICs to an outside clinic. The initial medical examination consists of a full history and physical examination, vaccinations, and testing for tuberculosis. Adolescents 13 years and older are also tested for human immunodeficiency virus, and children at any age are screened for sexually transmitted infections if they disclose sexual abuse or activity (any disclosure of abuse that occurred in the United States must

be reported to child protection authorities, as it is for all children). If there are abnormalities identified through the initial medical examination or known, preexisting conditions, the children are referred to local subspecialists. While in ORR custody, UICs are covered by health insurance, and ORR—as well as shelter staff, by officially designated extension—has medical decision-making authority on their behalf. (30) However, healthcare providers are encouraged to contact the UIC's parent or other family member, as appropriate, to be sure that an accurate health history is obtained and those who know the minor best are able to contribute to the formulation of their medical plan of action.

When UICs are released from ORR care to live with their sponsors, the health insurance coverage they previously received is terminated. In 6 states (Washington, Oregon, California, Illinois, New York, and Massachusetts) and the District of Columbia, children are eligible to receive public health insurance coverage regardless of immigration status. If the child will be living in one of the remaining 44 states, it is likely that he or she will be uninsured (unless the sponsor can provide private insurance coverage). Thus, access to care can be a challenge, and these children typically require financial assistance programs and/or charity care to meet their health needs. If the sponsor and child do not bring the records of vaccinations and laboratory results from ORR to their new health facility after release, they can be requested at the ORR website (<https://www.acf.hhs.gov/orr/resource/unaccompanied-childrens-services>).

Families in Detention

Before spring 2021, there was a small but significant minority of children who arrived in the United States with a parent or guardian and were placed in family detention together. There were 3 such facilities in the United States, with a total capacity of approximately 3,700 individuals within family units. (31) Although the medical services varied among facilities, children and adults generally did not receive any screening other than a rapid examination for scabies, lice, and varicella. The families had access to health care on site for acute needs and hospital referral for emergencies only. Occasionally and without a predictable pattern, family detention centers conducted tuberculosis testing or full physical examinations of children but did not typically give vaccinations. (32)

Per the Flores Settlement Agreement, children should not be held in detention for more than 20 days. (33) Although this limit was violated at times, most families who were placed in these detention facilities were eventually released, and most of them went on to stay with friends or family in

the United States while their asylum claim was processed. Because these children are living in US communities and accessing local health-care, it is important to recognize whether they have a history of detention, to assess for any signs or symptoms of resultant trauma, and to facilitate connections to mental health services, as needed. In addition, note that immigration policies change over time and families could again be held in detention in the future.

PROTECTING THE PEDIATRIC PRACTITIONER

As a result of the everyday challenges of caring for immigrant children and families, frontline practitioners working with this population are at high risk for burnout. Care must be taken to prevent the compassion fatigue that can result from burnout as well as recognize and intervene when it is beginning to manifest. Although self-care such as yoga and meditation have proved to be beneficial in decreasing stress, interventions that increase resilience and self-efficacy have been shown to be more effective in alleviating burnout. (34) An important avenue through which to build this resilience in practitioners for immigrant children is through advocacy. This can come in the form of contacting elected officials on a particular topic or writing resolutions on immigrant-related issues for state medical societies. (35) Practitioners can also join professional organizations, such as the AAP, in raising awareness about the structural injustices that form the root of health inequities in immigrant children and supporting legislation to reform the system. Although the societal, environmental, and economic challenges facing immigrant populations are staggering, medical professionals can partner in their advocacy with organizations and individuals that address factors across the spectrum of social determinants of health. It is this fortifying, action-oriented collaboration of health professionals, social workers, educators, politicians, faith leaders, service organizations, legal advocates, and immigrant parents, among others, that is the ultimate antidote to burnout and the fuel to keep the fire burning on behalf of immigrant children for as long as they continue to come.

Summary

- Based on strong research evidence, immigrant children in the United States are a heterogeneous population, the care of which requires specialized clinical knowledge of particular global health concerns as well as cultural humility in its approach. (2)
- Based on strong research evidence, the gold standard for immigrant children (as it is for US-

born children) is to receive health services in a medical home that can provide referral support, care coordination, and community connection. (7)(8)(9)

- Based on some research evidence as well as consensus, the history of an immigrant child should include information related to premigration, during migration, and postmigration to elicit risk factors to guide screening, physical examination, diagnostic evaluation, and treatment. (14)
- Based on some research evidence as well as consensus, immigrant children typically have not received care equivalent to US-born children in their country of origin and could have been exposed to pathogens uncommon in the United States. Therefore, in addition to following standard guidelines for all children in the United States, immigrant children at any age might need laboratory studies, physical examinations, and vaccinations that were previously missed as well as targeted testing or presumptive treatment for specific exposures. (14)(22)
- Based on some research evidence as well as consensus, immigrant children should be

followed closely in the postmigration period to build trust and rapport between practitioner and patient, assess for acculturation concerns, ensure compliance with Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics guidelines, monitor chronic conditions, and address any new issues. (2)(14)(22)

- Based on some research evidence as well as consensus, children who were admitted to the United States as unaccompanied immigrant children or refugees, as well as those who experienced family detention, are subpopulations of immigrant children who require particular understanding of their unique, respective circumstances. (29)(30)(31)(32)(33)
- Based on some research evidence as well as expert opinion, pediatric practitioners working with immigrant children are at high risk for burnout and can mitigate that risk by building resilience through advocacy. (34)(35)

References for this article can be found at
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1. You are seeing a 4-year-old girl who recently immigrated to the United States with her family from Somalia. Her father has a position at your local university and has been in the United States for a year. The girl, her mother, and 2 siblings arrived last week from Somalia and are establishing care with you. The father and the girl's 8-year-old sister speak English, Somali, and Italian. The girl, her mother, and her younger brother speak Somali and Italian. A family friend drove the mother, your patient, and the older sister to the clinic. The family friend speaks Somali and English. You do not speak Somali and there are no colleagues or staff members in your practice who speak Somali. However, you do speak Italian at a beginner level. Which of the following is the best option to communicate with the family?
 - A. Ask the older sister to translate in Somali in person.
 - B. Ask the adult family friend to translate in Somali in person.
 - C. Ask to reschedule the visit to a time when the father can attend the visit.
 - D. Communicate with the family in Italian.
 - E. Use a certified interpreter who speaks Somali.

2. A 5-year-old boy and his family have been placed in your city by a refugee organization. A care coordinator for the refugee organization set up the appointment with you for a health supervision evaluation. The mother is confused by why her son needs an evaluation because he is not ill. Your medical assistant asked the boy to undress and put on a gown for the examination. The mother was upset because she does not want her son's genitals to be seen. Which of the following is the most appropriate approach that you should take in this situation?
 - A. Call the care coordinator from the refugee organization and ask for guidance.
 - B. Discuss the concept of the health supervision visit compared with the sick care visit.
 - C. Reprimand the medical assistant for asking the boy to put on the gown.
 - D. Reassure the mother that you have seen the genitals of many young boys.
 - E. Tell the mother that this is a required examination to stay in the country.

3. A 2-year-old girl recently emigrated from Bolivia with her family. Her physical examination findings are normal. Her height and weight are at the 10th percentile. Her mother brings an immunization record in the child's name with the correct date of birth, and the paperwork documents that her immunizations are up to date. In addition to ordering routine laboratory studies, which of the following is the most appropriate additional plan in the management of this patient?
 - A. Add ova and parasite stool testing to the laboratory panel.
 - B. Add measles serology to the laboratory panel.
 - C. Prescribe pyrantel pamoate for 3 days.
 - D. Refer the girl for a nutritional evaluation.
 - E. Start immunizations on a catch-up schedule.

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4. An 18-month-old boy is brought to the clinic by his parents to establish care as the family recently immigrated from India. Physical examination is unremarkable. You obtain the laboratory testing recommended for asymptomatic immigrant children, and treat the entire family presumptively for intestinal parasites. The family reports that he had received vaccines before and they do have the child's medical records with them at home but forgot to bring them to the clinic today. In planning follow-up visits for this child, you request the family to send you the records and discuss the future visit schedule and what will be done at the next appointments. Which of the following is the most appropriate follow-up plan for this patient?
- A. Add measles serology to the laboratory panel.
 - B. Follow-up at 2-years of age as per the US schedule and then yearly afterwards.
 - C. Follow-up in 4–6 weeks for record review and appropriate immunizations.
 - D. Give the 2-months vaccines today and follow-up in 2 months for next set of vaccines.
 - E. Next time he requires immunizations is at 4–5 years of age.
5. A 5-year-old boy and his family are refugees from Sudan, and he is seeing you for a first visit. Your evaluation shows average growth and normal physical examination findings. You discuss laboratory studies with the family. You would like to order a complete blood cell count, interferon- γ release assay, hepatitis C antibody, and hepatitis B surface antigens today. You schedule the patient for a follow-up visit in 3 months. You are most likely to order which of the following additional laboratory studies?
- A. Chagas serology today.
 - B. Human immunodeficiency virus testing at the next visit.
 - C. Lead level today and repeated at the next visit.
 - D. Newborn screen at the next visit.
 - E. Urinalysis and culture.