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TRAVEL AND TRANSITION

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TRAVEL AND TRANSITION

INTRODUCTION

The moment the adopted child is placed with his or her new parents is an unforgettable emotional event for families. As in the delivery room, the addition of a child to a family is one of the peak experiences of human life. An international adoption may follow months or years of waiting, often after the painful losses of infertility and the many anxieties and uncertainties related to bureaucratic hurdles. Parents have just arrived in a new and unfamiliar culture, and may be jet-lagged and exhausted. In some cases, parents will have already met their child on a previous trip, as required in some countries. Usually, however, this is the first moment the parent beholds the child. Fantasies, expectations, and dreams suddenly confront the reality of the actual child.

The transition is a critical period in the creation of a new family unit. The experiences of parents and children vary dramatically during this time. The transition may be defined as the interval from meeting the child until settling into a routine at home (often weeks or several months after adoption). The pediatrician will be called upon to provide advice throughout this transition. In this course, several important aspects of the transition will be reviewed, including travel, transition behaviors, sleep, food, toileting, and institutional behaviors, with an emphasis on minimizing stressors for both the child and the parent(s).

PARENT HEALTH

In the excitement of planning an international adoption, many parents neglect their own health. Parents must prepare themselves for international travel well in advance of the trip. Parents with chronic medical conditions should consult their physicians about health precautions during travel. All parents should consult their physicians or travel medicine specialist about needed vaccines early in the adoption process. It is essential that prospective parents receive hepatitis B vaccinations early in the adoption process. Hepatitis A vaccine should also be given, as well as updates of polio, tetanus, measles, varicella, and other vaccines as needed.

Inexperienced travelers need to be educated about basic travel hygiene (food, water, sanitation) and safety. Waterless hand cleansers (gels) are useful items to bring. Many travel clinics dispense prophylactic antibiotics to treat traveler's diarrhea. In some areas, malaria medication is needed. Adequate supplies of all prescription medicines should be taken in carry-on luggage. Parents may wish to consider purchasing emergency evacuation insurance if a prolonged trip is anticipated. (The child is not eligible for such coverage until the adoption and U.S. immigration procedures are finalized). Guidance on health issues for traveling adults in different regions is available at the Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov/), World Health Organization (WHO) (http://www.who.int/), and other websites. Accidents and injuries are the most common cause of serious problems among travelers. Several books also provide useful travel advice. Parents should recognize and try to compensate for the enormous emotional and physical stresses they experience from both the travel and the adoption.

TRAVELING WITH OTHER CHILDREN

Some families wish to travel with their older children to receive their adopted child. Several factors should be carefully considered. In addition to the usual concerns about international travel for young children, this type of trip presents special difficulties. Parents must help the new child adjust to the radical life change and must also complete complex legal procedures. Time for play, relaxation and sightseeing is limited.

Parents are likely to be preoccupied with the details involved in completing the adoption. If there are legal or medical complications, the trip may be traumatic and difficult. Young children may not understand if something goes wrong and the child is unable to travel home with them ("But we can't leave my sister here"). It's often advisable for an additional adult to accompany the family. If someone becomes ill, an extra pair of hands is invaluable.

Children who have themselves been adopted may become anxious that they will be left behind or "replaced" by the new baby if they return to their birth country. Some children become frightened to hear their birth language again after adjusting to the adoptive family. Parents must balance these concerns with the difficulties of leaving young, insecurely attached children behind for several weeks. These concerns should be addressed early in the planning stages of a second adoption.

The health of traveling children should be ascertained carefully prior to departure. Schedules for accelerated immunization schedules are available if needed. Traveling children should be up-to-date for all vaccinations. A pre-travel consult with your child's pediatrician is highly recommended.

Malaria vaccinations should be discussed on an individual basis if traveling to areas where outbreaks occur. Up-to-date recommendations for pediatric malaria immunizations are available on-line. Traveler's diarrhea is more frequent and more severe in young children than in adults. Parents should be prepared to manage traveler's diarrhea in their child with oral rehydration salts if necessary. Children accustomed to friendly neighborhood dogs must be cautioned about animal contacts, as rabies is a risk in some countries. Children should be tested for tuberculosis exposure before and after return from developing countries, especially if travel is prolonged and there is lengthy exposure to local citizens. Updated travel advice for young children is found at the website for the American Academy of Pediatrics (http://www.aap.org/).

TRAVELING TO RECEIVE THE CHILD

Most families travel to receive their child. The duration and timing of these trips vary depending on the legal requirements in the birth country. These requirements are subject to change, sometimes abruptly. The experience for prospective parents depends a great deal on the amount and quality of information available about the child prior to travel. The experience for the child relates to the child's age and preparation for adoption, as well as details of how the transition to the adoptive parents occurs. In most countries, families do not travel until a court date has been designated. The parents may arrive in the country only a day or two before the court date. Within several days, they receive the child and finalize the adoption, negotiating any necessary legal and bureaucratic hurdles.

In some countries, an interval between meeting the child and the formal adoption is legally mandated, or a period of "residence" in the country is required, ranging from 1 to 12 weeks. Most regions in Russia require several trips for adoptive parents. Families receive minimal information about the child prior to the first trip. After meeting the child, they receive more detailed information if they indicate willingness to proceed with the adoption. A court date is set for 2-12 weeks in the future, at which time families return to complete the legal process. In Ukraine, families receive no information about a specific child prior to travel, but are offered a series of dossiers to review at the National Adoption Center until a "satisfactory candidate" is identified. Information about the child is then provided and the parents are taken to meet the child. If the parents accept the child, a court date follows quickly and the adoption is finalized. After a 1-month waiting period, the parents may assume custody of the child. In contrast, most Korean children are often escorted to the United States and first meet their families at the airport. The specific legal requirements of frequent sending countries are available at the website for the United States Department of State, Bureau of Consular Affairs (http://travel.state.gov/).

MANAGING HEALTH PROBLEMS DURING THE ADOPTION

One of the greatest anxieties for traveling parents is the possibility that their new child will become ill. New parents worry especially about fevers, respiratory symptoms, and diarrhea. It is useful for the prospective parents to meet with the pediatrician well in advance of the travel date to review some basic precautions and to discuss management of possible illness. Parents should be knowledgeable in how to take the child's temperature so that this information is available if needed.

Perhaps the most useful information a physician can provide to traveling parents is how to reach the physician at home. Ask your pediatrician for her or his e-mail, fax numbers, and on-call phone numbers. In most cases, however, the orphanage physicians are available to care for the child or to refer the child appropriately for more serious conditions. In capital and large cities, the U.S. embassy or consulate will recommend physicians, hospitals, and laboratories in the case of emergency and provide other assistance for parents or for the child. In addition, the American Academy of Pediatrics Directory lists foreign members by city and country; occasionally these physicians may serve as local resources for traveling parents.

WHAT MEDICAL SUPPLIES TO BRING

Many families worry that needed medications may not be available, or if injections are necessary that sterile needles and syringes may not be used. Several medical kits specifically designed for children are available commercially. These usually include basic medical supplies, such as thermometer, ointments, syringes and explanatory reading materials. Other supplies to consider bringing include:

1. Acetaminophen (Tylenol)
2. Alcohol wipes
3. Antibacterial wipes
4. Antibiotic ointment such as Neosporin
5. Anti-diarrhea medication
6. Antihistamine
7. Antimicrobial hand cleaner (large size)
8. Band-aids in assorted sizes
9. Diaper rash cream
10. Dosage syringe
11. Insect repellent
12. Nail clippers
13. Nasal aspirator
14. Pedialyte
15. Sunscreen
16. Vaseline

In addition, many parents ask the pediatrician to prescribe antibiotics.

It is recommended to put the medical supplies in your carry-on bag. Also, don’t forget to take medical supplies for yourself.

WHAT NON-MEDICAL SUPPLIES TO BRING

1. Ziplock bags in both large and small sizes. These are useful to store wet clothes, snacks, dirty diapers, etc. in case of emergency, especially during the plane ride. For easy packing, take them out of the box and seal them in one bag.
2. Vinyl bibs which easily can be wiped clean. Disposable bibs can be brought instead.
3. If you are taking diapers, line your suitcase with diapers.
4. Different size clothes for your child - 3 sizes but not a lot of each size. You can never be sure what size the child is until you meet her/him.
5. Pack snacks for yourselves such as granola bars, trail mix, power bars, etc.
6. Snacks for your child such as Cheerios, Goldfish crackers, etc.
7. Take an extra suitcase that can fold flat in your suitcase.
8. Camera, camcorder, extra film, tapes and batteries.

ADDITIONAL TRAVEL TIPS

1. Pack clothes for each person into all bags in case one gets lost.
2. Take extra money. Ask your bank if the PIN code is different overseas.
3. Make sure you can dial home. Check the long distance carrier in foreign countries.
4. Have an e-mail address you can check from anywhere. Some hotels have internet access.
5. Take Post-Its to put on paperwork to quickly identify it, especially if the paperwork is in a foreign language.
6. Place copies of your passports into every piece of luggage.
7. Bring extra passport photos in case your passport gets lost or is stolen.
8. Leave someone the keys to your house, especially if you leave on short notice. This person could send or fax papers that may have been left behind, buy stuff that will be needed immediately when you return, etc.

MEETING THE CHILD

Most families carefully evaluate the referral information about their child prior to travel. They have some general idea of the child's health, as well as specific questions for the caregivers. The degree of growth delay may also be anticipated, especially if updated measurements are provided close to the time of travel. If a video has been reviewed, the parents may have some sense of the degree of developmental delay to expect, as well as some preconceptions about the child's personality and behavior ("she's smiley and sociable," or "he's a serious child"). Because the videos are brief snippets of a child's day and may be months out-of-date by the time the family travels, these expectations may be incorrect. Furthermore, the stress of the transition may alter the child's demeanor and behavior. Major questions about the child's health development, and behavior should be addressed prior to travel if possible, as analysis and interpretation of this sensitive and important information is difficult at the last minute.

The quality of the initial encounters of the parents and child depends on various factors. Parents have usually been well prepared by their adoption agencies about what to expect when they travel to receive their child; they must remember that the child often has had no preparation. Although little may be done to prepare young infants, older children have surprising ability to understand some of what happens with an adoption. In orphanages where children are frequently adopted, children may recognize that the appearance of strangers is followed by disappearance of one of their group. This may create a great deal of anxiety. If the transition is gradual, children may see that the child being adopted gets special attention as she comes and goes from the group. When the child returns from outings with her parents, she may have new clothes and toys. Jealousy, anxiety, and fear may create misbehaviors and emotional upset in the entire group of children.

Some children are understandably terrified of the adopting parents. Although the parents have had months to study their child's photograph (and possibly video), the child abruptly experiences a removal from all familiar sights, sounds, smells, tastes, and people. In extreme cases this is emotionally comparable to kidnapping. Many orphanages are sensitive to these issues for the children and are willing to help prepare children for adoption. Parents sometimes prepare a family book with photos of family members, pets, the house, neighborhood, and other appropriate things. If labeled in English and the local language, caregivers may review the photo album with the child in advance of the adoption. Even for infants, a photo of the parents to place by the bedside may ease the transition. Some parents send audio tapes of their voices singing or reading stories (and electronically compatible tape-players). A special toy sent in advance, joined by a matching one at adoption, may help children make the transition to their new family more comfortably.

After receiving the new child, most parents undress the child and anxiously inspect the child's body. Families should be prepared prior to travel for likely physical findings, including a vaccination scar, Mongolian spots, buttock fat atrophy from multiple injections, and dental caries. Any scars or unusual findings should be noted. Some children have scars encircling their wrists or ankles. This can be alarming to parents who assume these result from ties or restraints. Although this is a possible explanation, such marks may also result from elastic bands on clothes that were too small for the child, unfortunately a common occurrence in orphanages. Other unexplained scars are sometimes found.

CHILD BEHAVIOR DURING THE TRANSITION

For first-time parents, a review of expectations for normal behavior, sleeping, eating, and elimination, including the wide range of normal and common alterations seen in children from orphanages, will be reassuring. Behaviors such as hyperactivity, passivity, clinginess, and temper tantrums may be prominent in the first few weeks after adoption but quickly abate afterwards. Children may become distressed when confronted with unfamiliar routines, for example, with food, bathing, and toileting. Whatever techniques parents use are different from what is familiar to the child: from the child's point of view, everything the parents do is "wrong." Parents must understand the immensity of the transition their child is experiencing and be empathetic about the adjustments the child is making to new styles of care and parenting.

SLEEP

Sleep schedules

Many parents are given their child's daily schedule from the orphanage and wonder how strictly to adhere to this after adoption. Most orphanage schedules include lengthy nap times and early bed times. In Romania, one orphanage for healthy 4-7 year old children enforced a 3-hour nap for the children every afternoon. Children may be accustomed to such schedules, but quickly adapt to change. Jet lag may interfere with sleep schedules for a time after arrival home.

Sleep quality

Sleep disturbances are extremely common among international adoptees, especially in the first few months after adoption. Children often display anxiety at bed or nap times. Nightmares, "daymares" (during naps), and night terrors are common among this group of children, but these usually subside over the first few weeks after adoption. Most children have never been alone in a bed and definitely not alone in a room. The American custom of placing children in their own rooms to sleep may be frightening.

Some children (notably those from Korea and Cambodia) have become accustomed to sleeping with caregivers and are inconsolable when expected to sleep alone. Some children awake crying and become alarmed when their parents arrive to comfort them -- some parents have felt the children were expecting someone else (a previous caregiver, for example) -- and are disoriented to find someone else responding to them. For some children, sleep states seem to be associated with grieving for lost caregivers; some children cry sadly and deeply when going to sleep or awakening.

Psychological processing of the immense changes in the child's life may manifest as sleep disturbances, although this is difficult to prove. Parents must recognize that insecurity and anxiety underlie most of these "early-onset" sleep disturbances among internationally adopted children. This is in contrast to manipulative behaviors related to sleep and bedtime that sometimes develop in young children. Management of these sleep problems requires specific attention to the underlying psychological issues. Many parents find that co-sleeping for the first few weeks or months after adoption greatly reduces the child's anxiety. Transition to more conventional sleep arrangements is easily accomplished when bonding to the family is more firmly established. Repeated expressions of love and provision of needed attention and security are key methods to manage sleep problems in newly adopted children.

FOOD

Amount

Unusual behaviors related to food are common among post-institutionalized children. Parents frequently report that their children are ravenous, consuming "unbelievable amounts" of food, and still wanting more. Most children with these behaviors have suffered significant hunger and should be offered food freely. Older children may be more confident about the food supply if given a small box to store a personal supply of food to consume as wished. Other children inspect the refrigerator and cupboards frequently to be sure that food is available; others hoard or hide food or stuff it in their mouths ("chipmunk cheeks"). Parents should offer food freely; usually the voracity diminishes within a few days or weeks when the child becomes confident that the food supply is reliable. Some parents find it useful to calmly offer more food to the child after he is done eating, even if he has eaten an enormous amount of food.

Sensory issues related to food

A surprising number of children have sensory issues related to food. The most common is an inability to tolerate textures. Many children have subsisted on soups, liquids, and purees, and have missed some of the oral-motor milestones related to chewing solids. Nipples used for bottle feeding in many orphanages have large openings, probably to speed feeding. Children fed in this manner develop oral-motor reflexes to prevent choking, but have reduced oral-motor tone. These children may be "open mouthed" in appearance and ma drool excessively. When offered conventional nipples, the children have difficulty producing an adequate suck to withdraw the formula. These children may have considerable difficulty tolerating a spoon because of overactive tongue thrust and may become distressed when presented with foods containing any texture (lumps). Usually these difficulties abate within a few weeks, but some children have exceptional difficulties and may benefit from the assistance of a feeding team. In some children, esophageal reflux contributes to food aversions.

Introducing a new diet

Parents often wonder if the orphanage diet should be maintained during the transition, and especially whether formula must be gradually switched from a local brand to an American brand. Although some children appear sensitive to changes in diet, the vast majority of children do well, and graded switching is not necessary. Concerns about lactose intolerance in Asian infants are misplaced.

Some children display a pronounced unwillingness to try new foods. Whether this relates to taste or texture can be difficult to determine. Orphanage diets tend to be bland and predictable. For children in this category, slow introduction of new foods may be better tolerated than presentation of a wide array of tastes and textures.

Indifference to food

Surprisingly, some children, even if malnourished, are indifferent to food. These children usually have significant failure to thrive, but normal or near-normal cognitive development. These children often seem oblivious of hunger and never request snacks and meals. Their dismayed parents are at a loss to understand why a malnourished child refuses food or is indifferent to food; psychological problems between parent and child often ensue. These children must be carefully evaluated for medical reasons for failure to thrive. Occasionally, supplemental nighttime feeds are needed, and may eventually trigger normal hunger responses. Careful interventions may allow these children to eventually learn to eat properly; many never seem to particularly enjoy eating.

TOILETING

Toilet training expectations and methods differ among cultures and are managed differently in institutional care than in families. Many parents are told in advance that their child is "potty-trained," only to discover to their chagrin (especially if they have come without diaper supplies) that this is not true. Most orphanages regularly schedule "potty-time" after each meal or snack. Infants even as young as 6 months may be placed on a potty - often tied on to the potty seat if too young to maintain balance -- for lengthy periods after eating. This routine minimizes the number of soiled or wet diapers over the course of the day. Adoptive parents inevitably abandon this schedule because of the irregular events during the transition period (court appearances, travel, etc.), with the result that the "potty-training" vanishes. Parents adopting children less than age 3 or even 4 years of age should prepare for diapers, at least until they return home and establish some routine in the course of the day.

Many children are remarkably apprehensive about diaper changes. Prior painful experiences during diaper changes fear of clothing removal, or simply a change in the technique of the diapering could contribute to the child's anxiety. Regardless of the cause, this fear usually abates within a short time.

BATHING

Attempts to bathe the child may be met with crying and distress. In orphanages, bathing may not be a pleasant experience (cold water, rough wash cloths and towels, etc.). Understandably, orphanage workers must bathe many children quickly. Bathing usually does not include pleasant, soothing water play. Children take some time to realize that bath-time means warm water, enjoyable sensations, and a chance for interesting play.

CLOTHES AND TOYS

One of the tangible expressions of the adoptive parents' love for the new child is the desire to provide material items such as clothing and toys. Usually one of the strongest urges of a new parent is to undress and inspect the child, then to bathe her and dress her in all new clothing. Parents should be cautioned to restrain these impulses during the early hours of the transition. Under most circumstances, the child has abruptly lost all that is familiar -- language, culture, people, places, and things. All that remains is her clothes, which smell and feel familiar. These should be removed and replaced only after the child has had a period of time with her new family. Stiff, new clothes may feel uncomfortable and unfamiliar; new clothes are a rarity in the orphanage. Most items should be washed prior to use and tags removed to prevent irritation.

Similarly, encounters with multiple new toys may be unfamiliar and frightening for children who have never had personal possessions. A child living in institutional care may never have had someone show him how to play with (as opposed to fling or bang) toys. Assisting the child's interaction with toys is a valuable activity for parents in the early days of the transition.

INSTITUTIONAL BEHAVIORS

Institutional behaviors often are noted in the early hours and days after adoption. These 'institutional behaviors' include rocking; swaying or 'bobbing"; head banging; head shaking; head bopping; hand staring or flapping; spacing out (dissociating); staring at lights, fans, shadows; biting, hitting, or scratching self or others; smelling objects; hair twirling or ear pulling; teeth grinding; looking at objects very closely.

These behaviors may be upsetting to unprepared parents. Occasionally institutional behaviors are captured on videos supplied to parents prior to adoption; however, this is uncommon. More frequently, these behaviors are observed after the child is placed with the family. These behaviors provide self-comfort, sensory stimulation, or attract adult attention. For children lacking physical comfort, toys, social interactions, and other experiences, these behaviors are adaptive and promote neurologic development in an abnormal environment. Some of these behaviors may be considered survival skills.

Children who have been physically deprived of proprioceptive, visual, and auditory stimulation often develop behaviors that stimulate these senses. The most common is rocking, which can be either on hands and knees, or in a sitting position flexing forward at the waist. Curiously, thumb sucking is rare, probably because it is physically strongly discouraged in most orphanages. Other sensory behaviors commonly seen are altered responses to pain, usually manifest as an extremely high pain threshold, and "daredevil" behaviors, or lack of sense of safety.

Some of these behaviors can be so pronounced as to raise the question of autism. Indeed, some children have such persistent behaviors that the diagnosis of "acquired institutional autism" seems appropriate.

A wide variety of attention-getting behaviors may be observed in internationally adopted children. These include biting, spitting, scratching and various tantrums and inappropriate behaviors. These unpleasant and difficult behaviors may have earned the child some extra attention in an environment where even negative attention (discipline) was preferable to no attention. New parents must direct their attention to the good behaviors the child exhibits, while ignoring or correcting these negative behaviors. With time, children realize that the route to adult attention has changed.

Survival skills include some of the eating behaviors discussed above. Also important are the social skills children develop to survive emotionally in an orphanage environment with multiple caregivers. Some of these behaviors may also be seen in the spectrum of reactive attachment disorder. The most common of these behaviors is overfriendliness. This behavior -- superficial charm and sociability with strangers -- is an adaptive response to inconsistent caregivers. Although these children are pleasant to encounter, they must be monitored closely for appropriate attachment to their parents.

Although some of these behaviors may occur in children raised in a family, institutionalized children often display them repetitively or obsessively. For most children, these behaviors resolve over a few weeks as the environment is enriched. For some, however, the behaviors are deeply ingrained and persist for years. Most common are self-rocking or head-shaking behaviors prior to sleep or during times of frustration.

THE POST-ARRIVAL VISIT TO THE PEDIATRICIAN

At long last, the new family is home. Many families are instructed by their adoption agency to be seen "immediately" by the child's physician after arrival in the U.S. Unless the child is ill, this is usually unnecessary and may add undue stress. Certainly a visit to the physician within the first 4-5 days is useful. At this time, the doctor should perform a physical examination to detect major problems and get a general sense of the developmental stats of the child. Vaccinations and blood tests are not warranted at the first visit, except under unusual circumstances.

A more complete evaluation should be performed 2-4 weeks after the child arrives home. At this time, the child should be thoroughly examined, remeasured to assess early signs of catch-up growth, and have screening blood tests performed. Vaccinations can be administered and a plan for completing needed vaccines made.

Follow-up Medical Examinations after Arrival in the United States [1]

The varied geographic origins of internationally adopted infants and children, their unknown backgrounds before adoption (including parental history and living circumstances), and the inadequacy of health care in many developing countries make appropriate medical evaluation of internationally adopted children a complex and important task. This evaluation should be performed within 2 weeks of the child's arrival in the United States. The content of the medical evaluation should be guided by the unique circumstances and needs of the child, taking into account the child's region and country of birth, past living conditions, and travel and medical history. In addition to the screening for infectious disease described below, a full medical and developmental assessment should be done, with attention to possible malnutrition, conditions undetected by limited prior care, and ectoparasites such as scabies and lice, in addition to other indicated tests, such as lead (5) or G6PD.

SCREENING FOR INFECTIOUS DISEASES

Infectious diseases, among the most common medical diagnoses, have been found in up to 60% of internationally adopted children, depending on their country of origin; many of these infections can be asymptomatic (6-10). Screening for these diseases is important for the health of the adopted infant or child as well as that of their adoptive family. The American Academy of Pediatrics (AAP) recommends that all internationally adopted children be screened with the following: hepatitis B serology, HIV serology, syphilis serology, Mantoux intradermal skin test for tuberculosis, stool examination for ova and parasites, and complete blood count including a peripheral eosinophil count and red blood cell indices (11). Regardless of eosinophil count, all international adoptees should have three separate stool samples, collected on 3 separate days, analyzed for ova and parasites. HIV antibodies in a child younger than 18 months of age may reflect maternal infection without transmission to the infant, and infection in the infant should be confirmed with an assay for HIV DNA by polymerase chain reaction. Two negative tests obtained 1 month apart are required for the child to be considered uninfected.

Tuberculin skin tests measuring less than 5 mm are negative; reactions larger than 5 mm are interpreted based on risk factors for diseases. For internationally adopted children born in regions of the world with high TB prevalence, a reaction of 10 mm or more of induration is always positive; a reaction from 5 to 9 mm is positive if the child is immunocompromised, has been exposed to tuberculosis, or has signs or symptoms of TB disease. If the TST is positive, a chest radiograph should be performed to evaluate for active TB disease. If evidence of TB disease is found, efforts to isolate an organism for sensitivity testing are very important because of the high proportions of drug resistance in many other countries, including countries in Eastern Europe, the former Soviet Union, and Asia. Some experts also recommend that health-care providers consider repeating the TST (if negative) 2-3 months after arrival when nutritional status has been

improved, particularly if the child had evidence of under- or malnutrition at the initial screening (10). Receipt of BCG vaccine is not a contraindication for TST. Because BCG does not prevent infection with TB and because of the high risk for exposure in most countries where BCG is given, the AAP recommends that children with a positive TST be given 9 months of isoniazid therapy (11).

Up to 35% of internationally adopted children have ova or parasites identified on stool examinations (6-10). For Giardia intestinalis and Cryptosporium parvum infection, stool examination for antigen by enzyme immunoassay may be more sensitive than microscopic exam. Giardiasis is particularly prevalent in internationally adopted children from Eastern Europe. Strongyloides stercoralis serologic testing, available at CDC on request through the state public health laboratory, should be considered for children who have a high eosinophil count. If enteric symptoms develop in the future, tests should be repeated, even if it has been several years after arrival in the United States.

Other screening tests may be recommended based on country of origin, risk factors, symptoms, or clinical findings. For example, children from schistosomiasis-endemic areas (see Map 4-11) should have serologic tests for schistosomiasis performed at CDC, which may be requested through the state public health laboratory (http://www.dpd.cdc.gov/dpdx/HTML/DiagnosticProcedures.htm). Screening for hepatitis C should be considered for all infants and children adopted from Asia, Eastern Europe, or Africa. Hepatitis C testing for children adopted from other areas should be considered if the records indicate potential risk factors, such as receipt of blood products or maternal drug use. Testing for hepatitis D, which is available at CDC, should be considered for children from the Mediterranean area, Africa, Eastern Europe, and Latin America who have chronic infection with hepatitis B virus.

Laboratory reports from the country of origin should not necessarily be considered reliable.

VACCINATION

Internationally adopted infants and children frequently are underimmunized and should receive necessary immunizations according to the ACIP-recommended schedules in the United States (see Tables 8-2—8-4) (12,13). In a retrospective review of records of 504 children, the majority (65%) had no written records of overseas vaccination. Among the 178 children with documented overseas vaccination, 167 (94%) had valid records and some vaccine doses that were acceptable and up to date under the U.S. schedule (14).

In assessing the immunization status of an internationally adopted child, only written documentation should be accepted as proof of receipt of immunization. In general, written records are deemed valid if the vaccine type, date of administration, number of doses, intervals between doses, and age of the patient at the time of administration are comparable with the current U.S. schedule. Although some vaccines with inadequate potency have been produced in other countries, most vaccines used worldwide are produced with adequate quality control standards and are reliable (11,13). However, immunization records for some internationally adopted children, particularly those from orphanages, may not reflect protection because of inaccurate or unreliable records, lack of vaccine potency, poor nutritional status, or other problems (2-4, 14). For any child, if there is any question as to whether the immunizations were administered or were immunogenic, the best course is to repeat them. Vaccination is generally safe and avoids the need to obtain and interpret serologic tests.

In an older infant or child who is thought to have been vaccinated appropriately, judicious use of serologic testing can be helpful in determining which immunizations may be needed and can decrease the number of injections required (10,11). Children who do not have serologic evidence of previous hepatitis B infection should receive the full vaccine series. Many adopted children acquire hepatitis A virus infection early in life and are immune thereafter. Thus, in the United

States it may be cost effective to screen these children for previous immunity before initiating the vaccination series. Verification of protection from MMR vaccine requires testing for antibodies to each virus. Serology is of limited availability or difficult to interpret for Haemophilus influenzae type b (Hib) and poliovirus. Vaccination for these, as well as varicella and pneumococcal disease, which are not administered in most countries, should be administered to internationally adopted children based on age and medical history.

Data indicate increased risk of local adverse reactions after the fourth and fifth doses of DTP or DTaP. In some circumstances, judicious use of serologic testing of antibody levels to assess immunity may be helpful in decreasing the possibility of vaccine side effects. For children whose records indicate that they have received more than 3 doses, options include initial serologic testing or administration of a single booster dose of DTaP, followed by serologic testing after 1 month. If a severe local reaction occurs after revaccination, serologic testing for specific IgG antibody to tetanus and diphtheria toxins can be measured before additional doses are administered. No established serologic correlates exist for protection against pertussis, but protective concentrations of antibody to both diphtheria and tetanus toxin can serve to validate the vaccination record.

Source: CDC Health Information for International Travel 2008 – Traveler's Health Yellow Book - http://wwwn.cdc.gov/travel/yellowBookCh8-Adoptions.aspx

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