



POLICY STATEMENT

Providing Care for Immigrant, Migrant, and Border Children

abstract

FREE

This policy statement, which recognizes the large changes in immigrant status since publication of the 2005 statement “Providing Care for Immigrant, Homeless, and Migrant Children,” focuses on strategies to support the health of immigrant children, infants, adolescents, and young adults. Homeless children will be addressed in a forthcoming separate statement (“Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity”). While recognizing the diversity across and within immigrant, migrant, and border populations, this statement provides a basic framework for serving and advocating for all immigrant children, with a particular focus on low-income and vulnerable populations. Recommendations include actions needed within and outside the health care system, including expansion of access to high-quality medical homes with culturally and linguistically effective care as well as education and literacy programs. The statement recognizes the unique and special role that pediatricians can play in the lives of immigrant children and families. Recommendations for policies that support immigrant child health are included. *Pediatrics* 2013;131:e2028–e2034

INTRODUCTION

Many children in immigrant communities face multiple barriers to accessing comprehensive, affordable, and culturally and linguistically effective health care services. Some of these barriers include poverty, fear and stigma, high mobility, limited English proficiency, little information or misunderstandings about how the US health care system works, and lack of insurance and/or access to care. Many children of immigrant families belong to racial and ethnic minority groups that face health status disparities resulting from complex determinants that are exacerbated by children’s living circumstances. Inadequate availability of basic necessities, such as housing, and lack of information regarding previous medical care are among the persistent challenges faced by these vulnerable families. For some, the fear of violence or harassment because of their immigrant status compounds their already fragile living conditions. For many within this population, care can be episodic, fragmented, and oriented to care of acute conditions.¹ Although many children in these circumstances face similar challenges, there are some differences of experiences among migrant and border immigrant subgroups (see Fig 1).

COUNCIL ON COMMUNITY PEDIATRICS

KEY WORDS

immigrant, migrant, border, underserved communities

ABBREVIATIONS

CHIP—Children’s Health Insurance Program

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2013-1099

doi:10.1542/peds.2013-1099

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

Copyright © 2013 by the American Academy of Pediatrics

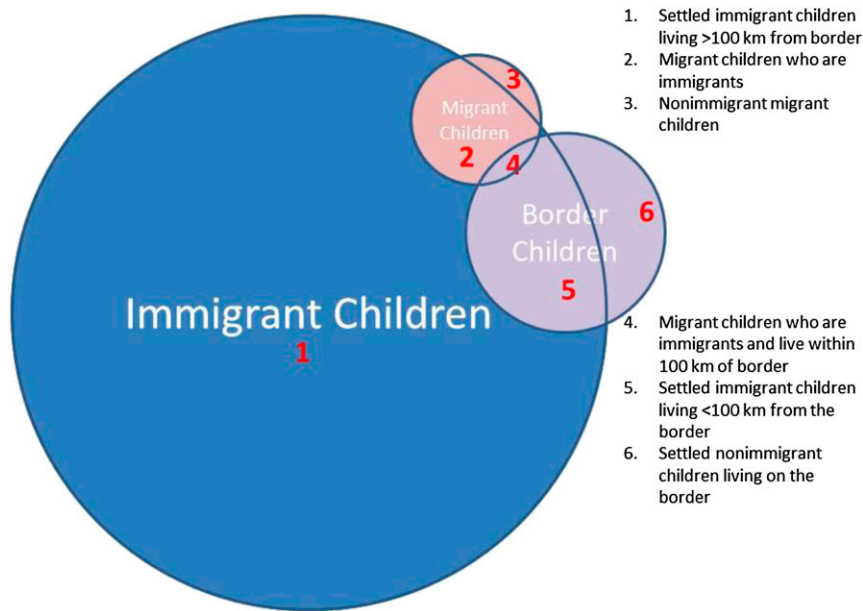


FIGURE 1

Representation of the populations of immigrant, border, and migrant children: separate and overlapping groups.

DEFINITIONS

“Immigrant children” are defined as children who are foreign-born or children born in the United States who live with at least 1 parent who is foreign-born.²

Many immigrant children are in migrant families that move across the country seeking seasonal or temporary employment in a variety of industries. “Migrant children” may work in the industries in which their family members are employed and move frequently because of changes in their parents’ employment. Migrant families are often located in areas that have many agricultural workers and/or where rapid growth is occurring.

“Border children” are those who live within 100 km of the US-Mexico border.³ Immigrant children have a significant presence in the border states of Arizona, California, New Mexico, and Texas. Many border children are of Mexican origin, and a significant number are US citizens whose ancestors have been US citizens for generations. For the purposes of this discussion,

only children living north of the Mexican border are described, although many children south of the border share similar characteristics. Children living along the Canadian border are not discussed in this statement, because there is far less immigration across that border and discrete immigrant communities there have been rare.

DEMOGRAPHICS

Immigrant children represent the fastest growing segment of the US population. One in every 4 children in the United States, approximately 18.4 million children, live in an immigrant family. Eighty-nine percent of these children are born in the United States and are US citizens.⁴ Immigrant children accounted for most of the US child population growth over the past decade. Although 64% of all children of immigrants live in 6 states (California, Texas, New York, Florida, Illinois, and New Jersey), immigrant children are dispersed throughout the country. Since 1990, the largest growth in percentage

of immigrant children has occurred in North Carolina, Nevada, Georgia, and Arkansas.⁵ Families immigrate for a variety of reasons that may include seeking opportunity, fleeing war/chaos, or escaping persecution.

Pediatricians may be surprised by the high degree of diversity of the immigrant population and by the variety of immigrant communities within their midst, such as Haitians in Florida and eastern Virginia or Somali families in Seattle and Minneapolis. Among families are present in the Central Valley of California.⁶ In response to the growth of these immigrant communities, some health care and social/community service providers have begun providing culturally appropriate care and services.

Approximately 43% of immigrant children have parents of Mexican origin, and 20% are of Central American descent. An estimated 22% of immigrant children have parents of Asian or Middle Eastern origin. Fifteen percent of children have parents with origins in Africa, Central and Eastern Europe, Western Europe, Canada, and Australia.⁷ Given this rapid demographic growth, most pediatricians will provide care for immigrant children in their practices.

COMMON CHALLENGES FOR IMMIGRANT, MIGRANT, AND BORDER CHILDREN

All 3 groups of children face a variety of challenges to their health and well-being, including poverty, lack of health insurance, low educational attainment, substandard housing, and language barriers.

Poverty is a strong determinant of child well-being and is very common among immigrant children. Poverty is closely linked to negative physical, developmental, and mental health-related outcomes.⁸ A family’s socioeconomic status has a direct effect on its ability to access high-quality health

care services and to achieve good health, social, and emotional outcomes. In 2010, 30% of children in immigrant families lived below the federal poverty level, compared with 19% of children with US-born parents.⁴ This is despite the fact that immigrant children are more likely to live in 2-parent families and have parents who work and work more hours compared with parents of US-born children.⁹ Immigrant children tend to live in larger families, with 19% having 4 or more siblings, compared with 14% of US-born families.¹⁰ Housing is often substandard and/or overcrowded for these families.

Lack of health care coverage is more common among children in each of these groups than for nonimmigrant children. Children of immigrants are nearly twice as likely to be uninsured (15%) as are children of nonimmigrant families (8%).⁴ Many of the immigrant children who are uninsured are eligible for Medicaid or the Children's Health Insurance Program (CHIP) but are not enrolled. Many immigrant parents fear that accessing services for their eligible children will lead them to be considered a "public charge" (a person dependent on the government for the expenses of living¹¹) and worry about how that may negatively affect their immigration status and prospects. They may also fear that agencies offering assistance will share information with immigration enforcement agencies. Other families may not be aware of their children's eligibility for coverage. These same reasons may affect parents' ability and willingness to access other programs and benefits that their children may be eligible for, such as the Special Supplemental Nutrition Program for Women, Infants, and Children; Supplemental Nutrition Assistance Program; the Temporary Assistance for Needy Families program; and Supplemental Security Income.

Current federal law allows states to apply waiting periods for up to 5 years for legal permanent residents to become eligible for Medicaid coverage. Medicaid also excludes undocumented children from all but emergency health care. Although states may choose to cover children sooner, waiting periods can exacerbate the lack of health insurance coverage for immigrant children. The Affordable Care Act of 2010 (Pub L No. 111-148) also restricts the access to health insurance exchanges of children and adults who are undocumented immigrants.¹²

Language and communication barriers may impede medical care for many children in each of these 3 groups. Although many immigrant children speak English, their parents may not, creating a barrier that can prevent families from accessing health services and/or causing inadequate communication with health care providers. Without access to qualified medical interpreters in health care settings, language barriers can place English-speaking children in the difficult position of interpreting between health care providers and their family members. Use of children and other family members as untrained interpreters should be avoided. These challenges can result in major barriers to accessing health care and decreased satisfaction with services received. Providing care to families with limited English proficiency without appropriate medical interpretation services can ultimately lead to a higher incidence of medical errors when delivering care.¹³

Educational levels and health literacy are often lower among parents of immigrant, border, and migrant families than among native-born US families. Thirty-one percent of immigrant children have a mother without a high school education; the proportion of fathers without a high school education is similar.⁴ It is important to note

that the level of maternal education is an important determinant of child health. Lower education levels are associated with lower health literacy. Low health literacy creates a barrier for patients in understanding medical information and is associated with poor health outcomes.

Health Status and Health Disparities

Although immigrant children may be vulnerable to many risk factors for poorer health outcomes, some groups of immigrant children enjoy a healthier infancy than expected. For example, Latino families have a relatively low incidence of low birth weight, preterm birth, and infant mortality compared with children of US-born parents.⁴ This phenomenon has been called the "healthy immigrant phenomenon."⁹ Immigrant mothers are more likely to breastfeed their infants than mothers born in the United States.¹⁴ Immigrant children also seem to benefit from some additional protective factors, such as growing up in 2-parent or extended families,⁹ as well as close identification with the cultural and spiritual practices of their family and community. In addition, as they grow up, immigrant children may also display relatively better adjustment and behavior in school compared with nonimmigrant peers. This phenomenon has been shown to fade with increased length of stay in the United States and is, therefore, an infrequent protective factor for health outcomes. On the other hand, the health of immigrant children as a group is, in some respects, worse than US-born children. For example, they are less likely to be perceived by their parents to be in excellent/good health and are less likely to have a usual source of medical care and to obtain specialty care when needed.¹⁵ They also have less access to dental care, despite the fact that

they have a higher prevalence of dental caries.¹⁶ The Affordable Care Act excluded undocumented immigrants from health care coverage made available through the Act, leaving that group of adults and children as the largest group who still will not have health insurance after the changes of 2014.¹²

Immigrant children who are foreign-born may not have been screened at birth for congenital syphilis, hemoglobinopathies, hearing deficits, and inborn errors of metabolism. In comparison with US-born children, they also have lower immunization rates, especially for vaccines that are not routinely administered in their countries of origin. Some children may lack immunization records. Foreign-born immigrant children have a higher incidence or prevalence of some infectious diseases, such as tuberculosis, hepatitis A, amebiasis, and parasitosis.¹⁷ Immigrant children with asthma are less likely to be prescribed the recommended preventive medications.¹⁸ Immigrant families may be uniquely vulnerable to mental health problems and experience high levels of stress, depression, grief, and traumatic events compared with nonimmigrant families.¹⁹ Additionally, many experience the stress of family separation, in which some of the siblings or, in some cases, 1 or both of the parents do not reside in this country with them.

Development, Early Education, and School Success

Many immigrant, migrant, and border children also experience educational disparities compared with US-born children. As noted, immigrant children may enjoy a healthy start as infants but may experience developmental stagnation as toddlers compared with non-immigrant children.²⁰

In general, children who grow up in bilingual homes should attain major

language developmental milestones at the normally expected times. At the same time, children raised in homes with impoverished language have a greater chance of being delayed in language acquisition, whether their families are monolingual or bilingual. When language delays are suspected in children growing up in limited English proficiency households, they present complex evaluation and intervention issues. When in doubt about a suspected language delay in a bilingual child, timely referral to a knowledgeable, bilingual speech and language pathologist is ideal.

Many immigrant children have less access to quality early education programs and are less likely to be enrolled in preschool programs, such as Head Start.⁴ Once enrolled in school, cultural and linguistic barriers between parents and schools can lead to decreased family interaction and involvement. As they advance in their schooling, children in immigrant families are less likely to graduate from high school than are their non-immigrant peers.⁴

Fear and Discrimination

Immigrant children and families may face discrimination and be fearful of attitudes and behaviors of the people they interact with outside their communities, including health care providers, which can reduce access to health care and lead to negative child health outcomes. Families may face anti-immigrant sentiment. Fear and discrimination can exacerbate a feeling of isolation and contribute to mental health problems, such as child and family depression, leaving these populations vulnerable.

Family Separation

Immigrant children may have 1 or more undocumented family members. An undocumented immigrant lacks the

proper records and identification to live in the United States.²¹ Immigration enforcement and related policies can lead to the sudden removal of an undocumented parent or other key family member without notice or preparation. Children whose parents are taken into custody and/or deported have been shown to experience mental and emotional health problems, including sleeping and eating disturbances, anxiety, depression, poor school performance, and other types of distress. Forced separations because of immigration enforcement can also result in the loss of family income and have been shown to result in family housing and food instability.²² This can negatively affect a child's safety, health, and development.

FACTORS SPECIFIC TO MIGRANT CHILDREN

A large number of migrant children are also immigrants. For that reason, virtually all of the points made earlier about immigrant children may also apply to those who are migrants. Because of their migration patterns, migrant children are even more likely to lack medical coverage and a medical home than other immigrant children. They are also more likely to be socially, culturally, and linguistically isolated because of their mobile lifestyle.

Many migrant children face a panoply of health problems related to their living and working conditions, including workplace injuries, substandard housing, and unreliable transportation.²³ These factors can contribute to higher rates of respiratory tract and ear infections, bacterial and viral gastroenteritis, tuberculosis, nutritional deficiencies, intestinal parasites, skin infections, dental problems, lead and pesticide exposure, and undiagnosed congenital anomalies.²⁴ Additionally, at times, migrant adolescents travel

on their own from 1 job site to another, putting them at increased risk of many health-related problems.

FACTORS SPECIFIC TO BORDER CHILDREN

Immigrant children living at the US-Mexico border share almost all of the characteristics of other immigrant children but may experience additional challenges. Children who have crossed the border to enter the United States may have experienced trauma in the form of threat of death, abuse, and exploitation that leave serious psychological scars. Once in the United States, these children may experience an enhanced fear of a family member's deportation, imprisonment, or abuse because of documentation status. Children and families who have recently crossed the border can also experience difficulty adapting to the new cultural environment of the United States and experience stress from the absence of an extended family (including a parent or head of household) that is located in another country. Border children may be even more stigmatized or mistreated by the nonimmigrant populations living nearby, as their families are falsely presumed to take advantage of scarce resources and not pay taxes.

Many border communities are poor and lacking in resources, including medical care. In general, border communities lack sufficient numbers of primary care pediatricians, and those present may lack appropriate cultural and linguistic capacity to serve minority border children. In addition, primary care providers bear an especially high proportion of Medicaid, CHIP, and self-pay patients, with few privately insured patients to whom costs may be shifted. As a consequence of these deficiencies and because of high costs of medical care in the United States, families living close

to the border may use medical care and pharmaceutical resources south of the border.

RECOMMENDATIONS

Immigrant children represent a considerable part of the economic and social future of the nation. It is in the national interest that we work to ensure that all children within the United States, including immigrant, border, and migrant children, grow up physically and developmentally healthy. The future prosperity and well-being of the United States depends on the health and vitality of all of its children, without exception. The following recommendations address how pediatricians can help support immigrant child health in practice.

1. Pediatricians and the American Academy of Pediatrics should advocate for health insurance coverage for every child and every individual living in the United States, as lack of coverage for any family member affects the health of the entire family.²⁵ This advocacy should focus on expanding access to quality health care within a medical home. Barriers to enrollment must be addressed, including the removal of any waiting periods for documented immigrant children to enroll into coverage. Efforts must also address barriers to enrollment for children who are potentially eligible for Medicaid and CHIP but not enrolled. Simplified enrollment for both programs and federal or state funding for those who are not currently eligible for Medicaid or CHIP is also essential.
2. The provision of comprehensive, coordinated, culturally and linguistically effective care, and continuous health services provided in a quality medical home should be integral to all efforts on behalf

of immigrant children.²⁶ This is especially critical for children with chronic health care needs and emotional or behavioral health problems. Private and public insurance payers should pay for qualified medical interpretation services.

3. Pediatricians caring for immigrant children should evaluate immunization adequacy and should conduct careful developmental surveillance and screening at regular intervals as recommended by the American Academy of Pediatrics.²⁷ Appropriate referral for early intervention services or psychoeducational evaluation should be initiated as soon as a concern is identified.
4. Pediatricians should recognize the barriers to health that are faced by immigrant children and take these barriers into account while providing care. They should inquire about beliefs and practices related to health, illness, and disability, as well as traditional healing practices and medication use while obtaining a patient's medical history. Knowledge, attitude, and skill development in culturally and linguistically effective practices and cross-cultural communication should be part of every pediatrician's professional agenda.
5. Pediatricians should be knowledgeable about the unique emotional, behavioral, mental, and physical health advantages and problems that may be faced by immigrant children, including those related to family separation. Appropriate screening to identify family, environmental, and social circumstances, as well as biological factors, should be incorporated into routine pediatric assessments, such as in Bright Futures history forms.

6. Pediatricians should have access to information regarding federal, state, and community programs that can serve as resources to at-risk children and families. Culturally relevant programs that address social and economic challenges, such as food and housing security, English literacy, and legal services, are particularly important. Medical-legal partnerships should be supported to help immigrant families with these issues.
 7. Pediatricians should play a key role in helping immigrant parents assess and review the educational progress of the child and encouraging parents to become involved in and interact with teachers and the school community. If a child exhibits difficulty or academic underachievement, pediatricians are in a unique position to advocate for the child and encourage and help parents to obtain appropriate evaluation and intervention from the school system.
 8. Pediatricians should routinely use available screening and diagnostic protocols for evaluating foreign-born children for infectious diseases and other medical conditions when providing care for newly arrived immigrant children.²⁸ Additional screenings, including lead, vision, and hearing screenings, should be considered whether required for school entry or not.
 9. Pediatricians should advocate for an array of culturally effective early intervention services, including the establishment of evidence-based early literacy promotion programs, such as Reach Out and Read, in immigrant, border, and migrant communities. Because reading is such an important skill, these programs are important tools for improving the school readiness of all children, just as fostering health literacy in parents is important to the well-being of their children.
 10. Pediatricians should use their positions of respect in communities to promote the value of diversity and inclusion and to advocate for children and families of all backgrounds.
- Given the challenging circumstances many immigrant children face because of their family's immigration status, the following recommendations address how immigration policies can support child health and well-being.
11. The health, well-being, and safety of children should be prioritized in all immigration proceedings. Whenever possible, the separation of a child from his or her family and home environment should be prevented, and family reunions should be expedited.
 12. In no circumstances should a child have to represent himself or herself in an immigration proceeding.
 13. Health care facilities should be safe settings for immigrant children

and families to access health care. Medical records and health care facilities should not be used in any immigration enforcement action.

LEAD AUTHORS

Lance A. Chilton, MD
Gilbert A. Handal, MD
Gonzalo J. Paz-Soldan, MD

COUNCIL ON COMMUNITY PEDIATRICS EXECUTIVE COMMITTEE, 2011–2012

Deise C. Granado-Villar, MD, MPH, Chairperson
Benjamin A. Gitterman, MD, Vice Chairperson
Jeffrey M. Brown, MD, MPH
Lance A. Chilton, MD
William H. Cotton, MD
Theresa B. Gambon, MD
Peter A. Gorski, MD, MPA
Colleen A. Kraft, MD
Alice A. Kuo, MD, PhD
Gonzalo J. Paz-Soldan, MD
Barbara Zind, MD

CONTRIBUTOR

Ricky Choi, MD, MPH – *Chairperson, Special Interest Group on Immigrant Health*

LIAISONS

Benjamin Hoffman, MD – *Chairperson, Indian Health Special Interest Group*
Melissa A. Briggs, MD – *Section on Medical Students, Residents, and Fellowship Trainees*
Frances J. Dunston, MD, MPH – *Commission to End Health Care Disparities*
Charles R. Feild, MD, MPH – *Chairperson, Prevention and Public Health Special Interest Group*
M. Edward Ivancic, MD – *Chairperson, Rural Health Special Interest Group*
David M. Keller, MD – *Chairperson, Community Pediatrics Education and Training Special Interest Group*

STAFF

Camille Watson, MS

REFERENCES

1. Okie S. Immigrants and health care—the intersection of two broken systems. *N Engl J Med*. 2007;357(6):525–529
2. Child Trends. Immigrant children. Available at: www.childtrendsdatabank.org/?q=node/333. Accessed July 19, 2012
3. United States-Mexico Border Health Commission. What is defined as the border region? Available at: www.borderhealth.org/show_faq.php?id=16. Accessed July 19, 2012
4. Foundation for Child Development. Children in immigrant families: essential to America's future. Available at: <http://fcd-us.org/node/1232>. Accessed July 19, 2012
5. Fortuny K, Ajay C. *Children of Immigrants: Growing National and State Diversity*. Brief 5. Washington, DC: The Urban Institute; 2011
6. Fadiman A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York, NY: Noonday Press; 1998

7. Fortuny K, Hernandez DJ, Ajay C. *Young Children of Immigrants: The Leading Edge of America's Future. Brief 3*. Washington, DC: The Urban Institute; 2010
8. Conroy K, Sandel M, Zuckerman B. Poverty grown up: how childhood socioeconomic status impacts adult health. *J Dev Behav Pediatr*. 2010;31(2):154–160
9. Mendoza FS. Health disparities and children in immigrant families: a research agenda. *Pediatrics*. 2009;124(suppl 3):S187–S195
10. Lansford JE, Deater-Deckard K, Bornstein MH, eds. *Immigrant Families in Contemporary Society*. New York, NY: Guilford Press; 2007
11. US Citizenship and Immigration Services. Public Charge Fact Sheet, April 2011. Available at: www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnnextoid=775d23cbea6bf210VgnVCM10000082ca60aRCRD&vgnnextchannel=8a2f6d26d17df110VgnVCM1000004718190aRCRD. Accessed July 19, 2012
12. National Immigration Law Center. How are immigrants included in health care reform? Washington, DC: National Immigration Law Center; April 2010. Available at: www.nilc.org/contact_us.html. Accessed July 19, 2012
13. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111(1):6–14
14. Singh GK, Kogan MD, Dee DL. Nativity/immigrant status, race/ethnicity, and socioeconomic determinants of breastfeeding initiation and duration in the United States, 2003. *Pediatrics*. 2007;119(1 suppl 1):S38–S46
15. Capps R, Fix M, Ost J, Reardon-Anderson J, Passel JS. *The Health and Well-Being of Young Children of Immigrants*. Washington, DC: The Urban Institute; 2004
16. Liu J, Probst JC, Martin AB, Wang JY, Salinas CF. Disparities in dental insurance coverage and dental care among US children: the National Survey of Children's Health. *Pediatrics*. 2007;119(suppl 1):S12–S21
17. Strine TW, Barker LE, Mokdad AH, Luman ET, Sutter RW, Chu SY. Vaccination coverage of foreign-born children 19 to 35 months of age: findings from the National Immunization Survey, 1999–2000. *Pediatrics*. 2002;110(2 pt 1):e15
18. Tienda M, Haskin R. Immigrant children: introducing the issue. *Immigrant Children*. 2011;21(1):3–18
19. Kupersmidt JB, Martin SL. Mental health problems of children of migrant and seasonal farm workers: a pilot study. *J Am Acad Child Adolesc Psychiatry*. 1997;36(2):1–9
20. Fuller B, Bridges M, Bein E, et al. The health and cognitive growth of Latino toddlers: at risk or immigrant paradox? *Matern Child Health J*. 2009;13(6):755–768
21. Legal Information Institute. Immigration law: an overview. Available at: www.law.cornell.edu/wex/immigration. Accessed July 19, 2012
22. Chaudry A, Capps R, Pedroza JM, Castenada RM, Santos R, Scott MM. *Facing Our Future: Children in the Aftermath of Immigration Enforcement*. Washington, DC: The Urban Institute; 2010
23. McLaurin J, ed; American Academy of Pediatrics. *Guidelines for the Care of Migrant Farmworker's Children*. Elk Grove Village, IL: American Academy of Pediatrics; 2000
24. Migrant Clinician's Network. Children's health. Available at: www.migrantclinician.org/issues/childrens-health.html. Accessed July 19, 2012
25. Ku L, Broaddus M. *Coverage for Parents Helps Children, Too*. Washington, DC: Center on Budget and Policy Priorities; 2006
26. American Academy of Pediatrics Committee on Pediatric Workforce. Culturally effective pediatric care: education and training issues. *Pediatrics*. 1999;103(1):167–170
27. Hagan JF, Jr, Shaw JS, Duncan P, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
28. Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds; American Academy of Pediatrics. *Red Book: 2012 Report of the Committee on Infectious Diseases*. 29th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012

Providing Care for Immigrant, Migrant, and Border Children
COUNCIL ON COMMUNITY PEDIATRICS

Pediatrics 2013;131:e2028

DOI: 10.1542/peds.2013-1099 originally published online May 6, 2013;

Updated Information & Services

including high resolution figures, can be found at:
<http://pediatrics.aappublications.org/content/131/6/e2028>

References

This article cites 11 articles, 6 of which you can access for free at:
<http://pediatrics.aappublications.org/content/131/6/e2028#BIBL>

Subspecialty Collections

This article, along with others on similar topics, appears in the following collection(s):
Current Policy
http://www.aappublications.org/cgi/collection/current_policy
Council on Community Pediatrics
http://www.aappublications.org/cgi/collection/council_on_community_pediatrics
International Child Health
http://www.aappublications.org/cgi/collection/international_child_health_sub
Immigration
http://www.aappublications.org/cgi/collection/immigration_sub

Permissions & Licensing

Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
<http://www.aappublications.org/site/misc/Permissions.xhtml>

Reprints

Information about ordering reprints can be found online:
<http://www.aappublications.org/site/misc/reprints.xhtml>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Providing Care for Immigrant, Migrant, and Border Children
COUNCIL ON COMMUNITY PEDIATRICS

Pediatrics 2013;131:e2028

DOI: 10.1542/peds.2013-1099 originally published online May 6, 2013;

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

<http://pediatrics.aappublications.org/content/131/6/e2028>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2013 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

