



Providing Care for Children in Immigrant Families

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Children in immigrant families (CIF), who represent 1 in 4 children in the United States, represent a growing and ever more diverse US demographic that pediatric medical providers nationwide will increasingly encounter in clinical care. Immigrant children are those born outside the United States to non-US citizen parents, and CIF are defined as those who are either foreign born or have at least 1 parent who is foreign born. Some families immigrate for economic or educational reasons, and others come fleeing persecution and seeking safe haven. Some US-born children with a foreign-born parent may share vulnerabilities with children who themselves are foreign born, particularly regarding access to care and other social determinants of health. Therefore, the larger umbrella term of CIF is used in this statement. CIF, like all children, have diverse experiences that interact with their biopsychosocial development. CIF may face inequities that can threaten their health and well-being, and CIF also offer strengths and embody resilience that can surpass challenges experienced before and during integration. This policy statement describes the evolving population of CIF in the United States, briefly introduces core competencies to enhance care within a framework of cultural humility and safety, and discusses barriers and opportunities at the practice and systems levels. Practice-level recommendations describe how pediatricians can promote health equity for CIF through careful attention to core competencies in clinical care, thoughtful community engagement, and system-level support. Advocacy and policy recommendations offer ways pediatricians can advocate for policies that promote health equity for CIF.

DEMOGRAPHICS

Health care of children in immigrant families (CIF) in the United States has received increasing attention over the past decade, in part because of increasing migration of children caused by conflicts globally, greater diversity among migrant populations, and divisive sociopolitical discussion regarding immigration policy. Definitions regarding immigrant children vary, but for the purposes of this policy statement, immigrant

abstract

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DOI: <https://doi.org/10.1542/peds.2019-2077>

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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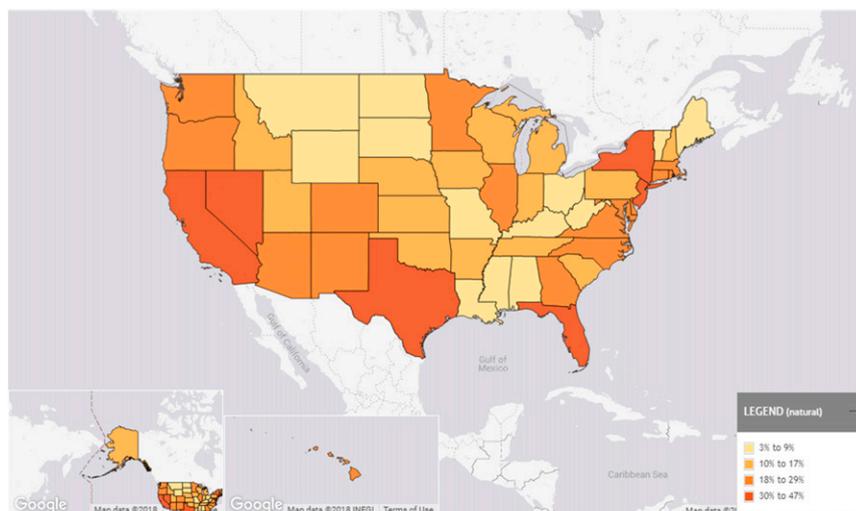
FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

To cite: Linton JM, Green A, AAP COUNCIL ON COMMUNITY PEDIATRICS. Providing Care for Children in Immigrant Families. *Pediatrics*. 2019;144(3):e20192077

children are those born outside the United States to non-US citizen parents. The term CIF includes both those who are foreign born and those who are born in the United States and have at least 1 parent who was foreign born. In 2015, 43 million people, representing 13% of the US population, were immigrants, approaching the historic high of 14.8% in 1890.^{1,2} Currently, 3% of US children are foreign born, and 25% of US children live in immigrant families.^{3,4} It is projected that by 2065, 18% of the US population will be foreign born and an additional 18% will be US-born children of immigrants.² Immigrant children and CIF reside in all 50 states (Figs 1 and 2).

Children immigrate to the United States with or without their parents for diverse and complex reasons, including, but not limited to, economic needs, educational pursuits, international adoption, human trafficking, or escape from threatening conditions in pursuit of safe haven. Immigrants may arrive



Children In Immigrant Families (Percent) - 2016

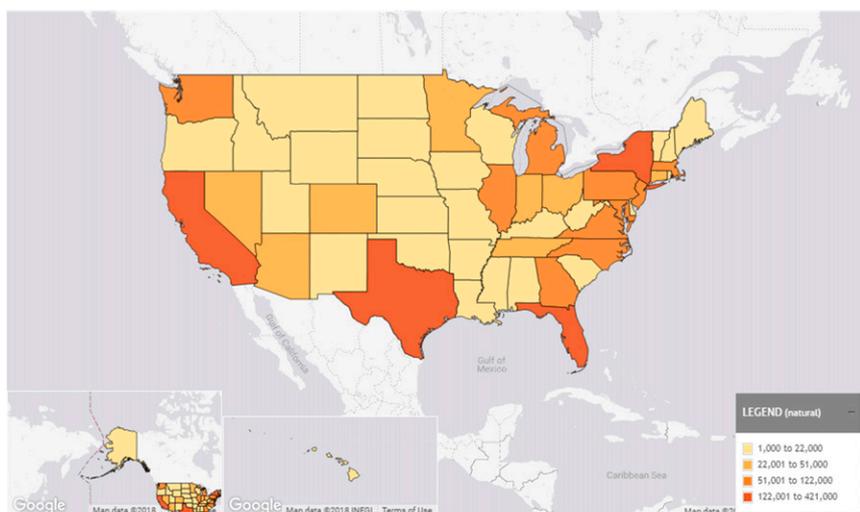
National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
A project of the Annie E. Casey Foundation

FIGURE 2

CIF, 2016. Reprinted with permission from The Annie E. Casey Foundation, KIDS COUNT Data Center, <https://datacenter.kidscount.org>.

with temporary visas (eg, work visa, student visa, tourist visa, J-1 classification), have or obtain permanent permission to remain in the United States (eg, lawful permanent residents [LPRs] or “green

card” holders), come with refugee status, seek legal protection on arrival to the United States, or remain without legal status (Table 1). Refugees, who obtain legal status before arrival, and asylees, who can obtain legal status after arrival in the United States, must have a well-founded fear of persecution based on race, religion, nationality, sexual/gender orientation, political opinion, or membership in a particular social group.⁵ LPRs and refugees can apply for citizenship after 5 years of living in the United States.⁶ In addition to asylum, other forms of protection (eg, special immigrant juvenile status, T nonimmigrant status, and U nonimmigrant status) may also be available to particular children and families seeking safe haven in the United States.⁷ If parents or children do not qualify for a legal form of protection, they may choose to remain in the United States without legal status. Specifically, approximately 11.1 million individuals in the United States lack current legal status,⁸ and 5.1 million US children live with at least 1



Child Population By Nativity: Foreign-Born (Number) - 2017

National KIDS COUNT
KIDS COUNT Data Center, datacenter.kidscount.org
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FIGURE 1

Population of immigrant children in the United States, 2017. Reprinted with permission from The Annie E. Casey Foundation, KIDS COUNT Data Center, <https://datacenter.kidscount.org>.

TABLE 1 Definitions

Term	Description
Children in immigrant families (CIF)	Children who are foreign born and those who are born in the United States and have at least 1 parent who was foreign born
Immigrant children	Children born outside the United States
Lawful permanent residents (LPR)	Immigrants with permission to live and work permanently in the United States
Refugee	Children or adults who fled persecution in their home countries and legally entered the United States after being screened and approved by US agencies abroad
Asylum	Status that can be granted to people already in the United States who have a well-founded fear of persecution by or permitted by their government on the basis of 1 of 5 grounds and who satisfy the requirements for refugee status
T nonimmigrant status (“T visa”)	Victims of severe forms of trafficking who can demonstrate that they would suffer extreme hardship involving unusual or severe harm if removed from the United States
U nonimmigrant status (“U visa”)	Victims of certain serious crimes who have cooperated with law enforcement in the investigation or prosecution of the crime
Special immigrant juvenile status (SIJS)	Noncitizen minors who were abused, neglected, or abandoned by 1 or both parents
Temporary protected status (TPS)	Status granted to individuals physically present in the United States who are from countries designated by the Secretary of the US Department of Homeland Security as unsafe to accept their return
J-1 classification (exchange visitors)	Status granted to those who intend to participate in an approved program for the purposes of teaching, instructing or lecturing, studying, observing, conducting research, consulting, demonstrating special skills, receiving training, or receiving graduate medical education or training
Deferred Action for Childhood Arrivals (DACA)	Temporary relief from deportation with strict criteria based on age of arrival to United States, whether the individual is in school or working, and whether the individual has no criminal offenses or threats
Deferred Action for Parents of Americans and Lawful Permanent Residents	Temporary relief from deportation for parents of children who are US citizens or have LPR that was never implemented

immigrant parent without legal status.⁹

In 2016, half of the 22.5 million refugees worldwide were 18 years or younger, and less than 1% are resettled annually.¹⁰ Ongoing humanitarian needs are acutely exacerbated by global migration crises, exemplified by the displacement of nearly 12 million Syrians by the end of 2015.¹⁰ The number of refugees entering the United States is set annually by Congress and the president and historically has fluctuated on the basis of sociopolitical events. All 50 states, with the exception of Wyoming, have refugee resettlement programs.¹¹

Migration to the United States varies on the basis of global poverty, armed conflict, and exceedingly complex sociopolitical circumstances. Despite these complexities, the United Nations Convention on the Rights of the Child, endorsed by the American Academy of Pediatrics (AAP) but not ratified by the US government, is an

internationally recognized legal framework for the protection of children’s basic rights, regardless of the reasons children migrate.^{12,13} The AAP policy statement “The Effects of Armed Conflict on Children” delineates the impact of armed conflict on children and the role of child health professionals in a global response.¹⁴

Responses to migration, and especially migration of children, are equally varied and complicated.¹⁵ For instance, increasing arrivals of unaccompanied children and family units from Guatemala, Honduras, El Salvador, and Mexico at the southern US border beginning in 2014 triggered a series of governmental responses, including escalating detention of immigrant children, described in detail in the AAP policy statement “Detention of Immigrant Children.”^{7,16} Additionally, the Deferred Action for Childhood Arrivals (DACA) program was developed to allow young adults who had arrived in the United States as

children without legal status but had grown up in the United States to apply for deportation relief and work permits.¹⁵ A related program, Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA), would have offered similar protections for parents without legal status who have US-born children, but it was halted in federal courts and was subsequently rescinded by presidential executive order before it could be implemented.^{15,17} In 2017, the president signed new executive orders focused on heightened immigration enforcement, increased border security, and limits to the US refugee program. Furthermore, changes to temporary protected status (TPS), granted to individuals physically present in the United States who are from countries designated by the secretary of the US Department of Homeland Security as unsafe to accept their return, have created uncertainty for the nearly 320 000 TPS beneficiaries and their families.¹⁸

In addition to changes in the numbers and demographics of immigrants and the legal protections afforded them, family immigration status represents an important and often-neglected social determinant of health. The immigration status of children and their parents relates directly to their subsequent access to and use of health care, perceived health status, and health outcomes.^{7,19-26} Family immigration status is intertwined with other social determinants of health, including poverty,²⁷ food insecurity,^{28,29} housing instability,^{30,31} discrimination,^{32,33} and health literacy.³⁴⁻³⁷

RESILIENCE AND INTEGRATION

Despite the challenges that immigrant children and families often face, many offer tremendous assets and demonstrate remarkable resilience. On first arrival in the United States, immigrant children may be healthier than native-born peers, a phenomenon often described as “the immigrant paradox” or “the healthy immigrant effect.”^{27,33} A strengths-based approach to immigrant child health celebrates assets of immigrant families and populations, buffers marginalization, and supports integration. Understanding cultural assets, such as ethnic-racial identity and cultural values, may offer opportunities to build resilience among immigrant children.³⁸⁻⁴⁰ Furthermore, recognizing assets facilitates productive dialogue that supports immigrant families not as threats but as valuable resources to our society.⁴⁰

CULTURAL HUMILITY AND SAFETY

When caring for CIF, health care providers must recognize the role culture plays in understanding illness without reflexively assuming that challenges are always attributable to cultural differences.⁴¹⁻⁴⁵ Because culture is dynamic, cultural competency is never fully realized,⁴⁶

but rather serves as a developmental process.⁴⁷ Providers bring personal cultural biases, as well as biases of biomedicine, that can implicitly or explicitly affect the provision of care.^{48,49} Cultural humility is the concept of openness and respect for differences.⁵⁰⁻⁵² Cultural safety reflects the recognition of the power differences and inequities in health and the clinical encounter that result from social, historical, economic, and political circumstances.⁵³⁻⁵⁵ By recognizing ourselves and others as cultural beings, by building trust through respect and awareness of power differentials and cultural beliefs, and by developing and implementing communication skills that facilitate mutual understanding, health care providers work to minimize disparities and promote equity in a health encounter.

Culturally sensitive systems of health care, ones that value cultural humility and safety, emerge when patients and families are engaged with 3 core values: curiosity, empathy, and respect.⁵⁶ Some immigrants bring with them a system of healing that, like biomedicine practiced in the United States, claims to be curative, includes interventions that can be applied by an expert practitioner, and offers a body of theory regarding disease causation, classification, and treatment.⁵⁷ With acculturation, these individuals may or may not modify their healing system to incorporate biomedical concepts. Culturally sensitive care systems have the flexibility to support health literacy, to recognize values of community and family that may supersede individual rights, to engage spirituality and respect traditions, and to include diverse perspectives in implementation and evaluation. The reciprocity of culturally sensitive health care offers us a wider lens that reduces health inequities and strengthens the practice of healing through multicultural medicine and

medical practice that acknowledges nonallopathic traditions.^{58,59}

CARE OF CIF: CORE COMPETENCIES

Immigrant children benefit from increased access and communication offered in a patient- and family-centered medical home with an identified primary care provider in which care “is respectful of and responsive to individual patient preferences, needs, and values.”⁶⁰⁻⁶⁴ The medical home, infused with cultural humility and safety, supports continuous, comprehensive, and compassionate care and increases collaboration with community supports, including schools, places of worship, legal agencies, and extracurricular activities. Interpreters are an essential part of the medical team to support health literacy, improve access, and ensure quality medical care.^{65,66} However, disparities in access to care for CIF, and especially for those with special health care needs, have persisted.^{24,25,67-72} Immigrant families, particularly those with children with special health care needs, often benefit from intensive supports in negotiating a complex medical system, special education system, and network of community resources. Pediatric providers can play a lead role for the medical home team in implementing and educating on core competencies that are meant to build health equity for CIF. Core resources for the provision of care for CIF include, but are not limited to, the AAP Immigrant Child Health Toolkit⁴⁴ and the Centers for Disease Control and Prevention Refugee Health Guidelines.⁷³

Cross-cultural Approach

Rather than learning generalities of a given culture, a practical framework can guide the clinical approach.^{74,75} A classic patient-based model recommends assessing for core cross-cultural issues, exploring the meaning of the illness, determining the social

context, and engaging in negotiation around treatment plans.⁷⁶ Core cross-cultural issues include styles of communication, trust, family dynamics, traditions and spirituality, and sexual and gender considerations.⁷⁵ Kleinman and Benson's⁴⁵ 7 questions for cultural assessment are helpful to explore patient's perspectives; most crucially, this includes what matters most to the patient and family within the context of illness and treatment (Table 2). The efficacy of treatment may need to be understood "within the scope of cultural beliefs and not that of the scientific evidence."^{77,78} Therefore, there may be need for cross-cultural negotiation facilitated through tools like "LEARN" (listen, explain, acknowledge, recommend, negotiate).^{57,79}

Knowledge and skills can be developed regarding cross-cultural patient care, migration health issues, and unique vulnerabilities and strengths of immigrant families. Although all children and families are unique, origin-country profiles may be helpful to provide generalized information about immigrant groups.⁸⁰⁻⁸²

Migration Health Issues

Care of immigrant children requires knowledge of unique health issues in the child's country of origin and country or countries of refuge before arrival as well as an understanding of

the challenges of resettlement and acculturation once within the United States. When taking a medical history, it is therefore necessary to elicit details of migration⁷³ as well as the child's birth; medical, immunization, developmental, social, and family history; and exposure to trauma and violence.^{73,83} Past medical and immunization records may require translation as well as awareness and management of different global immunization schedules.^{84,85} CIF often return to their families' countries of origin to visit relatives, and providers need to be familiar with travel risks, prophylactic medications, and unique vaccine needs.⁸⁶

Communicable Disease

When screening for and treating infectious diseases, a public health approach is advantageous.^{44,87} For refugees, some screenings may have been performed in another country, and presumptive treatments may have been provided through the International Organization for Migration.⁸⁸ Depending on the migration history, immigrant children may need screening on arrival in the United States for infectious diseases (eg, tuberculosis; malaria; Chagas disease; intestinal parasites such as helminths, schistosomiasis, and strongyloides; chronic hepatitis B; HIV; syphilis; and other vertically and horizontally transmitted sexual infections).^{44,87-94} Comprehensive reproductive and mental health services are warranted for immigrant children with a history of sexual activity, trafficking, exploitation, or victimization.

Oral Health

The global burden of oral diseases is high.⁹⁵ Caries risk varies depending on previous country of residence.^{96,97} Differences in oral health may reflect cultural practices and norms related to weaning and brushing, dietary changes, and limited oral health literacy.⁹⁸⁻¹⁰¹ Access to dental

services and education on oral health is essential for immigrant children.¹⁰²

Noncommunicable Disease

The incidence of noncommunicable diseases globally has grown.¹⁰³⁻¹⁰⁵ Rates of asthma, obesity, autism,¹⁰⁶⁻¹¹⁰ depression, anxiety, and posttraumatic stress disorder (PTSD) may be similar or disproportionately increased in immigrant children.^{71,111-114} In addition, newly arrived immigrant children may present with diseases not yet diagnosed or further progressed. Examples include genetic conditions related to consanguinity. Furthermore, newborn screening for hearing loss, hypothyroidism, metabolic diseases, or hemoglobinopathies may not have been performed.^{94,115} Vision problems and elevated blood lead concentrations are also common and must be considered.^{94,116-120}

Nutrition and Growth

During assessment of nutrition and growth on entry into medical care, immigrant children may be recognized as wasted, having underweight, having overweight, or stunted.^{97,121-124} Health care providers will need to be familiar with global diets, dietary restrictions, and vitamin and nutrient sources.¹²⁴⁻¹²⁶ Anemia, thalassemia, glucose-6-phosphate dehydrogenase deficiency, and micronutrient deficiencies (including iron, vitamin D, and vitamin B₁₂) may exist.^{97,127-129} Families can be screened for food insecurity and connected to relevant resources.^{126,130,131}

Developmental and Educational Considerations

Age-appropriate developmental and behavioral screening is possible with the use of validated multilingual screening tools, such as the Ages and Stages Questionnaire¹³² and the Survey of Well-being of Young Children,¹³³ and with historical assessment of milestones.^{134,135} Care must be taken to recognize cultural

TABLE 2 Questions to Elicit the Patient Explanatory Model

Questions
1. What do you call this problem?
2. What do you believe is the cause of this problem?
3. What course do you expect it to take? How serious is it?
4. What do you think this problem does inside your body?
5. How does it affect your body and your mind?
6. What do you most fear about this condition?
7. What do you most fear about the treatment?

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bias and experiential differences in skill development.¹³⁶⁻¹³⁹ Screening needs to be sensitive to cultural differences in parenting^{140,141} and disparities in reading or sharing books with children,¹⁴² but referral should not be delayed if screening results are concerning.¹⁴³ Age-appropriate vision and hearing screening is essential.¹⁴⁴ Providers' encouragement of a language-rich environment in the parent's primary language recognizes the strengths of bilingualism.¹⁴⁵⁻¹⁵⁰

One in 10 students from kindergarten to 12th grade in the United States is an English-language learner.¹⁵¹ Dual-language learners, defined as children younger than 8 years with at least 1 parent who speaks another language in the home other than English, make up one-third of young children in the United States currently. Dual-language learners are less likely to be enrolled in high-quality early child care and preschools compared with peers, potentially limiting kindergarten readiness.^{152,153}

All children are entitled to free public education and specialized educational services regardless of immigration status.¹⁵⁴ Immigrant children may face particular academic challenges.^{155,156} Before arrival to the United States, some children may have had no opportunity for formal schooling or may have faced protracted educational interruptions. Students with interrupted or no schooling may lack strong literacy skills, age-appropriate content knowledge, and socioemotional skills; in addition, they may need to learn the English language.¹⁵⁷ Learning may also be affected by traumatic brain injury, cerebral malaria, malnutrition, personal trauma, in utero exposures (eg, alcohol),⁹⁴ and toxic exposures (eg, lead).¹¹⁶⁻¹²⁰ Testing for developmental and learning challenges in the school setting may result in overrepresentation of students with limited English proficiency (LEP) in

special education.¹⁵⁸⁻¹⁶¹ Through collaboration with parents and schools, pediatricians can facilitate thoughtful consideration of learning difficulties in the setting of LEP. Supplemental anticipatory guidance may include recognition of family strengths and differences in parent-child relationships, child-rearing practices and discipline, dietary preferences, safety risks and use of car restraints and safe sleep practices, and acculturation.¹⁶²⁻¹⁶⁸

Mental Health

Many immigrant children and youth may have had disruptions to the basic experiences that allow for healthy development.¹⁶⁹ Immigrant children and their families may experience trauma before migration, during their journey, on arrival at our borders, and while integrating into American communities¹⁷⁰⁻¹⁷⁶ and, as a result of their increased risk, require "health and related services of a type or amount beyond that required by children generally."¹⁷⁷ Trauma may include personal history of physical or sexual abuse, witnessing interpersonal violence, human trafficking, actual or threatened separation from parents, or exposure to armed conflict.^{173,174,176,178} Traumatized children with traumatized parents (or, in some cases, without their parents) may be at risk for toxic stress or prolonged serious stress in the absence of buffering relationships.¹⁷⁹ In addition to intergenerational transfer of mental health problems, core stressors include trauma, acculturation, isolation, and resettlement.¹⁷² In particular, acculturation includes stressors that families experience as they navigate between the culture of their country of origin and the culture in their new country.¹⁷²

On arrival, many refugee and unaccompanied children have high levels of anxiety, depression, and PTSD.^{174,180-186} Compared with US-

origin youth, refugee youth have higher rates of community violence exposure, dissociative symptoms, traumatic grief, somatization, and phobic disorder.¹⁸⁷ Unaccompanied minors have even higher levels of PTSD compared with accompanied immigrants,¹⁸⁸ which may be further heightened if they are seeking asylum.¹⁸⁹ Immigration-related trauma history may be shared over time as a trusting relationship develops with the physician.¹⁹⁰ Some CIF who were born in the United States may face difficulty with emotional and behavioral problems relating to identity formation.¹⁹¹ Initial and ongoing screening for mental and behavioral health problems with multiple cross-culturally validated tools (eg, the Ages and Stages Questionnaire-Social Emotional, the Survey of Well-being of Young Children, the Strengths and Difficulty Questionnaire, the Refugee Health Screener 15, and the Child Behavior Checklist) facilitates recognition of distress and concerns.^{44,132,133,192-195}

By understanding the interplay of biological, social, environmental, and psychological risk and protective factors, emotional disorders can be modulated on population, community, and individual levels.¹⁹⁶ Protective factors and sources of resilience observed in immigrants include having a positive outlook, having strong coping skills, having positive parental coping strategies, connection to prosocial organizations such as places of worship and athletics, and cultural pride reinforcement.^{32,197-200} Resilience is fostered through strong family relationships and community support.²⁰¹ Bicultural identity, a strong attachment to one's culture of origin in addition to a sense of belonging within the culture of residence, promotes resilience.^{140,202}

Because of the shame and stigma associated with mental health problems, families may be reluctant to seek treatment.²⁰³ Providers can

increase access and minimize stigma by integrating culturally tailored mental health services into the medical home, in the school setting, and through engagement with community mental health resources,^{78,175,204} including home visitation.²⁰⁵ Community-wide strategies that foster belonging, reduce discrimination, and provide social supports can facilitate healing and reduce stigma.

Traditional Health Care and Cultural Practices

Traditional healing and cultural practices, common among some immigrant populations, warrant awareness by health care providers.²⁰⁶ Patients may not disclose use of herbal and traditional treatments unless directly asked.^{42,207} Some immigrant families use traditional forms of protection for vulnerable infants, such as prayer, amulets, kohl, or myrrh. Other immigrant families use traditional practices to treat illness (eg, cupping, coining, and uvulectomy), and stigmata of these traditional treatments may be observed on examination and may be misinterpreted as abuse.^{208,209}

Female genital cutting or mutilation (FGC/M) is still practiced in some communities in Africa, in the Middle East, and in parts of Asia despite increased efforts to educate on risks.^{210,211} Performing FGC/M is against the law in the United States and has been defined as torture by the United Nations, but foreign-born girls may have experienced this before entry into the United States.^{210,212} Resources exist regarding the types of FGC/M, complications that can result, recommended documentation in the medical record, and strategies to sensitively discuss this with families.^{213,214} In 2013, the United States passed the Transport for Female Genital Mutilation Act, which prohibits knowingly transporting

a girl out of the United States for the purpose of “vacation cutting.”²¹⁵ The need to screen for FGC/M further underscores the importance of examining the external genitalia of children at all preventive visits in addition to sensitively counseling families regarding the laws and other concerns regarding FGM/C.

PRACTICE-LEVEL BARRIERS AND POTENTIAL OPPORTUNITIES

Communication challenges between families with LEP and health care providers must be addressed to provide high-quality care. Fifty-four percent of CIF have resident parents who have difficulty speaking English.³ Parental LEP is associated with worse health care access and quality for children.^{216–220} National Standards for Culturally and Linguistically Appropriate Services in Health Care were issued by the US Department of Health and Human Services, in accordance with Title VI of the Civil Rights Act. Culturally and Linguistically Appropriate Services in Health Care Standards describe the federal expectation that health care organizations receiving federal funding must provide meaningful access to verbal and written-language services for patients with LEP.^{221,222} Interpreters are an integral part of the medical home team for CIF and hold the same confidentiality standards as the physician.^{67,68} Most state insurance programs and private insurers do not offer reimbursement for language services. Although teaching health care providers when and how to work with interpreters can improve care, few providers receive such training.^{223,224} For these and other reasons, some providers inappropriately use family members as ad hoc interpreters.²²⁵ However, family members, friends, and especially children are not acceptable substitutes for trained interpreters.^{226,227} Trained medical interpreters, via phone or tablet or in-person, facilitate mutual

understanding and a high quality of communication.^{228,229} Use of trained interpreters maintains confidentiality, reduces errors and cost, and increases the quality of health care delivery.^{227,228,230–232} Interpretation requires that extra time be allotted to health care encounters. Qualified bicultural and bilingual staff can receive medical interpreter training if expected to perform as interpreters, and bilingual providers can ideally demonstrate dual-language proficiency before engaging with families in their preferred language without an interpreter.^{233–235} Access can be further improved by the use of multilingual signage, screening tools, handouts, and other key documents (eg, consent forms and hospital discharge summaries) that are prepared by qualified translators.

Although some immigrant families integrate without hardship, many CIF face inequities resulting from complex determinants, including poverty, immigration status, insurance status, education, and discrimination on the basis of race and/or ethnicity.^{32,33} For some, fear regarding family immigration status threatens children’s health, development, and access to care.^{22,32,236–238} For others, growing up in 2-parent families and having environmental stimulation at home, particularly for those with low socioeconomic status, may be protective.^{33,239} Screening for social determinants of health can trigger referrals to community-based supports.²⁴⁰ The hallmarks of the medical home, comprehensive care and enhanced care coordination, are important supports for immigrant families. Integrated mental health, nutrition, social work, and patient navigation services allow for ease of access and for reduction in stigma and barriers. Community health workers who are members of immigrant communities have been effective in reducing disparity and improving health outcomes.^{241–246}

Interagency partnerships with the local health department, home-visiting programs, community mental health providers, schools, and immigrant service organizations facilitate access to medical homes and cross-sector communication. “Warm hand-offs,” or in-person transfer of care between health care team members with patients and families present, can help to ensure linkage between providers and relevant resources.²⁴⁷

SYSTEMS-LEVEL BARRIERS AND POTENTIAL OPPORTUNITIES

Health literacy challenges experienced by CIF include not only language comprehension but also the myriad of system barriers in the health care network. Limited health literacy can complicate enrollment in public benefits for CIF. Immigrant children are specifically less likely to have a medical home^{67,68} and health insurance, resulting in delayed or foregone care.²⁴⁸ Most immigrant children with legal status are eligible for health coverage. A majority of states have opted to allow lawfully residing immigrant children to receive Medicaid and/or Children’s Health Insurance Program coverage using federal Medicaid and Children’s Health Insurance Program funds without a 5-year waiting period, an option given to states by the Children’s Health Insurance Program Reauthorization Act of 2009; however, 17 states have not taken the Children’s Health Insurance Program Reauthorization Act of 2009 option.^{249–253} Only a minority of states offer health coverage to children regardless of immigration status.^{252,253} Additionally, immigrant children without legal status, including DACA youth, are excluded from eligibility for most federal programs, including health insurance, although some states have included and/or are considering inclusion of DACA youth (or, more broadly, other noncitizen children) as eligible for

programs such as in-state tuition or professional licensing.^{254,255} Opportunities to mitigate these literacy, access, and health insurance enrollment challenges include system-wide use and funding of interpreters and multilingual tools and use of community health workers and patient navigators to reduce barriers through facilitation, education, and advocacy.^{43,58,59,256,257} For CIF without health coverage, federally qualified health centers, public health departments, free clinics, and charity care systems may offer access to consistent care. Home-visiting programs can support immigrant parents and parents with LEP who may be isolated and unable to access public services^{152,258}; attention to cultural safety is particularly critical when engaging in home-based services. Quality after-school programming, with support of school social work, can also facilitate integration and build resilience for CIF.^{259,260}

IMMIGRATION AND RELATED LEGAL ISSUES

Federal immigration policies can adversely affect immigrant health coverage, access, and outcomes. Immigration status of children and/or their parents continues to affect access to services and public benefits, despite some improvement.^{33,261,262} Increased fears about the use of public programs and immigration status has deterred immigrants from accessing programs regardless of eligibility.^{263–265} In addition, immigration enforcement activities that occur at or near sensitive locations, such as hospitals, may prevent families from accessing needed medical care.²⁶⁴ Sensitive locations include medical treatment and health care facilities, places of worship, and schools, and US Immigration and Customs Enforcement actions, including apprehension, interviews, searches, or surveillance, should not occur at

these locations.^{266,267} Fear of immigration enforcement or discrimination may exacerbate transportation barriers and worsen perceived access to care.^{23,237,268–271} Discrimination relating to immigration may intersect with religion (eg, Muslim immigrants) and race in complex ways.^{264,272–274} Discrimination and immigration enforcement policies may also create fear and uncertainty, which threaten the mental health of immigrant children²⁷⁵ and their families.^{19,236,264,276} Families living on the US-Mexico border face particular risk of mistreatment and victimization.²⁷⁷ Policies that offer protection from deportation, such as DACA, may confer large mental health benefits for youth and for the children of parenting youth.^{278,279}

Immigrant children who have been detained and are in immigration proceedings face almost universal traumatic histories and ongoing stress, including actual or threatened separation from their parents at the border.⁷ Immigrant children, including unaccompanied children, are not guaranteed a right to legal counsel, and as such, roughly 50% of children arriving in the United States have no one to represent them in immigration court.²⁸⁰ Lack of guaranteed legal representation for immigrant children and families at risk for deportation is further complicated by funding restrictions; specifically, medical-legal partnerships receiving federal funding that operate under Legal Services Corporation guidelines cannot accept most cases related to immigration.²⁸¹ Many nongovernmental efforts have sought to address lack of legal representation for children, but opportunities remain to better provide immigration-specific legal support for immigrant families,^{282,283} including novel medical-legal partnerships with different funding streams that do not exclude people without legal status

and offer representation in immigration court. In addition, traumatized immigrant children can benefit from system-level supports for integration of mental health and social work supports into schools, the medical home, and protected community settings.²⁸⁴

Evidence-based programs can systematically build resilience among CIF by supporting integration into US culture while preserving home cultural heritage. Although specific evidence regarding CIF is limited, home-visiting programs offer opportunities to celebrate unique strengths and mitigate stress in a natural environment.^{258,285}

Programs that support literacy and encourage play, such as Reach Out and Read, can reinforce parent-child relationships, build parenting skills, support development, and prepare children for academic success.^{150,286,287}

For children experiencing parental reunification after prolonged separation, mental health services and educational support are particularly critical.²³⁸ Given the strong role of communities in many cultures, community-based interventions may be particularly effective for immigrant families.

Opportunities to investigate strategies, mitigate barriers, and optimize health and well-being for CIF include research, medical education, and community engagement, including community-based participatory research and health education. Research used to examine acculturative stress and resilience of immigrant children over time is limited. Among CIF, diversity within and between racial and ethnic groups (eg, Hispanic, Asian, African, and Caribbean) and between CIF of varying socioeconomic statuses is also understudied and underappreciated.²⁸⁸ Medical education has become increasingly responsive to health disparities for immigrants and to the opportunities for experiential broadening of global

health. By implementing core competencies in the care of immigrant populations, trainees can learn to support a culture of health equity for CIF. Pediatricians can support families within and beyond the medical home through efforts supported by cross-sector community collaboration, including fields such as education and law, innovative research, and thoughtful advocacy, to inspire progressive policy.^{171,180,289} Grants that are focused on minority and underserved pediatric populations have the potential to mitigate inequities for immigrant children.¹⁷¹

SUMMARY AND RECOMMENDATIONS

With ever-increasing levels of migration worldwide, the population of CIF residing in the United States grows. The following practice- and policy-level recommendations offer guidance for pediatricians caring for CIF. Although it is aspirational to fully implement all recommendations in all situations, most are achievable by intentionally enacting practice- and systems-based changes over time.

Practice-Level Recommendations

1. All pediatricians are encouraged to recognize their inherent biases and work to improve their skills in cultural humility and effective communication through professional development.
2. CIF benefit from comprehensive, coordinated, continuous, and culturally and linguistically effective care in a quality medical home with an identified primary care provider.
3. Co-located or integrated mental health, social work, patient navigation, and legal services are recommended to improve access and minimize barriers.
4. Trained medical interpreters, via phone or tablet or in-person, are recommended to facilitate mutual understanding and a high quality

of communication. Family members, friends, and especially children are not recommended for interpretation. Materials may be translated into the patient's preferred language by qualified translators whenever possible. Consideration should be given for the extended time needed for interpretation during medical encounters.

5. It is recommended that pediatricians and staff receive training on working effectively with language services and that bilingual providers and staff demonstrate dual-language competency before interacting with patients and families without medical interpreters.
6. Pediatricians and pediatric trainees are encouraged to engage in professional development activities that include specific competencies (including immigrant health; global health, including the global burden of disease; integrative medicine; and travel medicine) and to incorporate these competencies into the evaluation and care of CIF.
7. Pediatricians caring for CIF are urged to apply a trauma-informed lens, with sensitivity to and screening for multigenerational trauma. Mental health professionals adept at treating immigrants can be integrated into the medical home or identified in the community.
8. Screening for social determinants of health, including risks and protective factors, is recommended.
9. Assessment of development, learning, and behavior is warranted for all immigrant children, regardless of age. Pediatricians can support dual language as an asset and as part of cultural pride reinforcement.

Advocacy and Policy Recommendations

1. The AAP endorses the United Nations Convention on the Rights of the Child and the principles included in this document as a legal framework for the protection of children's basic rights.
2. All US federal government, private, and community-based organizations involved with immigrant children should adopt policies that protect and prioritize their health, well-being, and safety and should consider children's best interests in all decisions by government and private actors.
3. Interagency collaboration is recommended between service providers (eg, medical, mental health, public health, legal, education, social work, and ethnic-community based) to enhance care, prevent marginalization of immigrant families, and build resilience among immigrant communities.
4. Health coverage should be provided for all children regardless of immigration status. Neither immigrant children with legal status nor their parents should be subject to a 5-year waiting period for health coverage or other federal benefits.
5. Private and public insurance payers should pay for qualified medical interpretation and translation services. Given the increased cost-effectiveness and quality of care provided with medical interpretation, payers should recognize and reimburse for the increased time needed during a medical encounter when using an interpreter.
6. Both the separation of children from their parents and the detention of children with parents as a tool of law enforcement are inhumane, counterproductive, and threatening to short- and long-term health. Immigration authorities should not separate children from their parents nor place children in detention.
7. Immigration enforcement activities should not occur at or near sensitive locations such as hospitals, health care facilities, schools (including child care and Head Start), places of worship, and other sensitive locations. Pediatricians have the right to report and protest any such enforcement. Medical records should be protected from immigration enforcement actions. Health systems can develop protocols to minimize fear and enhance trust for those seeking health care.
8. Children in immigration proceedings should have access to legal representation at no cost to the child. Medical-legal partnerships that include immigration representation (eg, Terra Firma²⁹⁰) and efforts to increase legal representation (eg, KIND,²⁹¹ the Young Center for Immigrant Children's Rights,²⁹² RAICES²⁹³) should be supported practically and financially at local, state, and federal levels.
9. Immigration policy that prioritizes children and families by ensuring access to health care and educational and economic supports, by keeping families together, and by protecting vulnerable unaccompanied children is of fundamental importance for comprehensive immigration reform. Humanitarian protection (eg, refugee resettlement and protection for victims of trafficking and asylum seekers) supports trauma-informed care of children and is an essential component of immigration policy.
10. All children with LEP merit early, intensive, and longitudinal educational support with culturally responsive teaching. Literacy skills are necessary for health literacy, an essential health need.
11. Enhanced funding is recommended to support research regarding immigrant child health, including, but not limited to, health outcomes; screening tools for development, mental health, and social determinants of health that are culturally and linguistically sensitive; developmental and/or learning difficulties in children whose home language is not English; and reduction of barriers to health access and equity.
12. Medical education can facilitate education of trainees and health care professionals through implementation of core competencies in the care of immigrant populations and through advocacy curricula that incorporate special populations, including CIF.
13. AAP chapters can work with state governments to adopt policies that protect and prioritize immigrant children's health, well-being, and safety.

CONCLUSIONS

CIF represent a growing, diverse demographic in the United States. Pediatricians play an essential role in addressing vulnerabilities, minimizing barriers to care, and supporting optimal short- and long-term health and well-being of CIF within

the medical home and in communities across the nation.

With compassionate, respectful, and progressive policy, CIF can achieve their full potential for health and well-being.

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ACKNOWLEDGMENT

We thank Jennifer Nagda, JD (Young Center for Immigrant Children's Rights).

ABBREVIATIONS

AAP: American Academy of Pediatrics
CIF: children in immigrant families
DACA: Deferred Action for Childhood Arrivals
FGC/M: female genital cutting or mutilation
LEP: limited English proficiency
LPR: lawful permanent resident
PTSD: posttraumatic stress disorder
TPS: temporary protected status

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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Pediatrics 2019;144;

DOI: 10.1542/peds.2019-2077 originally published online August 19, 2019;

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The online version of this article, along with updated information and services, is located on the World Wide Web at:

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