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Approach to the Care of New Immigrant, International Adoptees, and Refugee Children in the United States

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Children who live in the U.S. and are born internationally can have a varied path leading them to the U.S. but face similar medical needs after arrival. The American Academy of Pediatrics (AAP) defines immigrant children as any child "born outside the United States to non-U.S. citizen parents." It is important to know the difference between an immigrant and a refugee. An immigrant chooses to settle in another country, while a refugee is forced to flee his or her country because of persecution, fear of persecution, war, or natural disaster. Refugees are screened and approved before arrival, while an

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asylum seeker pursues approval after arrival in the U.S. as someone seeking asylum for fear of persecution in their country of origin. The number of asylees and refugees can vary according to political policy, armed conflicts, and global poverty. The total number of children who come to the U.S. as international adoptees has decreased, however, the number of foreign-born people in the U.S. has quadrupled since the 1960s. In Iowa, the number of children with at least one immigrant parent has jumped from 17,000 in 1990 to 81,000 in 2019. While there has been a lot of press about Afghan refugees coming to Iowa in 2021, most immigrants living in Iowa are from Asia and Latin America, 35% and 34% respectively, with about 16% from Africa and 12% from Europe.

The medical home and access to healthcare

Establishing a medical home is critical for access to healthcare for all immigrant children. Adoptees are considered no different from biological children in terms of a family's insurance coverage. Most immigrant children with legal status are eligible for health insurance coverage, however, the population of children without health insurance are at high risk for not having a medical home.

There are some opportunities in Iowa for children without health insurance coverage. Vaccinations are available through local public health departments through the Vaccines for Children Program. Emergency Medicaid is available for coverage for two calendar months, for qualifying conditions. Families may also seek care at Federally Qualified Health Centers. Additionally, local communities have joined together to help care for this population by creating free or sliding-scale clinics such as the UI Mobile Clinic run by medical students at the University of Iowa (**https://iowamobileclinic.org**). Another community-funded option are school-based clinics that provide care for children without insurance through the public school system. Currently these school-based clinics are in Des Moines, Iowa City, Cedar Rapids, and Sioux City, among others. **https://www.iowacityschools.org/Page/1164**.

Cultural sensitivity

Medical homes caring for immigrant children must be culturally sensitive to provide the best quality care. Immigrant families may practice a different form of

healing than the traditional medical system. The family's health beliefs may change with exposure to the health system. However it's important to be sensitive to a variety of definitions of health. A culturally sensitive practice shows curiosity, empathy, and respect toward other cultures. Practically, this means that interpreters should be readily available and patient information should be made available in a patient's home language.

Interpreters are an important part of the medical home caring for immigrant children. Initial evaluations should be done in the preferred language to identify developmental delays as soon as possible. Trained medical interpreters in person or used via electronic means are invaluable and should be used instead of asking family members or friends to translate. The American Academy of Family Physicians has resources and guidelines that are helpful to incorporate interpreters into the medical practice at: **https://www.aafp.org/fpm/2014/0300/p16.html**.

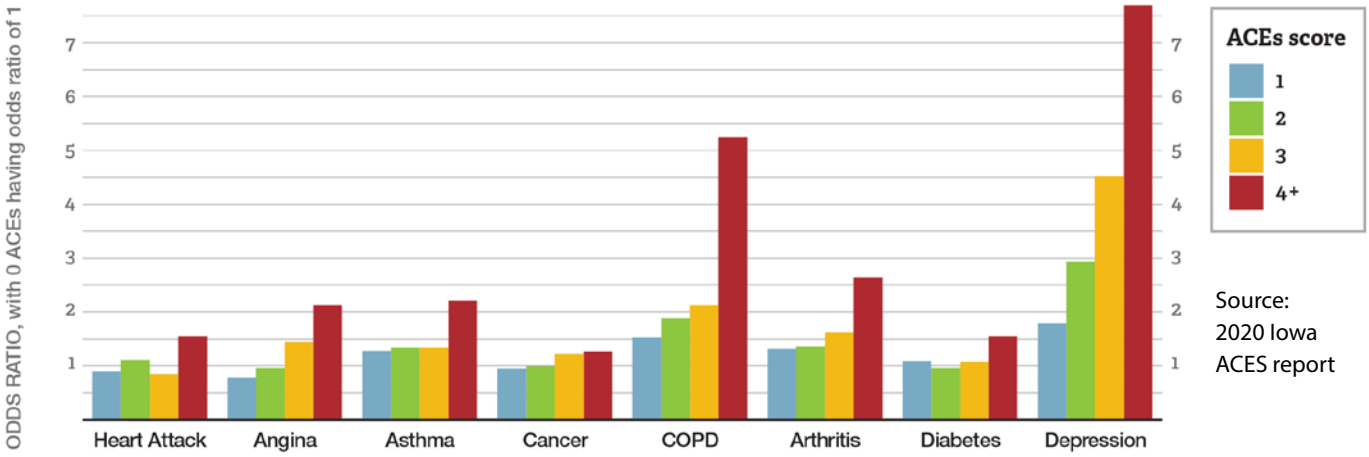
It is important for providers to know that cultural differences may still impair communication, despite correct use of interpretation services.

The initial visit

Most immigrant children arriving in the U.S. legally will have had some form of screening medical exam before leaving their home country. This exam is extremely basic and tends to include only high-priority public health screenings, such as syphilis, HIV, and tuberculosis. Given that this exam can vary it is reasonable to repeat all

ODDS OF DEVELOPING HEALTH CONDITIONS BASED ON ACES/NEGLECT

The measured effects of ACEs score on each chronic condition were controlled for age, race and ethnicity, gender, and education.



Source: 2020 Iowa ACES report

recommended screening unless the results of these exams are in hand. Recommended diagnostic testing is summarized in Table 1 on page five.

In the initial exam, all available medical records should be obtained and evaluated. Caregiver concerns should be addressed. Additionally, a completely unclothed physical exam should be performed. Given the numerous recommended screenings and potentially complicated history, it is reasonable that the components of the initial visit be spread out over multiple visits. It is also reasonable to wait to perform an unclothed exam, especially if there is a history of abuse or trauma.

It is important to remember that newborn testing and screening done routinely in the U.S. should also be considered for immigrants. Depending on the age of the child, a newborn metabolic screen could be performed in infants. It's also reasonable to perform formal hearing and vision screening. A dental home should be established for the child as soon as possible. A fluoride varnish can be applied in all children under five years of age. Additionally, the child should receive all preventive care recommended by the AAP's periodicity schedule according to age.

Immigrant children should have developmental screening performed in their home language as soon as possible after arrival. The Ages and Stages Questionnaire (ASQ) as well as the Survey of Well-being of Young Children™ (SWYC) can be used as appropriate by age, recognizing that some questions may not be culturally relevant and results may need to be evaluated with cultural sensitivity.

Depending on age, immigrant children should also be screened for trauma, abuse, and mental health disease, as well as behavioral disorders. The Ages and Stages Questionnaire-Social Emotional (ASQ-SE), GAD7, and PHQ-9 are surveys that could be used to further elucidate behavioral concerns.

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ODDS RATIO OF STUDENTS WHO EXPERIENCED FOUR OR MORE ACES COMPARED TO THOSE WITH ZERO ACES:

3.4x more likely to experience academic failure

4.9x more likely to have severe attendance problems

6.9x more likely to have behavior problems

Source: Blodgett and Lanigan, 2018 Note: This is not Iowa-specific data.

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It is possible that child immigrants may not have accurate documentation of their birth, or caregivers could present with persistent concerns that the child's age is not accurate. Before changing a child's birthday, it is reasonable to wait 12 months after arriving in the U.S. to account for any catch-up growth that could occur or nutritional deficiencies to normalize, before a determination is made. There are no specifically recommended tests for age determination, an overall clinical determination is reasonable, using all pieces of the child's history, parental input, and specialist input.

An accurate immunization record is vital. It is important to note that some countries may use an alternative calendar so be careful when transcribing immunization records into your system. For example, Ethiopia follows a calendar that contains 13 months, so calendar dates need to be transcribed to the Gregorian calendar used in the U.S.

If a child arrives without immunization records, the child should be immunized according to the AAP catch-up schedule. If a child does have an immunization record, it is possible, especially if the child lived in an institutional setting, that the vaccines were poor quality or were stored inappropriately causing no serologic transformation. In this case, shared decision-making should guide the decision to either completely reimmunize the child, perform serologic testing to test for antibodies, or to just accept the immunization record as valid.

ACEs, trauma, and trauma-informed care

It is important to evaluate for Adverse Childhood Experiences (ACEs) in immigrant children especially among refugees and asylum seekers. ACEs are stressful events that are caused by abuse, neglect, or household dysfunction. Current research shows that prolonged toxic stress during childhood caused by ACEs is associated with, among others, a higher likelihood of learning, developmental, and behavioral disorders early in life, and substance abuse, obesity, and chronic disease later in life. Epigenetic studies show differences in gene expression based on a stress versus non-stress environment and support the idea of ACEs causing lifelong problems from a genetic perspective.

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Table 1– Recommended Diagnostic Testing

The following information is summarized from Table 3 in **https://publications.aap.org/pediatrics/article/143/5/e20190657/37176/Comprehensive-Health-Evaluation-of-the-Newly** and also taken from Tables 3 and 4 of "Care of the Immigrant Child," see Reference #3 on page 7.

TEST	NOTES
Hep B surface antigen, Hep B surface antibody and Hep B core antibody	Repeat screening for Hep B after 6 months if high risk.
Hep C antibody	
Hep A (IgM and IgG)	
HIV	Repeat screening for HIV after 6 months if high risk.
Syphilis serological testing: Syphilis EIA, reflex RPR, if positive	May skip if prenatal lab results or recent maternal results are available with negative screens.
TB screen: Interferon gamma release assay (IGRA), tuberculin skin test (TST)	Screen regardless of history of BCG vaccine. If IGRA unavailable, may use TST at any age. Repeat TB screening in 6 months.
T cruzi, if coming from countries with endemic infection https://www.cdc.gov/parasites/chagas/gen_info/detailed.html	
Stool exam for ova and parasite and enteric pathogen infections OR presumptive treatment with albendazole AND Strongyloides IgG OR presumptive treatment with Ivermectin if >15kg	Consider presumptive treatment with albendazole (if there are no contraindications) for soil-transmitted helminth infections without testing for children over 12 months. If testing stool, obtain three tests collected on separate days >24 hours apart with specific request for *Giardia* and *Cryptosporidium*. If patient is from sub-Saharan Africa, test serology IgG for *Schistosoma* or treat presumptively. If the child has diarrhea, also order testing *for Salmonella, Shigella* and *Campylobacter* and *E. Coli 0157:H7* and *C. difficile* if the diarrhea is bloody.
CBC with red cell indices and differential	Consider recommending a multivitamin with iron as indicated for clinical evidence of poor nutrition. If absolute eosinophil count >450 cells/mm3 and negative stool ova and parasite exam, perform serologic screening for *Strongyloides, Schistosoma, Toxacara canis* and/or lymphatic filariasis, depending on country of origin.
Malaria thin and thick blood smears x 3 times OR Malaria Rapid Diagnostic Test OR Presumptive treatment for P. falciparum	New immigrants from endemic areas of sub-Saharan Africa or if there are signs or symptoms of infection. If not pre-treated per CDC guidelines prior to departure and history of living in area with high malaria risk, consider treatment with atovaquone-proguanil or artemether-lumefantrine (if > 5kg), given that subclinical malaria infection is common and blood testing lacks sensitivity, particularly for areas that have greater than 40% endemicity for malaria infection. For infants and pregnant teens with symptoms consistent with malaria, CDC recommends blood PCR testing.

Hemoglobinopathy and blood disorder screening if the child is of African, Asian, Hispanic or Mediterranean ethnicities: Sickle cell disease, Thalassemia, G6PD deficiency.	
Blood lead testing	Repeat in 3-6 months in children 6 months-6 years.
Thyroid function: TSH	All children 6 months-3 years (screening for congenital hypothyroidism).
Newborn metabolic screen (young infants)	Infants can be screened for all disorders up to one year of age in Iowa. Only congenital hypothyroidism and CAH will not result for children over 1 year of age.
Rickets screening (calcium, phos, alk phos) for high-risk children (institutionalized, growth delay, poor vitamin D intake or limited sunlight)	
If suspected abuse history, include testing for gonorrhea, chlamydia, and other STD at all suspected sites of abuse.	
Pregnancy test for adolescent females	
Vaccine serology, if indicated	

CHILDREN WHO SUFFER 7 OR MORE TYPES OF ADVERSITY IN THE FIRST THREE YEARS OF LIFE HAVE A

100% CHANCE OF DEVELOPMENTAL DELAYS.

Source: Harvard University, Center on the Developing Child

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Resilience is the key to keep ACEs from becoming toxic and causing lifelong harm. For children, resilience is learned from a trusted caregiver who can help guide them through stressful events. Many asylum and refugee child immigrants may have challenges with a caregiver's ability to teach resilience and provide guidance through stressful events, as many caregivers may be going through significant trauma and need help themselves

There are many ACEs screening questionnaires that are available to screen for ACEs in immigrant children. Specific counseling such as Trust-Based Relational Intervention (TBRI) can help children with trauma-related issues. Many behavioral issues in this population may require parenting or provider advice that differs from traditional advice. Advice should focus on ensuring the child is not experiencing further trauma, helping the child feel safe and promoting healthy attachment to their caregivers. More information about TBRI is available at **https://child.tcu.edu**.

Many institutions have adopted a trauma-informed care model to improve their care of patients with ACEs. This may require an overhaul of institutional policy and practice to make sure patients with a history of trauma do not feel threatened, do not experience traumatization, and are supported during recovery. Examples of TIC that were incorporated in a pediatric office can be found at: **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6907915/** and **https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf**.

Conclusion

Caring for a child immigrant in the medical home can be challenging as this can require extra time and medical resources. However, the benefits of providing culturally sensitive care for this population can be very rewarding. Trauma-based care studies show the more we can help this population experience a healthy and safe childhood, and correct neural pathways that have been damaged by trauma while their brain is young and plastic, the more dramatic improvement we can have on their medical, behavioral, and mental health for the rest of their lives.

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