National Association *of* Pediatric Nurse Practitioners℠ | Global Health Care SIG

Care of the Newly-Arrived Refugee Child

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The United Nations High Commissioner for Refugees (UNHCR) defines a Refugee as "someone who has fled their country and is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a social group, or political opinion".[1] It is estimated that thirty-thousand refugees entered the United States (US) in 2019.[2] Almost 50% of the world's 30,000 refugees are children under 18 years of age.

It is a stressful and lengthy effort to obtain refugee status. If approved for resettlement, the USCIS assigns the refugee to a US resettlement agency, which will then coordinate a medical exam, cultural orientation, housing, financial assistance, employment support, and school enrollment.[1,3]

HEALTH CARE

Initial visit within 30 – 90 days of arrival in US[4]
Introduction to US health system and establishment of medical home.

LAB VISIT Screenings (ideally 2 days before comprehensive visit)

- Infectious diseases:
  - Tuberculosis (Quantiferon Gold > 2 years old, TST if 6-24 months) with reading in 48 hours. No U.S. testing if clear documentation of TB status from overseas..
  - HIV, syphilis
  - CBC with differential
  - STIs (age dependent)
- Non-infections conditions
  - Vitamin D, other micronutrient deficiencies
  - CBC with differential (anemias, blood disorders, parasite risk)
  - Parasites
  - Urinalysis
  - Malaria (if indicated by location)
  - Pregnancy (age dependent)
  - Newborn screening (age dependent)
- Sensory screening: Vision and Hearing

LEAD SCREENING[5]

- Potential exposures: environmental, household, personal
- Venous sample: All children ≤ 16 years old: > 16 if suggestive history
- Review preventive measures
  - Handwashing
  - Wet mop/towel cleaning
  - Running AM water for 5 minutes before use
  - Repairing peeling paint

INITIAL COMPREHENSIVE VISIT WITH PEDIATRIC PRIMARY CARE PROVIDER

- Plot on growth chart (exact dates of birth may not be accurate, monitor growth from initial plotting or if other concerns consider obtaining bone age).[6]
  - Note: wasting, stunting, underweight, and BMI > 2 yr.
- Obtain histories
  - Refugee history – trauma, violence, imprisonment, trafficking, journey
  - Social history: family members, education, employment, consanguinity
  - Medical history of children
    - Birth, hospitalizations, chronic conditions, blood transfusions, etc.
  - Medical history of parents (especially NCD)
  - Mental health history of parents and children
  - Use of traditional medications or products
- ROS for each child: Exposures, symptoms, during travel or from home country.
- Comprehensive physical exam
- Review of previous screenings with interventions as needed.
  - Iron deficiency and other micro deficiencies

- Parasites – if not treated pre-departure, give one dose of albendazole (200mg 12-24 months; 400 mg> 2 years) check for contraindications[7]
- Positive tuberculosis screening with pediatric management plan
  - LTBI – CXR, INH for 9 months or Rifampin for 4 months
  - Active TB – refer to ID specialists for management
- Establish pharmacy and instruct in concept of "refills"

IMMUNIZATIONS[8]

- Many now given at Vaccination Program for US-bound Refugees
- Written records of other immunizations given in local community pre-departure
  - May be used if consistent with age and similar schedule as US ACIP guidelines.
- Titers for some conditions (Hep A, Hep B, varicella) may be obtained at screening.
- Begin to update immunizations if no documentation or evidence of immunity using CDC catch-up series at this visit.
- Brief nursing visits in one month for further catch up immunizations.

NUTRITION AND GROWTH[6]

- Take complete diet history and assess for deficiencies
- Treat identified deficiencies (iron, vit d, iodine, etc.)
- Direct to local markets for specialty foods, halal, kosher, etc.
- Connect with community resources; enroll in WIC if eligible
- Reinforce continuation of traditional healthy foods and discourage use of less healthy US snacks.
- Monitor growth carefully at each follow up visit
- Refer to dentist

MENTAL HEALTH NEEDS[9]

- May not be obvious or identifiable at first visit
- Will differ based on experience in country and refugee experience
  - Exposure to violence and trauma
  - Separation from extended family, culture, and language
  - Stress of adaptation and social isolation
  - Anxiety, depression
- US screening tools likely do not reflect culture of refugee children.
- Monitor adjustment to home, school, neighborhood by asking open-ended questions to child and parent.
  - Sleep
  - Nightmares
  - Irritability
  - Energy level
  - Behavior changes
  - Appetite changes
  - Somatic complaints
  - Refer to mental health providers as needed and assure good interpreter services available.

REFERRALS

Specialists if indicated by initial screenings, history, and physical examination

FOLLOW UP VISIT

3 months after arrival

- Questions, concerns, adjustment of family members
- Housing – safety, cleaning for lead exposure, rodents, insects
- Growth and nutrition[6]
  - Plot growth carefully
  - Check on access to healthy and traditional foods, WIC, SNAP
  - Review diet
- Dental – review daily hygiene check if appointments scheduled
- Immunization catch up schedule[7]
- Mental health: Review past concerns, current issues, treatment if receiving[9]
- School adjustment: Parental contact with school with interpreter as guaranteed by law
  - Friends
  - Bullying
  - Learning progress
  - Language support
- Development – best to evaluate at first follow up visit, not initial visit
  - Cultures may have different understanding of "development"
  - Concerns? Be specific – is your child talking, moving, playing like siblings did?
  - Detailed history, current skills across domains
  - Parental Evaluation of Developmental Status (Glascoe,[9]) organizes questions
- Employment for parents
- Language learning for parents: Check with settlement agency
- Integration into cultural community, if interested and if available
  - Places of worship, grocery stores, connections with other refugee families
- Follow up with repeat blood work: Known health issues or issues identified at initial visit:
  - IDA, high lead, low vit D, GI symptoms etc.
  - Venous lead repeated on all children ≤ 6 years even if original value was normal
- Models of refugee care and follow up
  - Refugee clinic: Seen every three months for first year, then use of AAP WCC schedule. Effort to have same provider.
  - Initially seen in refugee – focused clinical setting, then incorporated into primary care provider panel and followed up for ongoing and identified needs: lead, TB, anemias, chronic and acute conditions, etc.
  - Immediately placed on primary care provider's panel and needs met using CDC guidelines for screening and follow ups.
  - There may be many other models for resettlement into the US health system.

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