Podcast: Collaborating with Pediatricians and Families to Care for Newcomer Children

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Transcript

Introduction

Sarah Clarke: Welcome to the Switchboard podcast. Switchboard is a one-stop resource hub for refugee service providers in the United States, funded by the Office of Refugee Resettlement. Today's podcast is made possible through a partnership between Switchboard and the Society of Refugee Healthcare Providers. The Society of Refugee Healthcare Providers is a nonprofit organization dedicated to improving the health care of refugees and asylum seekers, as well as addressing equity in health care.

Today's Speaker

SC: My name is Sarah Clarke, Executive Director for the Society, and I am your host today. In this four-part podcast series on newcomer health, refugee health experts answer questions submitted by service providers about supporting newcomers' health. In this series, we will cover children's health, complex medical cases, Afghan women, and culturally driven health communications. In today's episode, collaborating with pediatricians and families to care for newcomer children, I'm delighted to have the amazing Dr. Anisa Ibrahim joining us. Dr. Anisa is a pediatrician, medical director, and leader in refugee health. Dr. Anisa, thank you so much for being here. Can you start by introducing yourself and your approach to care?

Anisa Ibrahim: I'm Dr. Anisa Ibrahim, and I am a general pediatrician and the medical director of the Harborview Pediatrics Clinic, which is a clinic within the county hospital here in Seattle, Washington. My specific expertise has been in refugee and immigrant health, and I mostly care for immigrant children with medical complexity. In my clinical practice, I've been very involved in both the society, but also on the American Academy of Pediatrics Council on Immigrant Child and Family Health, trying to promote immigrant and refugee health, not as a specialty, but as something everyone needs to know and do, given our current statistics. I'm also a huge advocate for partnering with service providers, community-based organizations, people really outside of the four walls of the hospital, because that's where we know where health and wellness really lives. I'll start off talking about my general approach to care, with a focus on how I view partnerships outside of clinic with service providers and community-based organizations. I hope to generalize, but there's a special piece in my heart for children with medical complexity, either developmental or medical. So I think there's variability with how clinics approach care, and health care providers are always limited by time and the need to do many things within a small period. First and foremost, the biggest thing when welcoming a new immigrant or refugee into clinics is information.

I spend a majority of that first visit really getting to know the family. It might be jarring to them because they're coming to a medical facility. Maybe I tell them, I'm a pediatrician, I'm going to be your primary care doctor, I need an introduction to who I am and what I'm doing for them. Today, I'm going to ask you a lot of questions, and some of these are not going to be directly medical. They're not going to be directly about your child's medical illness or their general health.

They're going to be a way for me to get to know your family. We really focus on what we call migration history, and that gives us a lot of information looking at what was the journey of this family, because two people can leave from Iraq and go seek refuge in Turkey and come to the United States, and therefore their risk factors, the trauma they face, the help that they might once they're here could be wildly different. It helps us get to know families, linguistic preferences. You might be from Eritrea, but your language of comfort might be Arabic, and you can know that. I use this first visit to ask about literacy. This is the first time I'm getting to know the family. It comes off as a very non-judgmental question when I say I ask all my families, do you read or write in any language?

A person can speak six languages and read or write in none of them, or they can speak two languages and read or write in only one of them. That's really critical information, both for community partners who are going to be giving a lot of information in early-life families, but also clinicians who are going to be speaking to families or pharmacists who are really interacting with families. We also ask about family in the state. We think about family as a very nuclear thing, mom, dad, kids, but many families are grieving the loss of aunts and uncles and people who were considered parents to children. They were separated.

We lose a lot. We're just focusing on the nuclear family. In that first visit, we are trying to get a holistic picture of the child. Many times we are doing a lot of things, including vital signs. We focus in pediatrics a lot about growth and trauma. We're a lot of insecurity, financial insecurity, food insecurity, and their growth and development can be severely affected. So we're doing height, weight, a lot of measurements, hearing vision, and oral health screening.

Then as you can imagine, that's going to be a lot for families. One of the most important things for me as I'm getting a newly arrived, specifically a refugee family, is to be able to get that documentation paperwork of where on a growth chart is a child. One of the most common things that we see as a problem, even in healthy children who are not medically complex, is malnutrition or stunting due to availability of food that might not necessarily be healthy or vitamin and mineral deficiencies. We talk a lot about vaccines in school. I think one of the biggest things that all service providers could really help to partner with pediatricians and families is school. Pediatricians think about school all day, every day. It's where children are going to spend a majority of their time once they still in. The school culture here is very different.

The supports that schools give is very different. So, in rolling in school, having releases of information for any place that a provider might need to access or give information to is really important. Once that child is enrolled in school, we need to have active ways of communication. So that's one of the things that I'm always talking to parents about.

I'm not allowed to talk to anyone about your child unless I have your permission. This is the kind of information that we are seeking to pass along. I think the delays in school is something that I personally had a really hard time with because I know there's temporary housing issues, enrollment issues, and there's so much paperwork that goes to it. But I really do look at schools as a part of a child's job, right? Like that's what they do to grow, learn, and thrive in childhood.

So much of that has been taken away from families in this migration process because there's so many kids who are out of school. There's only so little that a clinician can do in that room to help get that process going.

Q&A

What are some of the main concerns you're seeing with pediatric, refugee, and newcomer patients?

AI: So there are kind of five common things that we see globally in newly arrived children. And then there is one that we see that's variable. It depends on which country people are from. The most common thing that we see is malnutrition. Malnutrition varies from obesity to wasting.

Obesity is a form of malnutrition because it could be access only to foods that are unhealthy. But it could also be, for example, I had a family who, because they were internally displaced in Iraq, did not leave their home for two years. The kids did not leave home. So food would come into the house.

They did not feel safe leaving. So all of the children were obese because they did not have anywhere to go. And whatever food they got, that's whatever they ate. We want patients and families to have a good relationship with food. Food is so important. Food is love. Food is how people are really shared. So the conversation can be very touchy because some kids can come in obese and some kids can come in very wasted.

We want to have some kind of sensitivity around that. And then we know that food access can be variable even once you get to the United States. We have had families say, I don't know where a grocery store is because I haven't had a chance to ask a question or the walk as far as it doesn't feel safe, et cetera. So I'm often trying to partner with service providers or settlement agencies saying this is really important for this family. And this is how we'd like to promote their health and well-being. If they are falling on this, actually, malnutrition consists of the number one concern that children will have once they arrive here. Stunting is a form of malnutrition, but that's a height thing. And that is most often pointing to something like a medical etiology, multiple bouts of diarrhea, kids who have thyroid issues, kids who've had stunted parents.

And therefore that's kind of being carried genetically forward. So within the weight issue, it is very much a medical issue. The second thing we often see is infectious disease. Children might have GI issues. They might have worms, et cetera, not previously treated, which is why presumptive treatment for clinicians is so important. Presumptive treatments for worms, schistosomiasis, and strongyloides, which is routinely happening for refugees from endemic areas, but it is not happening for immigrants reuniting with families or coming through a different process. Tuberculosis and hepatitis are the other infectious disease things that we are really looking for and hoping to partner with our families. Two others that come up often in families are developmental delay and mental health concerns.

So often it is something that I try to not push on a family in that first visit when they're just meeting me, unless it's formation that the family has said. Developmental delay and mental health are both highly stigmatized in many societies and in many different cultures. There are not a lot of options for either treatment or support or there's no framework for the importance of therapies or support. So families are not willing to just let someone know about this particular issue because they want to protect their child, which is very reasonable. Sometimes I will see that a child's right have speech delay.

I will ask a family, are you concerned about your child's well-being or development? And if they say no, that is really not the time the first time you're meeting someone to say, well, I think your child is not speaking because they don't know you. They just met you there in a completely different environment.

They don't know if they trust you. So I will often kind of see that for the next visit as we talk about our approach to care and the framework for Western medicine. We know that mental health, neither mainly PTSD, depression, anxiety, adjustment disorders for immigrant children, that the frequency of how often these children are diagnosed with these issues is related to the degree of adverse events that they've experienced. Parents don't necessarily need to double all of their trauma to you, but I do ask, has your child witnessed any trauma?

I say, please share whatever you feel comfortable sharing because I don't want to re-traumatize you in having to tell me something that you're not ready to share. At what age is speech delay? Developmental is something that needs a framework of discussion for families because most of the world does not follow milestones in the way that we do here in the West. We are very used to thinking about a child should sit at this age, a child should talk at this age, a child should walk at this age, where many of the world's cultures really believe that a child has their own pathway to growth and development, and it will be a long time before they say that kid probably has some kind of delay.

So I don't discuss delays until I've discussed what we consider generally normal. As a pediatrician, even at 12 months, I can start to diagnose speech delay. At this age, your child should be saying this many words. Right now, at 9 months, we expect children to be babbling and imitating if they're not doing that can be considered a form of delay.

They should be responding to their name. And then around 12 months, they should have a couple of words and that increases exponentially. You can diagnose speech delay at a very young age. However, we have to establish normal and normalize looking at milestones and the variability of milestones for a family before we can say your child is delayed. Often, I will have to discussion and say your child is too.

I expect them to be saying many words and using two word sentences. What have you observed? Do you think he's doing the same things as the other two year old in your family? And that's a very good comparison because then they can say, what his cousin is doing this where he is not?

And it doesn't make it as scary because they have something to compare that to. And then I really focus on allowing this child to thrive and communicate because children, they're smart. They have a lot to say. And the worst thing is a child who has something to say and cannot say it. So getting that support for them as early as possible and not making it a very touchy subject.

I think that often it will push too hard, right? Because this is a family that probably did not have access to speech services wherever they came from. They don't have continuous access to it. They don't have a framework for if this therapy is going to be benefiting them. And the way that we describe speech therapy is someone's going to talk to your child and get them to try to talk.

Many families will say, I just got here. I need to find a job. I need to be financially independent.

I need to figure out a way to pay my rent. I don't have time for somebody to talk to my child. I could talk to my child because they don't know the skills of a speech therapist. Often it's really partnering with them and telling them this is what's actually going to happen. This is a framework for what this therapy is for. This is what we are trying to do in the system called what we're trying to achieve. So that's the approach to speech therapy and speech delay. But I think therapy in general, whether it's physical therapy, speech therapy, occupational therapy, all of that is a completely new framework for many people. If you're going to ask them to stop doing what they're doing, they have all of these other pressures, right? What's 90 days of support and then within six months you have to be financially independent. So it's really what you're asking me to do within this framework of me trying to live and survive.

It's new country. At what point do I have to ban which actually stop and say, okay, I can do this. I always tell families, you can tell me no a thousand times. If I think it's important, I will always check in with you. I will say, the child's three now, what do you think about speech therapy? I have families who come in that will be like, we're going to talk about vaccines again, aren't we? And I'm like, absolutely every time. We're going to talk about speech therapy again, absolutely every time. I think it's important. I'm not going to push you.

I will respect your boundaries, but I think we should have an ongoing conversation. And many families at some point do warm up to it because they start to see, okay, I've put out these fires in my life. I have helped in these sections of my life.

Now I'm ready to focus on this. And I think we do them in this service if we stop bringing things up because they sit in the long the past. There was a question about oral health and I think oral health is huge, right? Many families do not have access to oral health. And they often come in with a lot of dental care. When you're doing this checklist of survival, your teeth are one of the last things that you think about, right? Even here in the States, your teeth are often the last thing that you think about. I think there is a lot of partnership and education that even has to come with thinking about milk teeth because often the pushback I get is these are just milk teeth.

They're going to fall out anyway. The importance, I think we don't even do a good job of teaching this in the States and in Canada. Your milk teeth, your primary teeth are also important. They're the placeholders. Their health really affects the health of the other teeth.

And this is why we're trying to do this. I think that dental insurance and availability is really limited. I'm always saying here's a list of specialists that the child needs to see and one of them is a dentist. They need to get an evaluation because we need to make sure that these teeth are healthy. So that the teeth that are coming after them are healthy as well.

Oral health is really involved in the rest of your body's health. Last but not least because of the newest wave of migration, especially with the people coming from Afghanistan. We have seen elevated blood lead levels. Elevated blood lead levels really takes a lot of folks into helping outside of just the pediatrician's office. As a part of the new immigrant screening labs, lead should always be in there, whether they're coming from a high risk country or not. Lead is something that I test for in every child that walks through my clinic. If they're an inappropriate age because it's one of those things where if it's in your blood, I don't want to miss it. Some people will say, well, if this person's high risk, this person's low risk. And my approach is if I have a 12 month old in front of me and I'm getting iron deficiency and UMEA screening labs, I can throw in a lead in there and I can check it off the list because it's something that you absolutely do not want to miss.

I think the concept of lead and what it is where it comes from, et cetera, is something that requires partnership and teaching with families. And we have seen it a lot in our gone patients where sometimes the level will be a little bit high right now. I'll always encourage people to look at the CDC website for what is an elevated blood level. At what point is it reportable? At what point should we be getting follow-up labs and what kind of teaching needs to happen? For families who have elevated blood blood levels, I'm not sure if this is the case for other states or in Canada. It's a reportable condition, so we report it to the state. We also have a public health nursing team that do a home visit because we can ask the family many things. Lead is most often found in spices and food that is imported.

It can be in pottery, glaze, plates, et cetera. But sometimes... Families are not able to recall every single thing they have in their house. They just traveled here. So having that public truck nurse go out, do some teaching around that is really important.

I'm always a proponent for rechecking. I think it's very easy to assume that the blood level was, let's say, five, right? Not very high, but they came from Afghanistan and now they're in America, they're going to be fine. I don't think you can assume that. You don't know what the family has brought with them. You don't know where they're shopping.

You don't know what other exposures they have. The last thing you want to do is assume it's going to just go down on its own because we have seen many people who can have consistently elevated blood levels or some that were actually even going up. For example, in Washington state, a public health found out that there were pressure cookers that many Afghan families were either brought with them or nearby locally were sleeping lead. If we had assumed that the blood level was high because they were in Afghanistan and now they're fine because they're in the United States, we wouldn't have rechecked. The blood levels were not going down.

We kept checking and they were not going down. We found that there was these pressure cookers in the county. Many of these families said, I got that off of Amazon.

I got that from my local Afghan grocery store and that was the actual store. It's something to really keep the key eye on to recheck unless it completely normalizes. No amount of blood is normal in a child's blood, so we're going to keep checking and rechecking and making sure that this child has no ongoing exposures. Even at very low levels, blood can be dangerous for children, right?

Even if it's not at these high toxicity levels that need attention or medical treatment, it can lead to IQ loss, learning difficulties, poor school performance, all things that we don't want for children and families.

Is there anything else that you think medical and service providers caring for newcomer children and their families should be mindful about?

AI: There's so much going on for families once they first arise, regardless of where they're from or their migration path. There is a hope for the future, but also grieving the loss of a life once had. Leaving home is not something that people take lightly and it's not a decision that someone just wakes and makes.

The traumas might be different, but there are shared experiences in grieving a life that you lost. And then when they come here, there's so many expectations of them that I think it is really a time for partnership, understanding, support, and empathy for families. I will say, I feel like the first few visits in the clinic, we see families a little bit after they arise, because I'm seeing medically complex children. I see them four weeks later, because I know they'll be due for vaccines and that's a great time to get the seconds at an end. So much happens in four weeks and it's a good time to check in on adjustments.

How are things going? What did you not think to after that first visit that you're thinking about now? It allows them to see me another time that we can build trust. And then I see them one to two months later, depending on how complex they are or longer if they're not complex. But so much of what I do in those first visits, it's really an introduction to the Western framework of medicine. I'm your primary care provider. I will be partnering with specialists.

I might send you to a different hospital to see a specialist. We are going to be communicating, but it's not going to be me. I'm going to be bringing you in when your child is well.

We are going to be bringing you in for a well visit, which is not a concept that is understood. Here are the things that I'm looking at. Here are the things that I think are important. It's really good for me to see your child when they're well, but also support you when you're sick. We're going to be having shared decision-making, right? Because some families are like, you American doctors are actually crazy.

Why do you keep asking me what I think? I don't know for this. So really a partnership of you're an expert in your child. I might be an expert in pediatrics, but you're an expert in your child.

I'm never going to give you an option when I think there's a clearly better option. It's not a trick game, but it's really thinking about you're an expert in your child. What do you feel most comfortable? And that's where the shared decision-making is. It's not in most families. In other words, if you give me a choice, what if I picked the wrong one? That's not what shared decision-making is about. It's really about sharing our expertise and doing something we know will both feel comfortable moving forward. We also want to keep open communication. The last thing I want to do is tell you, we're a residential agency, here's the plan and no one is comfortable with it because then plans don't move forward, then they won't get done. This care is really about a lot of outreach, right? Families have a lot going on.

Many families are learning a new language. What you do for your typical patient population is not going to be what works for this patient population. But you'll say make an appointment for two months. For us, we just say let's schedule you for your given month appointment. We'll give you a reminder call.

We'll let your case worker know because that is all things that you need in order to support you coming to this visit. Many families might not read or they don't know what this letter is. They don't know what it means when Medicaid sends you paperwork and says come in for your annual visit and they probably have a lot going on. So we do a lot of outreach calls or reminder calls partnering with families and have invested in our systems and our clinics to have patient and family navigators, people that they know our language can grow or if they're not there are people with a lot of cultural humility that can help families navigate these systems. And it's so important when these patient navigators are from the community who can say I've shared this pathway with you so don't shy away from asking me any and every question to help families navigate these systems because we know these systems are hard to navigate. They're not built for patients. They're not built for families. So much of what happens for their health is really outside of the walls of hospital or the clinic.

SC: Thank you so much Dr. Anisa. I want to turn now to some questions we've received from our network of service providers. The first one is—

In some cultures they believe that when their child is big it's considered healthy. When is it appropriate to talk to families about obesity?

AI: That is very common for many places if your child is chubby or you know they have big cheeks and they have really adorable thighs and that means that family has enough food. That family can put food on the table. They're healthy, chump from a wealthier class. And then the other thing that I see happen is that children are malnourished overseas and when they get here and the families have access to food and appearance say by God I will feed this child. I won't give them everything they have so obesity is not necessarily looked at as a negative thing. I really try to focus on health and not numbers or physical appearance so I do an introduction to kind of like the growth chart right. The American growth charts were not based on a diverse subset of people. These percentiles were not created to represent people globally.

They were created to represent the children in America. The way in which I approach that is really slow and steady. I will talk about where the child is. I will talk about how access to food but also access to physical activity has changed significantly. So you know feeding your child is one of the most personal things that a family can do. I partner with them saying I want your child to be healthy. Here's an example of things that would be healthy and well balanced for them. Often that access we have to foods that are least expensive are also not good for your health. As clinician people and service workers we really have to think about what limitations families have right. I can sit in my chair all day and talk about these eat fresh fruits and vegetables but the reality is they might not have access to those foods. They are probably shopping at a grocery store where it's easier to shop in the center aisles with packages and preserved food. That's not fair for us to say you should really be eating fresh fruits and vegetables if we're not giving them any kind of support to be able to do that. And then the other mistake that I think I have seen is that we recommend things that are not culturally appropriate. My grandmother who had diabetes and lived in Somalia in Italy for all of her life they'd come here and she'd say, “oh yeah, they told me to eat broccoli again.”

She's like I'm not doing that. That's not my cultural food. I say yes doctor and I walk out and I do what I want so I often ask what foods do you eat, what foods do you frequent then talk about portions and what could make that food healthy because cultural foods are really important. I think we will lose our audience and our partnership with families if we're recommending foods that are not cultural. I've had many people ask me what is America's obsession with peanut butter.

Like why do we discuss peanut butter? So much more thinking about high calorie food. Your child needs to gain weight like soup, peanut butter but if that's not something that a family eats that's not something that they're going to incorporate in their diet. So it's having that discussion as well and then over time I start to think about activity because we want you to eat healthy food. I move on to age match peers and why I want this child to have a BMI that is lower so that they can be healthier later on in life. And I think this is getting this topic overall just getting to be even more sensitive because we don't want to fat shame. We don't want to have children focused on their bodies because we know that girls as young as six are already getting messaging. You should be saying your body should look this way and boys are starting to do the same thing so we want it overall to be a positive discussion that really focuses on their health and well-being.

A question we hear a lot from service providers is about partnering with families on vaccines and treatment for latent tuberculosis. Can you talk more about that?

AI: I think both vaccines and TB testing are really important and as much support as both health departments and clinics can give to TB especially is key because once you have a positive for latent TB we're talking about many months of daily treatment in there and daily treatment to treat that latent tuberculosis in the clinical part. I think there should be some kind of support around the explanation of why are taking a medication that's not going to make you feel great for many months for an issue you are currently not having a problem with because that is a complexity of latent TB. If that patient is saying I'm well I have no problem I don't have fever but you want me to take a medication that's probably not going to make me feel great.

Well that initial buy-in is really important. Clinics can support looking at whether prescriptions have been picked up or not. Public health departments can check in to make sure that families are taking the TB medications that they're compliant if they have any questions.

So I've really appreciated that partnership. If there's not a care manager or somebody from the clinic to really check in on families it's easy to forget about continuing medication. The other thing that I find really important about medications in general is that the concept of a refill is not really understood by many people and to be honest it kind of is a crazy concept right because I'm saying I need you to be on a medication for four months but when you go to the pharmacy I'm only going to give you one and then you have to go back and pick up the next month. If that is not carefully explained many families will assume that they've received all that you want them to take from the pharmacy at that time. So they'll say yes I've completed treatment but they've only taken one month. We try to explain that in the clinic anytime you're prescribing a medication and hopefully pharmacies are also helping in that regard.

Families will often share with case workers we really need to ask did you go back to the pharmacy pick up your next bottle or explain from the beginning this is how many times you're going to need to pick up the medication for you to be truly done with the treatment. I'm a huge proponent for vaccines and I think of vaccines as anytime you interface with anybody that can give a vaccine it should be offered. So in our clinic whether they come in for a wellness visit or an [inaudible] we are offering vaccines if they're due for them.

I think of it offering vaccines for convenient for families is also really great whether it's a mobile van or vaccines in their school all of those are opportunities to help vaccinate children and not put that extra burden on families if their primary care provider's office is not very close.

You mentioned case workers, so can you explain more about what your structure is—how you partner with and communicate with the resettlement agency nearest you?

AI: Oh yeah so we have several resettlement agencies close to us ours is a bit different because all of the children referred to us—unless their siblings are medically complex children—these children are more on the minds of people given their medical complexity. Families are referred to our clinic through their resettlement agency or their case worker. When we have that initial referral we make sure we get the contact information for the case worker and for the family because so much of what we do is going to require the case worker really helping the family navigate this as much as we're going to be helping the family. Often during that first clinic visit we ask permission from the family can we share information with your case worker so that they're able to help you navigate the system. Families will often say, yes, what we're mostly doing because our children are medically complex is we will have a visit and often that visit will generate many referrals in many things that we need the family to do.

We are communicating with case workers saying here are the referrals that we've done for the family once the appointments are scheduled we will pass that along to both the family and the case workers. We have a transportation company called Hope Link that helps families get to clinic appointments. The case worker will help set up Hope Link to pick up the families for the appointments. We communicate things like medications and what pharmacy is closest to the family so that we're sending a prescription to the right place and then having a case worker do some teaching and support about how to get to a pharmacy, how to get to a grocery store, things like that. And then we communicate with case workers a lot about school because as pediatricians we are trying to get kids in school whether they're medically complex or not as soon as possible. That's where they're going to get the most support. That's where a lot of their learning is going to happen so anything that we can do to help support that is really important to us.

What is the number one thing you think public health people should know about pediatric care for newcomers?

AI: Oh that is a hard one. I think it is getting children into primary care as soon as possible. I think that is the number one thing because children even complex children are going to look healthy. Their health does not work that way and their wellness does not work. Their illness does not work that way either.

So I think common mistake people make is that we think of children as little adults and follow the same processes. If you have a question reach out, get them plugged into primary care and never address the sick child. Never address the sick child period. Your kid can go from being sick to like I see you ready within a couple of hours.

If they're medically complex that gets even worse. So if you have an inkling that this child should be seeing someone or something pops into your head about this needs to be done to get them into care as soon as possible. Getting them into primary care really helps navigate those things that pediatricians or family medicine physicians think about on a regular basis that can help support the health and wellness of the child. I often think getting them into school and getting them into primary care are the top two things that's going to help that child's wellness.

Is there a good way as a program-adjacent nurse to help our refugees that we see through TB—to encourage them to get vaccinated and get their kids vaccinated?

AI: Yeah, I completely understand what you mean. I am always giving a strong recommendation for vaccination for families. Sometimes I've been close to multiple reminders. So we know that in order for kids to get into school, they need these vaccines. I remind families of that I want your child to be vaccinated not only because it's a requirement but because I want your child to be protected against these vaccine-preventable illnesses.

I feel like most families are willing to vaccinate. They don't have hesitancy around it. So ones that do, I think that requires a special conversation and the conversation really has to be curated around what that hesitancy is. So hesitancy in a Syrian family is very different than hesitancy in a Ukrainian family and it's different than hesitancy in a family from a different part of the world.

So what misinformation or hesitancy you're addressing is really important. And just getting them into care, making sure that we are offering vaccines, making them routine and easy for families to access so that they don't have to go very much out of their way to get this and then reminding them that this is really a ticket into school. In Washington state have been the top things that have really worked for me. And I think families are more willing to accept vaccines when they feel comfortable within the place that it's being offered. So again, giving them into primary care, getting them into their PCPs, because they're having so many other conversations that they're probably more likely to feel comfortable and accept the strong advice and recommendations from someone that they've seen multiple times rather than someone that they're only interfacing with one.

The last question we had was about suggestions for supporting parents who seem to not be interested in learning English. In the instance that this service provider is referring to, it's an Afghan father, but they're also wondering in terms of supporting newcomer parents from any community.

AI: Yeah, I think that's tough, but I feel like there is something going on that he's just probably not ready to share, whether it's something that he's struggling with personally. And this is his way of protecting himself and setting up barriers. That's what it feels like to me.

Obviously, I do not know anything about this water. And sometimes it does take giving that all of the branches saying, what are you willing to do? And here are the constraints that we have and here are concerns because these are the parameters that we need to work around. I do wonder if this father would benefit from an Afghan group or being involved with some kind of Afghan community-based organization, whether it is for mental health or general social support. And I wonder if something like that would encourage him to do that because learning English or failing at something could be a very scary environment. So if we get him into some kind of Afghan group or work with a group of Afghan people, you know, pulling that person out of isolation will probably get him to see the benefit of doing certain things.

There is power in numbers and comfort in numbers. Getting him into the job where people might encourage him and say, go to that class or here at other opportunities might get this dad to break out of the shell. When I see things like this, it makes me think about the mental health of the person involved in many communities, including my own.

There is a lot of stoicism about mental health in men. I'm not going to tell you wrong with me. I'm not going to tell you because I have my pride to protect and my family name. But I will show you with my boundaries what I'm willing and not willing to do.

I think continuing to support, even when you don't really see any change or engagement, because you don't know at what point that might change. Even within our clinic, I've had other clinics tell us, well, you guys do a lot of handholding. If it takes handholding for a child to be healthy, I am hand holder chief.

Sometimes some families really need that extra. All right, we're going to go above and beyond for you because there's something preventing you from achieving this thing that's really important for you. And it will be better for everyone if we're able to at least say we did everything we could and put in our all to help address this in the way that feels most comfortable for you.

Conclusion

SC: Thank you so much, Dr. Anisa, for joining us today and sharing your expertise. We really appreciate you and all the great care that you're providing to newcomer families. If you are a resettlement service provider and are looking for more materials on refugee health, you can check out the latest resources available on the Switchboard and Society websites. Don't forget to listen to the other episodes in the Newcomer Health series. Thank you for tuning in.

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