NUOVE INDICAZIONI GLNBM-SIP
PER L'ACCOGLIENZA SANITARIA AL MINORE MIGRANTE

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STANDARD OPERATING PROCEDURE FOR HEALTH ASSISTANCE OF NEWLY ARRIVED MIGRANT MINORS

NATIONAL WORKING GROUP FOR MIGRANT CHILDREN ITALIAN SOCIETY OF PEDIATRICS

Rome - November 30th, 2013

www.glnbi.org

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Introduction

Immigration in Italy has always been heterogeneous and evolving. Over the last two decades, a gradual change has occurred in our country both in terms of the number of immigrants and their native country and of the different types of immigration status in the adult and pediatric population.

Globalization and the increase of armed conflicts have generated an imbalance, particularly in the poorest and disadvantaged areas, determining a new health profile of the Migrant Minor (MM) in Italy, with the need for a consequent new approach to the health-reception of the newly arrived migrants.

The **National Working Group for Migrant Children** of the Italian Society of Pediatrics (GLNBM – SIP) has been working for twenty five years for the right to migrant child's health and healthcare, following the changes that have characterized the migrant pediatric population and its health needs.

Several protocols concerning health-reception have been drafted and redefined from time to time, according to emerging issues. The first GLNBM - SIP Protocol - "*The Health Assistance for Children Adopted Abroad"* - was drafted in 2002, approved by the International Adoptions Committee in the same year and later modified and simplified (Pisa, 2007). This protocol has also been used in recent years for the newly immigrated children coming from risk countries. Lately, GLNBI – SIP Guidelines have been further modified (Rome - November 30th, 2013) in order to take into consideration the following parameters: recent types of immigrant children (e.g. unaccompanied minors, refugee parents' children); children coming from different geopolitic contexts, who experienced different journey situations, if compared to previous migration flows.

This new draft considered both current scientific evidence and the cost-benefit analysis of healthcare within the National Health System.

Besides, even though pediatricians are recognized in their key role of a child's health guardian, the identification of various levels of intervention can enable physicians other than pediatricians to use these guidelines to the best of their knowledge and to adapt them to children based on their origin and family history. Any standardized approach is likely to focus attention on epidemiological and infectious aspects without any positive effects on both the individual needs and health care costs and without any real benefits in terms of public health.

All of the above shall be applied, thereby also increasing public awereness, in order to promote – within a framework where inclusion and fairness prevail - foreign children's access to pediatric health services as well as their National Healthcare System registration.

GLNBM SIP
Executive Board

STANDARD OPERATING PROCEDURE FOR MIGRANT MINORS' HEALTH-RECEPTION

FIRST STEP

1) HISTORY

- Personal and family history

    - Country of origin and transition, living conditions before migration: children living with parents, institutionalized children, children living in refugee camps, urban, suburban or rural areas …
    - Education
    - Religion
    - Eating habits
    - Adopted child history: Pre-Adoptive Foster Care, "special needs" …

- Factors influencing migration routes: length of the journey, accompanied and unaccompanied minors, undocumented children, adopted children …

- Medical history: recent and remote

- Vaccination

2) MEDICAL EXAMINATION

It presupposes:

- informed consent
- the presence of at least one person beside the physician, one of the two being of the same gender as the minor's
- compliance with the minor's culture and religious traditions
- clinical findings according to age and gender

It includes:

- Vital signs: body temperature, pulse rate, breath rate, blood pressure.
- Hydration (dehydration signs and symptoms)
- Weight and height using the WHO Child Growth Standards (www.who.Int/childgrowth/standards/en)
- Hearing, vision, and oral health
- Skin and Skin appendages: scars and lesions allegedly inflicted by torturing, mistreatment, and abuse
- External genitalia development and perineal area (abuse, female genital mutilation …)
- Neurological, psychomotor and cognitive assessment, speech and language assessment
- Dismorphism and musculoskeletal disorders

3) FIRST-LEVEL LABORATORY TESTS:

- Complete Blood Count with Differential
- Serum glucose, calcium and phosphorus, electrolytes (sodium, potassium, chloride, carbon dioxide), blood urea nitrogen (BUN) and creatinine
- Serum iron and ferritin
- Urinalysis
- Thyroid-stimulating hormone
- Hepatitis B serologic testing, (hepatitis B virus HBV-specific antigens and antibodies), anti-HCV and HIV serology with respect to the exposure to seroconversion window periods in infections
- Syphilis serology
- Immunization serology [1] : Antibodies (Ab) to tetanus only measured in children under seven years of age and without a documented and validated card showing the number of vaccination doses

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[1] Regarding vaccination coverage in newly arrived immigrant children there is currently no international agreement as to the strategy to be implemented. The assessment of Ab levels is expensive and does not distinguish between specific immunity acquired naturally by infection and artificially by immunisation, except for serological tests for hepatitis B. In case of uncertain and incomplete immunization status and lack of documentation, new vaccination without further delay is recommended. Children under seven years of age and without a documented and validated card showing the number of vaccination doses shall not receive more than 6 doses of Diphtheria-Tetanus vaccine for the risk of a more extensive local reactions, although rare, to tetanus. In this case it is indicated to perform quantitative assessment of the Ab to tetanus and evaluate the immunization: a Ab titer of ≥ 0.1 IU/ml is considered protective to both tetanus and also diphtheria.

- Stool cultures and ova and parasites examination of up to three different stool specimens collected on three different days at 2- to 3-day intervals
- Intradermal Mantoux test

Attention: The recommended immunization schedule is not homogeneous in all Italian regions, let alone immigrant children's countries of origin. Therefore, immunization status shall comply with the vaccination schedule relevant to the Italian region of residence.

4) INSTRUMENTAL EXAMINATION

- to be performed only if indicated by clinical findings
- Eye examination is recommended for 3-year-old children and in case of history of prematurity and/or perinatal asphyxia

SECOND STEP

1) SECOND-LEVEL LABORATORY TESTS:

- to be performed only if indicated by the above-mentioned clinical and instrumental findings

- Haemoglobin-associated disorders and G6PDH deficit, based on CBC and country of origin
- Anti-Strongyloides, anti-Schistosoma, and anti-Toxocara Ab, based on Eosinophilia (>450cell/mm3)[2] in asymptomatic children also showing a negative parasitological tests.

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[2] Normal values of eosinophils in children correspond to the absolute number of ≤300/mm^3 (2-3% percentage) (PR Dallmann, 1977). Eosinophilia is defined based on the number of eosinophils in the peripheral blood (≥450 cells/mm^3) and can be mild (450-1500 cells/mm^3), moderate (1500-5000 cells/mm^3), or severe (>5000 cell/mm^3) (Cleckley AM, 2010).

- Anti-Filaria Ab, based on Eosinophilia > 20% in asymptomatic children older than two years[3]
- Screening for malaria and coproculture, in case of fever with gastro-intestinal symptoms.
- IGRA (interferon- gamma release assay) using QuantiFeron-TB in case of positive MANTOUX[4]
- Vitamin D, PTH and blood magnesium in case of suspected rickets and vitamin D deficiency.

2) INSTRUMENTAL TESTS:

- Chest x-ray in case of positive MANTOUX

Attention: The use of left hand and wrist x-ray does not allow to establish evidence-based **unaccompanied minors' age.** Minors shall therefore be referred to a public health facility for multidisciplinary assessment by a pediatrician, a psychologist, a social worker, and a cultural mediator.

3) SPECIALIST EXAMINATION (to be performed only if suggested by the above-mentioned clinical and instrumental findings):

- Audiologist in case of developmental and learning disorders
- Pediatric specialist in neuropsychiatry in case of common and complex psychiatric and behavioral conditions
- Pediatric infectious disease specialist

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[3] Symptomatic children are referred to pediatric infectious disease specialists.

[4] Tubercolin skin test interpretation depends on measurement in millimeters of the induration and not of the erythema. A positive induration is ≥5 mm if a recent contact was established with a person with TB disease (in HIV-infected persons or persons who are immunosuppressed for other reasons); ≥10 mm in recent immigrants (< 5 years) from high-prevalence countries; ≥15 mm in any person, including persons with no well known risk factors for TB.

- Dentist
- Pediatric surgeon and plastic, maxillofacial, and oral surgeon, if required
- Orthopedic surgeon
- Endocrinologist
- Dermatologist
- Cardiologist

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LINK

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