Clinics for Migrant and Refugee Children: Psychosocial and Organizational Considerations

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Overview

Clinics serving refugee and migrant children vary in size, structure, and level of financial support. As such, considerations and challenges will differ greatly across the range of clinical models. However, whether you work in a large federally funded clinic in urban America or a small NGO clinic in rural Uganda, similar threads run through many migrant clinics. The importance of trauma-informed care, the critical role of social workers or case managers, and the essential need for local partnerships, for example, are aspects that hold true across locations and organizations.

Trauma-Informed Care

The effect of trauma upon healthcare utilization, for both chronic and acute health needs, has been well demonstrated [1, 2]. It is upon healthcare providers to recognize and minimize these effects where at all possible, from intake staff to lab technicians to security personnel. Providing trauma-informed care may be as simple as offering to leave the door slightly ajar to minimize feelings of captivity or claustrophobia, or remembering to have caregivers nearby at all times, especially when doing physical exams. In addition, it is important to encourage self-care of all clinic staff in order to minimize secondary trauma and prevent compassion fatigue.

While the care of refugee and migrant children must involve addressing mental and behavioral health concerns, these conversations do not necessarily need to be had on the first clinical encounter. Establishing rapport and building trust take time, especially in these children with transitory and often traumatic pasts. Many of these

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children-on-the-move have not had consistent medical homes and familiar healthcare providers in years—if ever—and winning their trust can be a prolonged process, but worthwhile nonetheless. Establishing a safe, dependable medical home can guard against care that is fragmented, duplicative, and often fails at prevention.

Providing trained medical interpreters is another important aspect of trauma-informed care. In addition to ensuring that needs, concerns and responses are effectively communicated, interpreters can serve as cultural brokers, liaising between individuals from potentially very different backgrounds. If possible, it is important to confirm that the family is comfortable proceeding with a particular interpreter, to make sure they will be able to communicate freely.

Small, simple measures can go a long way. For example, learning to say "Hello," "How are you," and "Open your mouth please" in several languages can put an anxious child at ease and help build rapport with caregivers. Also, waiting rooms outfitted with multilingual reading materials and culturally acceptable toys will be much more welcoming to children and families from different backgrounds.

Public Health and Preventive Health Considerations

Requirements for medical and infectious disease screening and immunizations vary depending on clinic location, government resources, trending epidemiology, and a child's immigration status. For example, many refugee children in the US will have received some vaccines through the Vaccination Program for US-bound refugees, which is supported by the CDC and Department of State. Migrant children arriving through less organized immigration routes may present without any documentation of immunization status, nor any health records at all. Refugee and migrant children alike are advised to follow national immunization schedules, such as those outlined by the CDC's Advisory Committee on Immunization Practices, and demonstration of full vaccination status is a requirement for citizenship in many countries such as the US. For most up-to-date information on immunization and infectious disease screening recommendations, refer to resources listed at the end of the chapter including CDC guidelines, the *AAP Redbook*, and relevant policy statements from the American Academy of Pediatrics [3, 4]. With public health and preventive health considerations recommendations and requirements in mind, it is important to note that all immunizations and laboratory testing need not be done during the first clinic visit, which is often already quite frightening and re-traumatizing for a newly arrived child, as long as close follow-up is feasible.

While some clinics will only provide the minimum basic screening services to refugee and migrant populations, others may have sufficient resources to also link patients to ongoing preventive and primary care services. The same general preventive measures that are routinely offered to local children should be offered to refugee or migrant children, such as developmental assessments, nutritional counseling, and anticipatory guidance, on an ongoing basis. When establishing care with a newly arrived refugee or migrant child, it is important to obtain a full medical and surgical history—which may require multiple rounds of questioning in different

ways, over multiple visits. For example, was the child born prematurely? Was he/she seriously ill in the past, or ever require hospitalization or surgery? Was the child ever malnourished? Details of a child's early history, in particular, could explain current cognitive impairments or behavioral problems. Be aware that caregivers may be reticent to share information about serious illnesses in the past (or present), perhaps due to fear of judgment, stigmatization of certain diseases, guilt, or fear of other possible repercussions. It may take several clinic visits to earn sufficient trust to flesh out a child's entire story.

At each visit, special attention should be paid to behavioral issues, such as adjustment and possible bullying at school or around the camp, which may manifest differently over time. In addition, newcomers should be screened for problems, such as iron-deficiency anemia, elevated lead levels, and vitamin D deficiency, which are common among pediatric migrant populations globally and can sometimes manifest as behavior and/or developmental problems such as inattention, learning disabilities, and mood disorders. Please refer to the guidelines listed at the end of the chapter for full screening recommendations.

The concept of regular preventive visits may be new to many families and thus require further and perhaps repeated explanation. Prior to resettlement, many children may not have experienced well visits or any sort of clinical encounter focused on health promotion and disease prevention. Thus, it is important to continually reiterate the importance of preventive visits and health-promoting behaviors, encouraging the development of healthy lifestyles as these children transition to their new home environments.

Ethical and Legal Considerations

Many countries will provide free healthcare for refugees and asylum seekers alike. According to the WHO, all resettled displaced persons should have access to comprehensive healthcare. In the US however one of the many points distinguishing registered refugees from other migrant groups is refugees' access to public benefits such as health insurance. Undocumented children or those without refugee status may be discouraged from seeking medical care due to financial barriers or fear of legal ramifications. Providers must continue to push back against these barriers by advocating for adequate healthcare for all children, regardless of citizenship or immigration status. Local resources such as asylum clinics or pro bono legal services may be available in certain areas and could provide valuable partnerships. In addition, many community health centers offer sliding-scale fees for patients without health insurance and are an important resource for children without coverage or whose coverage has lapsed.

Case Management and Clinic Flow

In addition to legal and financial barriers, refugee and migrant children experience a number of additional social challenges, often complex in nature. Their caregivers may lack transportation or protected time to take them to appointments. They may be allotted housing that is substandard or unsafe. Their caregivers may have different understandings of healthcare systems and different paradigms of health and wellness. Caregivers may carry culturally infused beliefs and stigmas against certain conditions, for example, not fully understanding the concept of a chronic condition or illness that has no cure, such as asthma or diabetes. Or, they may believe other conditions such as seizures are due to spirit possession and can thus only be treated by spiritual healers. These multidimensional barriers can collectively hinder a family's ability and/or willingness to navigate their current healthcare landscape.

A trained, culturally aware case manager or social worker can help overcome many of these barriers. In a new or less-resourced clinic, trained volunteers or community health workers can also serve this function. They can help arrange referral appointments and transportation, liaise with schools, employers, or housing managers, and offer information on clothing or food banks. On the individual level, case managers can be a tremendous help to a family learning to assimilate and navigate a new healthcare system, culture, and community. On the clinic level, case managers can enhance clinic flow by addressing these needs upfront, as well as helping patients find their way to the laboratory, radiology, or pharmacy departments. They can also help explore funding opportunities in order to expand clinic resources. And on the community level, they can help build relationships with local organizations such as refugee resettlement agencies, local youth groups, or church organizations.

Preemptively establishing systems and processes to ease clinic flow is essential to clinic efficiency and to improving the experience of staff and patients alike. Case managers and other ancillary staff who can assist with the nonmedical aspects of healthcare are critical members of the clinic team.

Building Partnerships and Building on Strengths

Meeting the many, complex needs that refugee and migrant children bring to your examining table will require collaboration and loads of creativity. Your clinic might not have mental health resources for non-English speaking children, for example, but the local public school system might have an arts-therapy program that could be beneficial. Local libraries might be willing to donate children's books, and student volunteers could be utilized to discuss the importance of early literacy. Determine the most pressing needs in your particular clinic situation and begin canvassing potential partners and resources. Be as specific as possible in desired interventions and seek to develop targeted programs for specified problems. For example, if worsening obesity is a trend among your Middle Eastern adolescent female patients, look for Arabic-speaking nutrition programs or culturally acceptable sports groups in your area.

The value of local partnership cannot be overstated. Resettlement agencies often can provide extended case management for high-risk families, classes in English or employment, and sometimes can provide volunteers to accompany patients to their appointments. Academic partnerships can be particularly useful, such as universities that have academic interests in migration issues, child health disparities, or refugee studies. Academic institutions can bring student volunteers, opportunities for grant funding and sponsorship, as well as consultation on clinical best practices and quality improvement. For example, Duke University Medical Center supports a community health clinic (Lincoln Community Health Center) in Durham, North Carolina, that cares for most refugees in that area. Duke provides a network of subspecialty providers for referral when needed, at a steeply discounted cost, as well as a cadre of volunteer service-learners that benefit from the local/global clinical experience.

Amid the myriad challenges of running a clinic for refugee and migrant children, the hidden assets are also many. As most of these children have endured various forms of hardship and instability both before and during migration, they are often resilient, adaptable, and quite grateful for reliable medical care. Many cherish the doctor–patient relationship and look forward to provider visits as special social occasions. Many also come from families that uphold strong religious and/or cultural values and a sense of family cohesiveness, all of which can contribute to a strong set of moral values for the child. Finally, staff working in refugee or migrant clinics are often drawn to these positions out of a sense of personal responsibility, compassionate awareness, and sometimes personal experience as refugees or migrants themselves. These are all qualities that can greatly benefit care providers in meeting the unique health needs of refugee and migrant children, who are striving to resettle in their newest home.

Two Vignettes

Below are two vignettes of very different clinics serving refugee and migrant children, authored by editors of this book, each with different challenges at hand, and different resources and creative solutions to address them.

Case Study One: A Child Migrant and Refugee Service in Gateshead, UK

Gateshead, a city in the North East of England, has the second-highest proportion per population of resettled refugees and asylum seekers in the UK. Newly arriving migrants struggle with access to health care for a variety of reasons, including not speaking the language, not knowing the health system, and the system not considering their health needs.

The Gateshead Child Migrant and Refugee Service started in 2018 as a pilot project at Queen Elizabeth Hospital, belonging to and funded by the state-run

National Health Service (NHS) as a "new entry" clinic where children of refugees and asylum seeker families resettled in Gateshead would have a comprehensive health screening, have their health needs identified, and addressed either within the same service or by linking the family to another statutory or voluntary service in the area. Following a series of surveys, focus groups, and workshops with service users as well as providers, the clinic is evolving into a holistic service provider for migrant families, having learned that successful integration is the key to long-term physical and mental health of migrant families. The clinic builds on evidence-based guidance for the assessment of refugees [5, 6].

The purpose of the initial health screening is to identify all health needs and address these at the earliest opportunity. Approximately 45 min are spent with each new refugee child. The main elements of this visit include:

Identifying and Welcoming—The service works closely with the local Council (responsible for housing refugees and asylum seekers), housing companies, family doctors (GPs), and charities to identify and refer families. Families are then contacted by a migrant health nurse specialist and invited to attend a health screening appointment at the hospital. The service has encouraged local GP practices to join an initiative started by the NGO *Doctors of the World*, which promotes registration in primary care. Arriving in the hospital clinic, families are welcomed into a child-friendly waiting area by the specialist nurse, interpreter, and play specialist. The clinical assessment follows evidence-based guidelines for immigrant and refugee health [5].

A Comprehensive Personal and Family History—With the help of an interpreter, the clinic doctor explores any concerns the family has about their child, any current symptoms, details of the family's travel history, past medical history, family history, and health of all family members. Although the clinic cannot treat adults, the doctor gives recommendations to the family doctor to manage any health issues of the parents. Older children and teenagers are given the opportunity to talk to the doctor alone and are offered sexual health support or referral if desired.

Mental Health Assessment—All caregivers are asked a detailed history of mental health symptoms, history, exposures to trauma, concerns about behavior, and developmental milestone screening. This is started at the initial visit and explored further in subsequent visits if necessary. The doctor does ask specifically about exposure to trauma and how this affects the child and uses the Strengths and Difficulties Questionnaire (SDQ, freely available in several languages) to screen for mental health issues and inform decisions about follow-up [7, 8]. On arrival in the UK, families often feel extreme relief of starting a new life in a safe place and mental health symptoms may not be very prominent, though traumatic experiences often resurface after a period of resettlement.

Clinical Examination, Growth and Developmental Assessment—All children have their vital signs taken (heart rate, respiratory rate, oxygen saturation, blood pressure, temperature), a urine sample checked with a point-of-care test, and their weight and height measured (in younger children, and where malnutrition is suspected, mid-upper arm circumference (MUAC) is also obtained). The clinic uses WHO Anthro and Anthro+ to log children's growth parameters. Children then have

a complete systems examination, focusing on common problems of refugee children: malnutrition, micronutrient deficiencies, dental decay, and features of parasitic infections and chronic infections.

Laboratory Tests—The following blood tests are obtained from all children during the initial screening:

- Full blood count.
- Kidney/liver function.
- Bone profile: Phosphate, Calcium, Alkaline phosphate.
- Thyroid function.
- Inflammatory markers (CRP, ESR).
- Micronutrient screen (iron, vitamins A, B12, D and E, folate, zinc).

Further investigations are obtained, depending on individual needs. Infection screens are tailored to exposure risks at the countries of origin, residence, and travel route, and may include a TB screening, hepatitis serologies, HIV testing, malaria testing, and Strongyloides and Schistosoma serologies. While a public health concern for host countries, the clinic found that management of infections is not the main health need of refugee and asylum-seeking families.

Comprehensive Recommendations—Families are provided with basic health recommendations, including information about available services in their native language. Specific written health recommendations are given to the family, the GP, the Council support worker, and any voluntary sector organization involved, keeping in mind patient confidentiality. The clinic uses social prescribing (where a doctor or nurse prescribes a social intervention with a health benefit, e.g., a physical activity program or a social worker visit) extensively to promote health and social integration. Common health problems identified include: malnutrition (stunting with undernutrition and obesity), nutritional deficiencies, mental health concerns, incomplete vaccinations, poor dentition, need for vision and hearing tests, and poor maternal health (e.g., multiple micronutrient deficiencies, especially with breastfeeding and having multiple children, and maternal depression). A major aspect of addressing health needs lies in the degree of social integration achieved by the family and helping overcome barriers inhibiting deeper integration. In addition to individual physical and mental health needs, the need for clinic follow-up is also determined by factors that inhibit integration (e.g., child's lack of access to education, lack of peer relationship experience, parental unemployment, poor housing, lack of language abilities, single parent, previous or current family experience of violence/racism, parental psychiatric diagnosis and/or disability). The clinic works closely with support workers and social workers to address issues of community integration.

Strategic Partnerships and Collaborations—Closely involving statutory services (e.g., primary, secondary, and tertiary healthcare, mental health services, local Council, social services, schools, employment services, public health departments), the voluntary sector (many specifically focused on the needs of refugees and asylum seekers, but also organizations providing general mental health care, children's education, food banks, cultural and religious organizations), and engagement with local

as well as migrant communities and their leaders have been key to the success of this clinic. In the future, the service aims to be a community and primary care service for the entire family.

Case Study Two: A Mobile Clinic for Refugees in Kibungo, Rwanda

The mobile clinic was organized under the auspices of a large NGO to provide health care to refugees who were returning from their refugee camps in Tanzania to Rwanda, their country of origin. The NGO established a program in Kibungo to provide healthcare to returning refugees who were all of the same ethnic group.

The returning refugees traveled in long lines. UN Agencies provided trucks that were intended to provide rides to women and children but most trucks were taken over by young, healthy men. So most women and children walked. Many walked for days to reach their hometowns or villages.

There were three mobile clinic vehicles, two pickup trucks and one Land Rover. Drivers were local men who knew the area. Three NGO expatriate volunteer physicians (two pediatricians and one internist) and three volunteer expatriate nurses rode in the vehicles.

Each evening the NGO replaced supplies in the mobile clinic vehicles. These included standard medications, gloves, syringes, needles and small surgical kits from UN agencies, basic obstetric packs, and small amounts of intravenous fluids. NGO volunteers added water, nutritional biscuits, and germicidal solutions.

The three clinic vehicles left the small town early each morning to drive along the refugee routes, stopping at feeding stations where physicians and nurses would examine refugees who needed medical attention. They were often told about someone who had collapsed along the route and was too ill to travel; the vehicle would then go directly to that person and transport them to a nearby district hospital. Lost children were also picked up along the way and brought to a church where they were photographed for reunification purposes and fed. The children were cared for by nuns at the church while the International Committee of the Red Cross officials took responsibility for family reunification efforts. Children in this church who needed medical attention were seen by health staff from the mobile clinics.

Many children were examined alongside the road in the mobile clinics. A common problem was skin infections of their feet because most children walked barefoot. Other common problems were malaria, upper respiratory illnesses, diarrhea, and dehydration. Periodically, the clinic staff were informed about a mother about to give birth and many small infants were delivered alongside the road. Most likely maternal malnutrition coupled with the stress of long travel was triggering premature labor.

The mobile clinic vehicles returned to the house rented by the NGO each evening at sunset. During the several weeks that the mobile clinics were active in this area, there was substantial illness among the NGO volunteers including cerebral malaria, diarrhea, and food poisoning. Occasionally, these illnesses reduced the number of mobile clinics that could be staffed.

The local medical staff working in the district hospital represented a different ethnic group than the refugees and would often display outright discrimination against ill refugees. Expatriate health staff were sometimes frustrated by this clear discrimination; however, they had no authority in these local decisions. And thus the mobile clinic volunteers continued to care for Rwandan refugees in this difficult landscape, to the best of their ability.

Additional Resources

AAP Immigrant Child Health Toolkit: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Immigrant-Child-Health-Toolkit/Pages/Immigrant-Child-Health-Toolkit.aspx

CDC Refugee Health guidelines: https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/checklist.html

AAP Red Book online: https://redbook.solutions.aap.org/redbook.aspx

MSF refugee health guidelines: http://refbooks.msf.org/msf_docs/en/refugee_health/rh.pdf

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food-insecure hospitalized children, which she later established as a 501c3, Growing Health, Inc. She then returned to the US to earn her masters in Global Bioethics and Science Policy from Duke University, followed by a fellowship in refugee child health also from Duke. Dr. Esmaili now works for Lincoln Community Health Center in Durham, NC, which serves primarily low-income, immigrant, and refugee children in the local community, where she also leads a grant-funded outreach program for refugee and immigrant families post-COVID. She has volunteered with humanitarian organizations in Greece, India, Nepal, Rwanda, and along the Thai-Burma border.