CARE FOR KIDS
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Where to Begin with a Child from the Congo

By Marguerite H. Oetting, M.D., Department of Pediatrics, UI Children's Hospital

Providers in Iowa are seeing new refugees in our clinics. In eastern Iowa we are witnessing an influx of children fleeing the war in Democratic Republic of Congo. Iowa also is becoming home to children from Burma, Central America, and more familiar countries such as Sudan and Mexico. In this article I hope to explain how to begin getting to know your patients from central Africa.

The children coming to Iowa from the Congo typically lived in a refugee camp in Tanzania, though Burundi, Rwanda, and Uganda also host refugees. The families were selected by the U.S. to resettle in this country. They should have undergone a physical prior to leaving their country of origin, received malaria and intestinal parasite treatment, and TB testing. Unfortunately, records of this evaluation are rarely available in our experience.

Refugees arrive in the U.S. at their "primary settlement," one of several cities that agree to host refugees. The family receives green cards, Medicaid eligibility, and three months of minimal financial support. Once their initial support ends, many families relocate to a place where they have extended family, friends, or jobs. These cities are called "secondary settlements" and they offer no specific support for refugees. Iowa is typically a secondary settlement for

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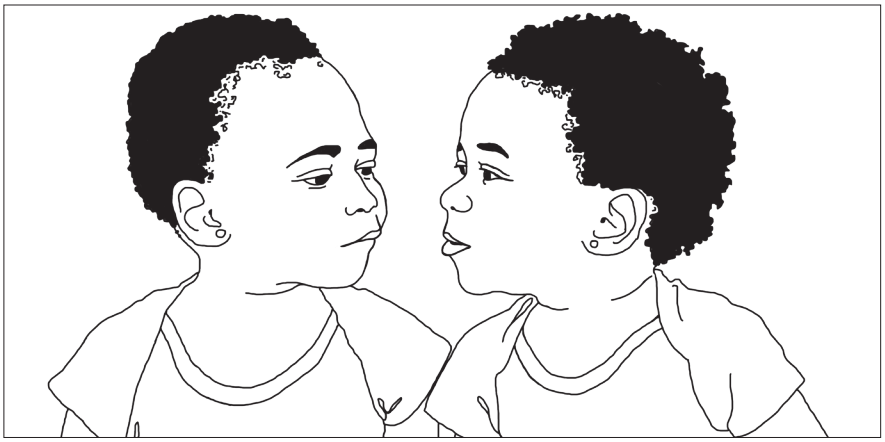

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Congolese. A few refugees "win the lottery," which is a different way to come to the U.S. These families also have green cards and Medicaid.

Congolese refugees are generally multilingual. French and Swahili are often second languages. Very few have any spoken English. Seventy percent of adults have only primary school education. The families are very large, with six to 12 children. Most families have limited access to healthcare. Most Congolese are Protestant Christian (Seventh Day Adventist, Jehovah's Witness, and Pentecostal). The war in Congo has had high incidence of sexual abuse and the camps have been violent, but mental illness may be considered a curse. All of these characteristics complicate care, but now the child is in the clinic.

What should you do first?

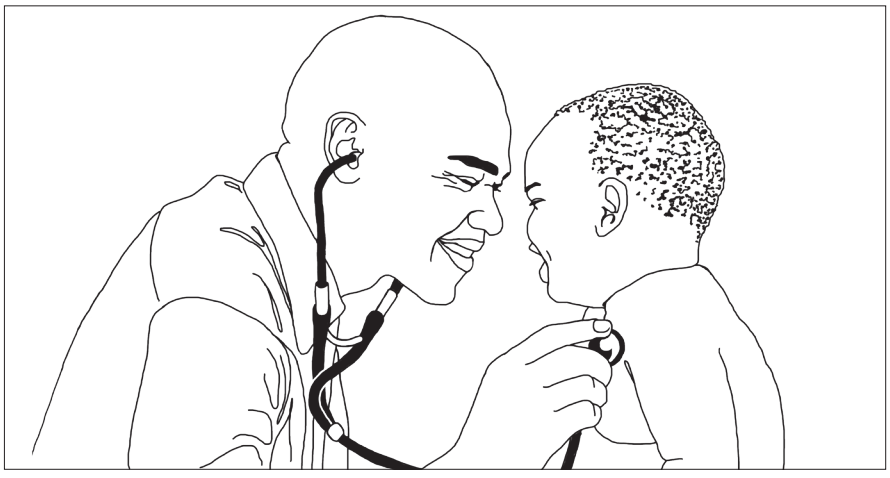
The clinic visit should be conducted in the patient's preferred language through an interpreter or a fluent clinician. If no immunization, lab, or exam records are available — start over.

TB testing: Testing should have been done and necessary treatment given before refugees departed their home country, but it must be repeated if no record is available. It is important to note that there is no "Gold Standard" for accurate TB testing.

★ Careful history must be obtained regarding TB risk and symptoms, and work up should be initiated if there are concerning symptoms regardless of TB test results.

★ Refugees with a history of treatment for either active or latent TB should be screened by symptomatology for recurrence. Contact a TB specialist if there are concerning symptoms.

★ There are two ways to test: PPD Tuberculin Skin Test (TST) and IGRA blood test (Quantiferon Gold or T-Spot).



★ PPD may be used for all ages and is preferred for children under five years old due to lack of data about IGRA reliability in this young age group. PPD requires a return clinic visit in 48-72 hours for reading or contact with a school/public health nurse to schedule a reading. This may be prohibitive for patients. The PPD has the potential to cross react with BCG vaccine, especially if vaccination was within two years of testing.

★ IGRA is acceptable in children of all ages but is not well studied in those under five years and should probably not be used in children under two years. IGRA is an acceptable alternative in children two to five years old who received the BCG vaccine. It is the recommended test in children five years old and older who come from a high-risk country and likely had BCG vaccine, since BCG does not cause a positive IGRA. IGRA are more convenient than PPD because there is no return appointment. IGRA are more expensive.

★ PPD and IGRA remain positive for life despite treatment, so there is no need to repeat if someone has a history of treatment. Severe local blistering can occur with repeated PPD placement in a patient with a previously positive PPD and should be avoided. ***Patients who have been treated should retain a copy of their documentation of completion for future employers.***

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★ The PPD or IGRA can be administered on the same day as live virus vaccines; otherwise they should be postponed for four to six weeks after live virus vaccination.

Lab testing:

1. HIV - All children should be tested due to prevalence of HIV in Africa and the frequency of sexual abuse in the refugee camps. Refugees have NOT been tested for HIV by immigration since January 2010.

2. G6PD - deficiency is common in African countries

3. Hemoglobin electrophoresis - sickle cell disease and other hemoglobin variants are common in Africa

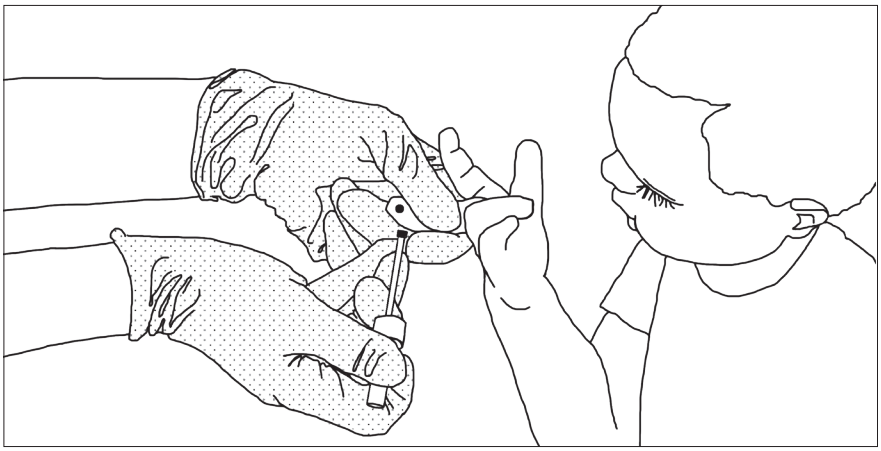
4. CBC with differential to screen for anemia and for eosinophilia > 400 cells/mm3. If the patient has eosinophilia, please consult an Infectious Disease Specialist (University of Iowa Children's Hospital Infectious Disease Clinic at 888-573-KIDS or Blank Children's Infectious Disease Clinic at 515-241-8300) regarding further work up.

5. Hepatitis B surface antigen

6. Hepatitis C antibody

7. Lead screen for children six months through 16 years of age

8. Intestinal parasites - Strongyloides serology for all sub-Saharan Africans



If a recently arrived patient is symptomatic, consider O & P x 3, giardia and crypto DFA, Hepatitis A IgM/IgG, and enteric culture. Consult Infectious Disease for any positives, as treatment is complicated.

9. Infant neonatal screen if less than three months old. Iowa will not run neonatal screen after three months of age.

10. VDRL for all children and adolescents with priority given to adolescents > 15 years old or sexually active

11. Chlamydia and GC Screening for sexually active or abused children

12. Urinalysis - screen for hematuria/glycosuria. Hematuria may indicate Schistosomiasis and schistosomes may be seen on microscopic exam of urine.

13. Malaria - All refugees from sub-Saharan Africa should have received presumptive therapy for malaria unless contraindicated. If there is no documentation of presumptive treatment, presumptive therapy should be given in the U.S. (contraindicated for pregnant women and infants less than 5 kg). Symptomatic individuals from any country should be tested for malaria with Giemsa Smear and PCR and treated accordingly. Presumptive therapy and/or testing for asymptomatic individuals not from sub-Saharan countries are NOT recommended.

Immunizations - Immunizations given in country of origin can generally be considered valid if documented and age and interval are within guidelines recommended by the AAP and ACIP. Of note, the month and day are often transposed in other countries **(**i.e., 12/30/14 may be written as 30/12/14). You can Google a foreign vaccine to see which antigens it contains.

(Article was written in consultation with Dr. Nathan Price, Infectious Disease Specialist at UIHC Department of Pediatrics.)

For a list of resources pertaining to this article, please see page five.

Cultural and Linguistic Competency in Home Visitation

By Jen Stout, Director, Strong Foundations, Visiting Nurse Services of Iowa

A common perception of Iowa is that it is home almost exclusively to vast fields of farmland and middle-class, English-speaking white families. Census data tells a much different story. In the past 10 years there has been a steady increase in cultural and linguistic diversity in Iowa. The current population of Iowa is 8.7 percent non-white, and 7.1 percent speak a primary language other than English (Census data, 2010). Between the years 2007-2012, 3,067 refugees resettled in Iowa. Of those whose primary language was known, a total of 52 different languages and dialects were spoken (Des Moines, Healthy Start Project).

Iowa's changing cultural climate affects all areas of service provision for individuals and families. The execution of home visitation services and developmental screening is no exception. Since the 1960s home visitation programs have been implemented in communities across the country and have undergone evaluations to test their effectiveness. This research suggests that home visitation programs have both immediate and long-term benefits to children and families. Some of the noted benefits include: improved birth outcomes, enhanced cognitive development and academic success, and strengthened parent-child interactions (Congressional Research Service, 2009).

There are various challenges to providing culturally and linguistically competent home visitation services. Some challenges include: barriers to program participants learning English; lack of interpretation services; difficulty with successful links to available community resources; and identifying and addressing trauma, interpersonal violence, and mental health concerns. The Des Moines Healthy Start Project, a program of Visiting Nurse Services of Iowa, has encountered all of these barriers as well as many others. By enhancing the already robust service delivery model, this home visitation program is providing valuable lessons learned.

A strong home visitation workforce is essential to achieving desired outcomes. Hiring staff directly from the diverse communities being served and utilizing these staff for interpretation and translation services and ongoing workforce development opportunities for others has been successful within the Des Moines Healthy Start Project. These staff members often fill the role of cultural liaison between the home visitor and participant during visits.

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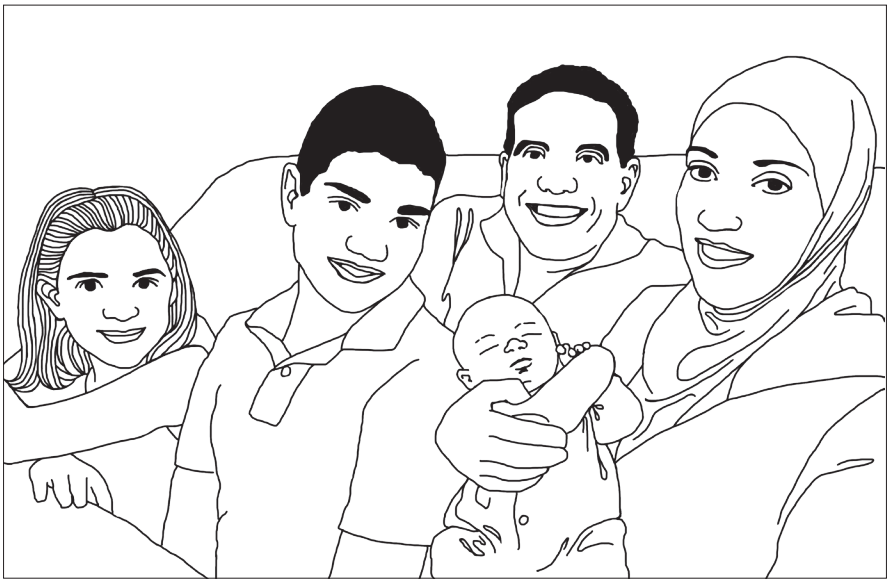

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RESOURCES

1. References may be found at: ***http://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html***
2. CDC Division of Global Migration and Quarantine, *"Guidelines for Overseas Presumptive Treatment of Strongyloidiasis, Schistosomiasis, and Soil-Transmitted Helminth Infections for Refugees Resettling to the United States."* September 17, 2013. ***http://www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/intestinal-parasites-overseas.html***
3. CDC Division of Global Migration and Quarantine, *"Domestic Refugee Health Guidelines: Malaria."* November 13, 2012. ***http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html***
4. CDC Division of Global Migration and Quarantine, *"Guidelines for Screening for Tuberculosis Infection and Disease During the Domestic Medical Examination for Newly Arrived Refugees."* April 16, 2012. ***http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html***
5. CDC Division of Global Migration and Quarantine, *"General Refugee Health Guidelines."* August 6, 2012. ***http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html***
6. AAP Technical Report: *Interferon-γ Release Assays for Diagnosis of Tuberculosis Infection and Disease in Children.* ***http://pediatrics.aappublications.org/content/134/6/e1763.abstract?rss=1***

African Refugee Initial Screening Labs for Asymptomatic Patients

1. TB testing if no record of testing available from country of origin:
   a. PPD if < age five
   b. IGRA (Quantiferon TB Gold) if > age five. May consider if > age two and received BCG.
2. HIV Antibody Screen (OraSure)
3. G6PD (Glucose -6-Phosphate-Dehydrogenase)
4. Hemoglobin Evaluation – Quantitative only
5. CBC with differential
6. Hepatitis B surface antigen
7. Hepatitis C antibody
8. Lead level – six months to 16 years
9. Strongyloides antibody, IGG (may need additional labs if symptomatic)
10. Iowa Newborn Metabolic Screen if < three months old
11. VDRL
12. Chlamydia and Gonorrhea PCR if sexually active or abused
13. Urinalysis and microscopic exam.

Update immunizations. Give presumptive treatment for malaria if there is no documentation that it has been given.

BE AWARE

Comprehensive developmental screening tools should be culturally appropriate. It is important to interpret results in the context of the child's family and culture. If a child appears unable to do a specific task, it is important to have a conversation with parents about the cultural expectations they and their community have for children of that age. ***www.theounce.org/pubs/Snapshots-FINAL.pdf?v=1***

Cultural and Linguistic Competency in Home Visitation

RESOURCES/CONTACTS

For more information about **The Ages and Stages Questionnaires** (ASQ-3 and ASQ:SE), visit the ASQ web site, or go to: ***http://agesandstages.com/ask-jane/*** to have specific questions answered. ASQ-3 is commercially available in four languages (English, Spanish, French, and Korean), and the ASQ:SE is available in three languages (English, Spanish, and Norwegian).

Tips for screening children from diverse cultures: ***http://agesandstages.com/free-resources/articles/tips-screening-children-diverse-cultures/***

Enhancing Developmentally Oriented Primary Care, EDOPC, in Illinois is instrumental in providing Iowa ASQ and ASQ:SE trainings and train the trainer events, visit: ***http://www.edopc.net/.*** Also on the site, is information about Identifying and Overcoming Barriers to Screening at: ***http://www.edopc.net/overview/barriers.aspx***.

The **Visiting Nurse Services of Iowa** is the primary contact in Mahaska, Poweshiek, Clinton, Jackson, and Scott counties in Iowa. ***http://www.vnsdm.org***

Contact your **County Health Department**; while it's not refugee specific, the health department is a good first point of contact. ***http://www.idph.state.ia.us/webmap/default.asp?map=public_health_contacts***

1st Five from the Iowa Department of Public Health provides statewide care coordination and employs bilingual staff when possible. ***http://www.idph.state.ia.us/1stfive/***

U.S. Committee for Refugees and Immigrants-Des Moines: ***http://www.refugees.org/about-us/where-we-work/uscri-des-moines/***

American Academy of Pediatrics Policy Statement on Providing Care for Immigrant, Migrant, and Border Children (PDF): ***http://pediatrics.aappublications.org/content/early/2013/04/30/peds.2013-1099.full.pdf+html***

Cultural and Linguistic Competency in Home Visitation
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They frequently consult on the implementation of program materials, such as screening tools and assessment materials to identify potential cultural barriers to implementation.

Coordinated outreach to low-income, minority, at-risk populations has been successful in the recruitment of staff, program, and community participants. This effort includes designated Outreach staff who are responsible for distributing marking items; providing interpretation services to consumers accessing community resources; and providing presentations to agencies, civic organizations, faith-based communities, and participating in culturally relevant community events.

Another vital component of providing culturally competent service is **ongoing professional development**. Pre-service education components may include materials addressing how to work with interpreters during home visits and basic medical interpreter reading materials. Continuing education during services may include specific cultural education led by content experts, as well as the inclusion of staff from diverse populations in all training offered to home visitors.

Appropriate screening tools for and addressing the areas of child development, depression, trauma, interpersonal violence, and mental health concerns prove to be daunting to even the most seasoned home visitor. Add the element of linguistic and cultural disparity, and this pivotal component of a successful home visitation program may fall short. Due to under-recognition and under-reporting of these areas of concern and continued stigma attached to these issues, many families run the risk of not receiving optimal services to address these critical needs.

Choosing screening or assessment tools that are available in a variety of languages is imperative. Having culturally diverse staff trained in the administration of the screening tools enhances the accuracy of administration. Including culturally diverse staff in all training and professional development related to these topics, and ongoing dialogue within the home visitation community about cultural similarities and differences can help overcome barriers.

The climate of Iowa is changing and programs must change with it. By exploring opportunities to partner with and engage culturally diverse populations, providers can move closer toward providing comprehensive, family-centered care. By addressing cultural and linguistic needs screening, identification and intervention for critical concerns can be successfully implemented. These screenings can be completed early, and in the end outcomes for children and families improve.

For a list of resources and contacts to assist providers in finding information about screening patients from diverse cultures, please see page six.

CARE FOR KIDS
Early & Periodic Screening, Diagnosis & Treatment

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What's in this issue

If you have questions about **billing** related to EPSDT Care for Kids services, please call Provider Services: **1-800-338-7909**. If you have questions about **clinical issues** and EPSDT Care for Kids services, please call **1-800-383-3826.** Please note: Due to budget restraints, the *EPSDT Care for Kids Newsletter* is sent to offices and organizations, rather than to individuals. **The newsletter is also available on line at www.iowaepsdt.org**. Readers are welcome to photocopy or download material from the newsletter to share with others. If you wish to reproduce material from the newsletter in another publication, whether print or electronic, please obtain permission prior to publication by contacting the editor. Please include the following acknowledgment with reprinted material: Reprinted by permission of the Iowa *EPSDT Care for Kids Newsletter.*

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