

**Clinical guidance for
primary care and GPs
on the health needs of
UASC**



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Introduction

Unaccompanied children seeking asylum are children and young people aged under 18 years who have asked for asylum from their home country owing to fear of persecution. Unaccompanied children have become separated from their usual parent or carer, often for reasons such as the death of a care giver or separation during the journey, which is often traumatic, to the host country. Unaccompanied children have substantial health and social care needs, and the prevalence of physical and mental illness is higher in unaccompanied children compared to accompanied peers, or to the indigenous population of children in the UK.

Since August 2015 there have been increased numbers of unaccompanied children in Kent, which is reflective of an international crises caused by conflict in Afghanistan, Syria, and in the Horn of Africa.



Useful definitions

Asylum seeker: applies to be given refugee status under terms of 1951 UNHCR (United Nations Refugee Agency) Convention or someone who says he or she is refugee and has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights, but their application has not yet been definitively evaluated (UNHCR).

Unaccompanied minor: separated from both parents and no person can be found who by law or custom has primary responsibility (1951 UNHCR Convention)

Refugee: leaves or does not return to country of their nationality because of well-founded fear of being persecuted for reasons of race, religion, nationality, membership of particular social group, or particular opinion (1951 UNHCR Convention). This term is widely used to describe displaced people all over the world but legally in the UK a person is a refugee only when the Home Office has accepted their asylum claim

UASC: (Unaccompanied Asylum Seeking Children) A person who, at the time of making their asylum application is under 18 years of age or who, in the absence of documentary evidence, appears to be under that age and who is applying for asylum in his/her own right and is without a family member (s) or guardian (s) to turn to in this country. The definition for immigration purposes of an unaccompanied asylum seeking child is given by the Home Office as 'a person under 18 years of age or who, in the absence of documentary evidence establishing age, appears to be under that age' who 'is applying for asylum in their own right; and is separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so'. Children in this situation are also known as separated children or unaccompanied minors (UAM) (Kamena Dorling and the Migrant Children's Project team, May 2013)

What is "seeking asylum"? Asking for protection and permission to stay in the UK
Some UASCs will later become refugees if their claims for asylum are successful

An age-disputed child or young person: An age-disputed child or young person- is child or young person whose age has been disputed and has not had their claimed date of birth accepted by the Home Office and/or by the local authority that he or she has approached to provide support or protection. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and/or the local authority (Kamena Dorling and the Migrant Children's Project team, May 2013)

A separated child: A separated child- is a child who has been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. The Home Office definition of unaccompanied children does not include children who arrived in the United Kingdom in the care of a parent or other adult (for example, a relative or family friend) who by law or custom has responsibility for the child, even if the child is no longer living with such an adult due to the subsequent breakdown of such an arrangement (Kamena Dorling and the Migrant Children's Project team, May 2013).

Trafficking: Trafficking- is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered "trafficking in human beings" – Council of Europe Convention on Action Against Trafficking in Human Beings, ratified by the UK Government in 2008.

Legal aspects

Current UK Asylum Process

A refugee wishing to stay in the UK must apply for asylum. To be eligible they must have left their country and be unable to go back because of fear of persecution. Refugees should apply for asylum when they arrive in the UK or as soon as they think it would be unsafe to return to their own country. After applying, refugees will have a meeting with an immigration officer (known as a 'screening') and then an asylum interview with a caseworker.

Decisions about application are usually made within 6 months. Further information can be found on the Home Office website.

Unaccompanied Asylum Seeking Children and Young People

Following an initial age assessment by the Home Office and social services, a young person judged to be under 18 years of age, without an adult to care for them, is entitled to the same rights as other looked-after children and young people, including accommodation, some finance, education, statutory health assessments, support and reviews.

This group of young people will most likely be given discretionary leave to remain until 17 ½ years old leaving detailed processing of an asylum application for when they are older. They are entitled to legal aid. Therefore as much information as possible should be gathered using an appropriate interpreter at an early stage as this will be relevant to their application.

After full consideration by UK Visas and Immigration there is one of three outcomes:

- **Full Refugee Status**
The Young Person meets the definition of a refugee under the 1951 United Nations Convention Relating to Refugees. Granted Indefinite Leave to Remain after being in UK for 5 years. Not sent back.
- **Humanitarian Protection or Discretionary Leave**
this replaced Exceptional Leave to Remain (ELR) in 2003. This is time limited and actively reviewed.
Humanitarian Protection: removal places serious risk to life or person
Discretionary Leave: the UASC is allowed to stay until aged 18
- **Refusal:** May appeal, if unsuccessful are removed from UK. If UASC, not until 18. It is imperative that that UASC has legal advice during the process.



Age assessment

Most refugee children and young people will not have a passport, although some may have been given a passport to help them to leave a situation where they are at risk. Sometimes the child's stated age may be disputed; with serious implications for the outcome of their asylum claim and for their ability to access health services, education and welfare support (Crawley, 2007). Adults indicating that they are children present a risk to younger cohorts if placed into accommodation together. However the converse is true and vulnerable young people should not be placed with adults.

The Home Office and the Association of Directors of Children's Services have produced joint working guidance about how UK Visas and Immigration decide applications.

The Association of Directors of Children's Services have also produced age assessment guidance for assisting English social workers in conducting age assessments of unaccompanied children seeking asylum. This states that the process for age determination by the local authority should take place in the presence of an appropriate adult, by two qualified and one senior social worker, taking into account a number of social and other factors. If in doubt the local authority should give the young person the benefit of the doubt as to their age.

Age assessment guidance has also been developed in Scotland and Wales.

In these situations, remember that there is no single reliable method for making precise age estimates and the most appropriate approach is to use a holistic evaluation, incorporating narrative accounts, physical assessment of teeth, puberty and growth, and cognitive behavioural and emotional assessment (RCPCH, 2013). The use of radiological assessment is extremely imprecise and can only give an estimate of within two years in either direction and the use of ionising radiation for this purpose is inappropriate (RCPCH, 2007). The British Society for Paediatric Endocrinology and Diabetes are clear that it is not possible to accurately assess a child's age based on physical examination or bone age assessment (Dr Tabitha Randell).

A paediatrician has to be honest with the social worker when contacted regarding age assessment, explaining that dental x-rays, bone age and genital examination will not add any further information to the assessment process based on the current evidence available.

Some age assessments carried out by the Home Office have been subject to dispute with some young people subsequently assessed to be minors (Crawley 2007). Further information about age disputes is available from the Coram Children's Legal Centre, 2013.

- >50% of births in the developing world are not registered therefore a UASC's age cannot be validated with written proof.
- Age Assessments should be carried out only if:
 - there is no proof of age
 - Physical appearance/demeanour suggest that they may be younger or older than claimed
 - The Home office has disputed their age
- Carried out by two social workers
- Not a health responsibility but we should comment if appropriate
- 5 year margin of error (15-18)
- If in doubt, assume is a child
- Must follow Merton guidelines
http://mertoncs.proceduresonline.com/pdfs/app_1_age_assess.pdf



Experiences

Why unaccompanied?

- Danger of being murdered or imprisoned
- Parents/guardians have “disappeared”
- Danger of being forced to join army/other fighting unit
- Prevented from practicing their religion
- Forced to practice religion
- Intimidated or tortured
- Banned from political activity
- Forced to take part in political activity
- Member of persecuted social, religious, ethnic or political group

Experiences of UASC:

- War and terrorism
- Civil unrest
- Ethnic persecution
- Political persecution
- Religious persecution
- The journey to the UK
- The asylum-seeking process
- Media reporting

Possible effects of traumatic experiences

- Brutalised
- Start hating
- Want revenge
- Feel abandoned
- Stop trusting adults
- Wary about making new bonds
- Psychological symptoms



Key Risk Factors

- Loss of parent or primary caregiver
- Experiences of neglect and poor parenting before exile
- Exposure to violence
- Isolation
- Difficulties in the mourning process
- Difficulties in managing change and other difficult events
- Difficult experiences after arriving in the UK
- Identification with oppressive or aggressive political, religious and ethnic groups

Key Protective Factors

- Having an appropriate adult to provide care
- Having access to community and social networks and appropriate services
- Being able to encourage a natural healing process
- Being able to integrate into a normal life
- Finding meaning in what has happened and being able to process events
- Finding culturally sensitive ways to express loss and move on



Health needs overview

While many people seeking asylum arrive in the United Kingdom in relatively good health, it is also recognised that others will have physical and mental health needs at greater prevalence than the general population. Reasons for this include, the experience of imprisonment, torture or physical and sexual violation and the physical and psychological consequences of this; time spent in refugee camps which may be overcrowded and lack access to adequate food and sanitation, the journey to the host country, which is often long and arduous and limited or no access to basic healthcare prior to migration, particularly in people from countries which have or are experiencing prolonged periods of conflict, and the associated instability and destruction of local health infrastructure. Young people may have experienced particular health issues in relation to their age and reason for leaving their home country. For example some young people may be forced into or escaped from becoming child soldiers, or have been exposed to sexual exploitation, rape or trafficking.

The key areas of physical health which should be considered are:

- Communicable Diseases
- Nutrition and metabolic concerns
- Women's health, including family planning and maternity care
- Oral health
- Sexual health



Access to Healthcare

Refugee and unaccompanied asylum seeking children and young people have rights to primary and secondary healthcare. The Refugee Council provide a fact sheet in a variety of languages which contains information on healthcare eligibility and access for people seeking asylum in the UK. The Refugee Council have also developed an information pack for refugees which provides information about accessing health services.

For babies, children and young people born outside the UK, the usual route for obtaining an NHS number is to have one allocated through GP registration. In England, there is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services. Therefore all asylum seekers and refugees are eligible to register with a GP practice. For further information, see NHS England's Standard Operating Principles for Patient Registration.

Specific guidance on accessing NHS services is available for Scotland and Wales. In 2015 new regulations were introduced in Northern Ireland meaning that all refugees and asylum seekers (including refused asylum seekers) are not required to pay for their healthcare treatment, including primary care and secondary care.

Children aged under 16, and children 16-19 in full time education are entitled to exemption from charges for prescription items, free dental services and free eyesight tests following completion of a HC2 certificate. In order for unaccompanied children aged over 16 years and not in full time education to access these entitlements, the local authority must complete a certificate of exemption, HC1, confirming that the young person is on low income. Additionally, the UK Border Agency provides HC2 certificates to asylum seekers on behalf of the Department of Health (6).

Specific guidance for unaccompanied asylum seeking children and young people:

- **England:** Care of unaccompanied and trafficked children
- **Scotland:** The Scottish Guardianship Service
- **Wales:** Safeguarding and Promoting the Welfare of Unaccompanied Asylum Seeking Children and Young People

Specialist referral should be made in the usual way; however the referrer should be aware of factors which may impact on a child or family being able to make appointments such as language barriers and transport.

Where appropriate, a personal child health record (red book) should be issued. These are available from the health visitor and local health clinics and for some local authorities, online.

Local authority responsibilities for UASC

Corporate Guardianship – where a child comes to the United Kingdom to seek asylum and is not in the care of an appropriate adult, the local authority is obliged to assume the role of the child's 'corporate parent'. This role involves a number of responsibilities outlined below.

Named social worker/case manager - who will coordinate the assessment, planning, protection and placement of the child.

Accommodation – the majority of unaccompanied children require the level of support outlined in Section 20 of the Children's Act, 1989. While this does not define the nature of accommodation, the local authority should, so far as practical, provide accommodation that is suitable to the level of need of the child and in line with his/her wishes. In practice it is common for children under 16 years to be placed in foster care, and for children aged over 16 years to be placed in semi-independent living accommodation with variable additional support. In Kent all unaccompanied girls under 18 years and boys aged under 16 years are placed in foster care, and boys aged 16-18 years are placed in a reception centre for 4 weeks and then moved into semi-independent accommodation. Foster carers and staff working in residential facilities should have an understanding of the particular needs of

unaccompanied children. Where there is a concern that the child has been trafficked there should be an escalation plan in so that carers can raise concerns about ongoing risk of trafficking and have an action plan should the child go missing.

Immigration legal advice - Unaccompanied children require support in dealing with immigration questions or proceedings. Immigration legal advice must be provided only by a regulated solicitor or registered with the Office of the Immigration Services Commissioner (OISC) to provide immigration advice to the relevant level.

Role in supporting asylum application – it is critical that the local authority works alongside the child's case manager at the UK Border Agency to support the resolution of the child's asylum application.

Statutory health assessment, which includes an including assessment of physical, emotional and mental health. This assessment will result in a health plan to address any health issues identified during the Health Assessment including a timescale and responsibility for actions.

A personal education plan should be produced as part of the overall care plan. Where English is not the first language of the child, this should include access to English language skills training, as well as opportunities to develop literacy in skills in the child's mother tongue. Schools in which unaccompanied children are placed may require additional support to understand and meet the needs of unaccompanied children.

Rights of care leavers – immigration status does not affect the obligation on Local Authority to provide support to young people who are leaving care. If the unaccompanied young person has been in the care of the local authority for 13 weeks prior to their 18th birthday they are entitled to the same care leaver's support as any indigenous looked after child, as outlined in the Children's Act and including having a named personal advisor to support their needs. Leaving care may be associated with increased risk of becoming isolated or vulnerable. Transition planning by the local authority should take into account factors which may decrease this risk, such as language and cultural factors.

What do we know about the Kent UASCs and their health?

[Public Health UASC Needs Assessment to be imbedded here](#)



Working with interpreters

For children and young people with English as a second language any assessment should be undertaken with the support of a culturally appropriate, registered interpreter (considering ethnic and gender issues). It is not appropriate for other children or young people to act as interpreters, or for people not trained as interpreters to perform this role. An interpreter telephone service can be used where access to a face-to-face interpreter is not possible.

It is important to remember that a health assessment/appointment may be the first opportunity that a child or young person has had to talk about their needs with a registered interpreter. Remember to look at the young person not the interpreter when speaking and use positive, friendly, non-verbal communication.

Previous interviews may have been adversarial so it is important to explain that you are not from the Home Office and they have a choice, explain what you will do with the information

It is important to explain to the young person and their carer that you will see the young person and their carer both individually, and then together. It is useful to discuss the care plan and any other issues (together with family and social worker if present) at the end of the assessment particularly if there is an interpreter present, provided consent and confidentiality issues are considered.

Guidance on using interpreters in health care settings and appointments

- When using interpreters to assist with assessments or meetings involving UASCs the following advice/information may be helpful: Make sure that your interpreter speaks the same language as the UASC including the same dialect if relevant and is also able to read and write in this language.
- Be aware that if the UASC is from an area of conflict then the possible political affiliation/ethnicity of the interpreter may be an issue for the UASC. If concerned about this check with the interpretation agency when booking or speak with the UASC's social worker about suitable interpreters.
- An interpreter of the same sex as the UASC may be more appropriate especially for those UASC's coming from cultural backgrounds where the sexes are more segregated than in the UK. The UASC will already be familiar with meetings involving the use of interpreters and will already have experienced at least one, probably with UK Visas and Immigration. It may be possible to arrange to book the same interpreter that was previously used – the UASC will probably find the process easier with a known interpreter. The UASC's social worker will be able to advise on previously used interpreters and whether they would be suitable to use in a health care setting/appointment.
- Make sure that the interpreter is clear about the purpose of the session and has been adequately briefed before starting.
- Encourage the interpreter to interrupt and intervene during the interview when necessary, for example if the member of staff is speaking too fast or for too long without pausing or the UASC or interpreter has not understood and needs clarification. But also explain to the interpreter that you want them to translate what the UASC is saying, and they are not to give their own opinion or add extra information unless directly asked by you. You will need to watch the UASC's body language to try to ensure that your questions and their answers are being translated appropriately. They will, however, indicate if they feel the UASC has not understood the question or needs clarification. They will also indicate if there is a cultural reason for a possible misunderstanding and will provide clarification and explanation about the cultural issue.

- Be aware of cultural issues depending on the background of the interpreter. It may not be appropriate to shake the hand of an interpreter from certain backgrounds, for example, especially if they are of the opposite sex. Similarly, it may not be appropriate to maintain prolonged eye contact with them, especially if they are of the opposite sex.
- Make sure that the interpreter is introduced to the UASC and that their purpose at the meeting is explained.
- Make sure that it is made explicit to the UASC that the interpreter will not pass on anything that he/she hears at the meeting – everything is confidential. A UASC may feel particularly worried about someone from his/her own cultural background hearing certain information in case anything is passed back to their country of origin.
- The interpreter should sit next to the UASC to facilitate communication.
- The doctor undertaking the assessment should speak and look directly to the UASC, not the interpreter. Questions should be phrased 'Do you ...' for example, not 'Does he/she...'.
• The doctor needs to speak at a reasonable pace and must remember to pause to allow the interpreter to interpret. Do not speak for too long without pausing as this will make it difficult for the interpreter to remember exactly what has been said. The doctor/nurse should use straightforward language and avoid jargon.
- At the end of the assessment check whether the UASC has understood everything and wants to know or ask anything else.



Consent

The clinician should refer to GMC Guidance regarding information about obtaining consent and what to do if consent is refused. Information is also provided in the Child Protection Companion (log in/subscription required), and by the BMA.

You must have consent or other authority before examining, investigating or treating a child or young person. Unaccompanied minors may be able to consent to their own treatment however it is always good practice to attempt to contact their parents/guardians for a history and to communicate follow-up management.

In the UK, children and young people, including unaccompanied minors, can consent to treatment if they are deemed Gillick Competent, meaning they can:

- understand the nature, purpose, benefits, risks and consequences of not proceeding;
- retain the information discussed;
- use and weigh this information, and
- communicate their decision to others.

A child or young person with capacity to consent, who refuses, should have their decision respected unless there are exceptional circumstances.

Young people over 16 years should be assumed to have capacity unless there is reason to believe that they have an impairment of mind or brain that affects their capacity for the specific decision at the specific time. If there is doubt about capacity, an assessment of capacity should be undertaken.

Young people aged 16 years or over who are assessed to lack mental capacity for a specific decision at a specific time should have an Independent Mental Capacity Advocate appointed, with the best interests decision-making process of the Mental Capacity Act 2005 followed.

More information on Mental Capacity and Best Interests can be found in the Disability Matters eLearning Package. Or from your local safeguarding team



Confidentiality

As for all children and young people, it should be explained that in the UK health information is recorded on a computer health system and shared with other health professionals, such as the GP and health visitor, and that health information may be shared with other agencies such as school and social services.

It should also be explained that details will not be shared with outside agencies such as legal or immigration officials unless the young person/family consent to this. A copy of the care plan and any information shared with other professionals should be sent to the young person/family in the usual way.

More detailed information about confidentiality is provided in the Child Protection Companion and the GMC also provide guidance on this. Caldicott principles on record keeping and information sharing should be followed.

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MANAGING HEALTH NEEDS

Immunisations

Many children and young people of refugee background will have unknown vaccination status, and paediatricians and or GP will need to assess the likelihood that standard immunisation protocols would have been followed in the child or young person's country of origin (Simmons and Merredew).

The following principles as outlined by Public Health England (PHE) should be followed for individuals with uncertain or incomplete immunisation status (PHE, 2015):

- Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned.
- Individuals coming to UK part way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for age.
- If the primary course has been started but not completed, continue where left off – no need to repeat doses or restart course.
- Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale – aim to protect individual in shortest time possible.

Further detail contained in PHE's Guidance on Vaccination of individuals with uncertain or incomplete immunisation status.



Blood borne virus infections

The majority of the countries of origin of our UASCs have high risks for BBVs and the young people are also deemed at risk because of the experiences that they may have had during their journey to the UK.

Please refer to the following guidelines for the screening of blood borne infections:-

a) Guidelines for the testing of looked after children who are at risk of a blood-borne infection issued jointly by BAAF and NCB

b) British Association for Sexual Health and HIV Guidelines

<http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx>

A detailed list of countries of origin and information regarding migrant health can be found at <https://www.gov.uk/government/collections/migrant-health-guide-countries-a-to-z>

Afghanistan	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Eritrea	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Ethiopia	All patients from this country should be offered and recommended an HIV test This country has an intermediate prevalence of hepatitis B.
Iran	This country has an intermediate prevalence of hepatitis B.
Kuwait	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK
Sudan	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK All patients from this country should be offered and recommended an HIV test
Syria	This country has an intermediate prevalence of hepatitis B.
Vietnam	This country has an intermediate prevalence of hepatitis B. This country has a considerably higher prevalence of hepatitis C than the UK



Anaemia and haemaglobinopathies

Many young people may not be aware of their sickle cell or thalassaemia status but given their countries of origin would be at high risk. Universal screening of this group has not been recommended but should be considered on a case by case basis – if there is a history of painful crises or the YP is presenting as clinically anaemic. It is more likely however that any anaemia noted is caused by malnutrition.

- The World Health Organization estimates that 2 billion people, over 30% of the world's population, are anaemic [1].
- Globally the most significant factor causing anaemia is iron deficiency, which is the most common and widespread nutritional disorder in the world.
- Where a migrant patient is found to be anaemic this should be investigated as for any patient. The determination of the cause is assisted by the blood film (microcytic, normocytic or macrocytic).
- Practitioners should be aware of the range of causes of anaemia that may be particularly pertinent to some migrant patients. These include not only iron deficiency but also haemoglobin disorders and a wide range of infections to which some migrants may be at higher risk.
- The treatment of anaemia should be based on its underlying cause.
- There are NHS antenatal screening programmes for anaemia and haemoglobin disorders.

Background information

- Haemoglobin disorders are inherited blood diseases that affect how oxygen is carried in the body.
- They fall into two main categories: sickle-cell disease and thalassaemias.
- WHO estimates that each year over 300,000 babies with severe forms of these diseases are born worldwide; the majority in low and middle income countries.
- Approximately 5% of the world's population are carriers of a trait gene for sickle-cell disease or thalassaemia. As many as 25% of the population are carriers in some regions. Most carriers lead completely normal, healthy lives.
- Disease can occur only when a child inherits the trait gene from both parents (autosomal recessive inheritance).
- These conditions are most prevalent in tropical regions.
- Genetic screening and counselling is the main approach to prevention of haemoglobin disorders.
- NICE guidelines recommend antenatal screening for sickle cell diseases and/or thalassaemias for at risk women by ten weeks of gestation.

Thalassaemias

- Thalassaemias are the commonest genetic disorders in the world and occur with a very high frequency in a tropical belt extending from Africa, throughout the Mediterranean region, the Middle East, the Indian subcontinent, and throughout South West Asia.



- There are two major types of thalassaemia, alpha and beta, which are named for the two protein chains that make up normal haemoglobin. Alpha and beta thalassaemias lead to variable production of abnormal haemoglobin and have both mild and severe forms. Beta thalassaemia major is the most common and severe form of the condition in the UK.
- The carrier incidence of beta thalassaemia in the UK amongst different Asian communities varies from around one in seven to one in 30. Eight out of ten babies born with beta thalassaemia major in the UK have parents of Indian, Pakistani or Bangladeshi ancestry.
- People with more severe types of thalassaemia are not able to make enough haemoglobin, which means that oxygen cannot get to all parts of the body. Organs then become starved for oxygen and are unable to function properly. Symptoms include:
 - Fatigue
 - Weakness
 - Shortness of breath
 - Jaundice
 - Bone deformities
 - Liver, spleen and gland damage
- Diagnosis is by history and blood test (hypochromic microcytic anaemia) with confirmation by haemoglobin electrophoresis.
- Patients diagnosed with thalassaemia should be referred to specialist services for management.
- Treatment of severe disease is mainly by regular blood transfusions to maintain haemoglobin levels.
- Secondary treatment is also required to manage iron overload resulting from multiple transfusions.
- Thalassaemias can sometimes be cured by bone-marrow transplantation where a suitable donor exists.

Patient information (English only)

A parent's guide to sickle cell disease developed by the NHS Sickle Cell and Thalassaemia Screening Programme

NHS leaflets and factsheets about sickle cell, thalassaemia and screening

Patient information (English and other languages)

Information on the NHS programme of antenatal screening for haemoglobin disorders - available in a range of languages

Afghanistan	No specific risks
Eritrea	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.
Ethiopia	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.
Iran	No specific risks
Kuwait	No specific risks
Sudan	There is a high risk of anaemia in people from this country. Be alert to this possibility and test as clinically indicated.
Syria	No specific risks
Vietnam	No specific risks

Tuberculosis

For a recent practice guideline See <http://www.bmj.com/content/352/bmj.h6747?sso=>

Tuberculosis—diagnosis, management, prevention, and control: summary of updated NICE guidance

What you need to know

- Undertake tuberculosis (TB) testing in close contacts of people with pulmonary or laryngeal TB, people who are immunocompromised and at high risk of TB, and new entrants from high incidence countries who present to healthcare services
- Seek specialist input in the diagnosis and management of TB in children, and in the management of people with multidrug resistant TB or those with TB and comorbidities
- Consider enhanced case management, including directly observed therapy (DOT), in patients with clinically or socially complex needs
- Apply appropriate infection control measures if a person has suspected or confirmed infectious TB (pulmonary or laryngeal TB)

Afghanistan	Screen all new entrants from this country for TB
Eritrea	Screen all new entrants from this country for TB
Ethiopia	Screen all new entrants from this country for TB There is a high burden of Multi Drug resistant TB in this country
Iran	No specific risks
Kuwait	No specific risks
Sudan	Screen all new entrants from this country for TB
Syria	No specific risk but consider countries travelled through
Vietnam	Screen all new entrants from this country for TB There is a high burden of Multi Drug resistant TB in this country

Libya (as many will have travelled through Libya and/or spent periods of time here): Screen all new entrants from this country for TB



Other Communicable diseases

- The prevalence and nature of bacterial and viral infections will vary across countries.
- A significant number of refugees and asylum seekers arrive from countries where blood-borne infections are highly prevalent, and/or they may have been at exposed to diseases on route to the UK. Paediatricians should consider the possibility of hepatitis, scarlet fever and malaria and refer appropriately.

Afghanistan	There is a risk of malaria in some areas of this country. There is a risk of typhoid infection in this country. Polio is endemic in this country. Be alert for signs and symptoms and ensure all new entrants are brought up to date with the UK immunisation schedule , including polio vaccine as required.
Eritrea	There is a high risk of malaria in this country.
Ethiopia	There is a high risk of malaria in some areas of this country Polio cases have been reported
Iran	No specific risks
Kuwait	No specific risks
Sudan	There is a high risk of malaria in this country.
Syria	For children <5 years please obtain faecal samples for testing of polio virus
Vietnam	There is a high risk of malaria and typhoid in this country

Be aware of unusual parasitic infections



Skin conditions

Tinea Versicolor:

<http://www.nhs.uk/conditions/pityriasis-versicolor/Pages/Introduction.aspx>



Scabies:

<http://www.nhs.uk/conditions/Scabies/Pages/Introduction.aspx>

<http://www.webmd.com/skin-problems-and-treatments/ss/slideshow-scabies-overview>

Infection related dermatological conditions in migrant patients					
Bacterial Skin infections	Creeping Eruptions	Ulcers	Pruritic conditions	Systemic rash with fever	Urticaria
Infected bites Impetigo Cellulitis Folliculitis	Cutaneous larva migrans Scabies Strongyloidiasis (larva currens) Loiasis Gnathostomiasis	Infected insect bites Cutaneous leishmaniasis Rickettsial tick eschar Spider bites Cutaneous diphtheria Cutaneous anthrax M. ulcerans Mycetoma Sexually transmitted infections Genital herpes	Insect bites Contact dermatitis Dermatophytosis Cutaneous larva migrans Scabies Cercarial dermatitis Marine creature contact dermatitis	Consider referral to specialist centre: HIV seroconversion illness Drug reactions Dengue Chikungunya Measles Rubella VHF Rickettsial infection Typhoid Syphilis Meningococcaemia Leptospirosis	Many non-travel/infection related causes, e.g. drug allergy. Helminth infections e.g. Acute schistosomiasis Strongyloidiasis



Sexual and reproductive health

- Asylum seeking children may have experienced rape and torture and some may have worked as commercial sex workers either before, en route to, or following arrival in the UK, while others will have been in consensual sexual relationships (BAAF Practice Note 53).
- Paediatricians should carry out a full sexual health review including questions about whether a young person is sexually active and whether they are pregnant as well as discussing contraceptive options. Ideally this should be carried out in the context of a comprehensive assessment, and in association with the local GUM service (BAAF Practice Note 53).

A number of factors should be taken into account with UASC and sexual health screening. Interpreters Face-to-face interpreting should be carried out with sensitive attention to gender, ethnicity, etc, to ensure an appropriate interpreter is chosen. Trauma relating events around rape and torture may be extremely traumatic for the child or young person. Information should be shared with other professionals when appropriate to avoid the child or young person having to repeat the information

Afghanistan	No specific risks
Eritrea	No specific risks
Ethiopia	Sexually active individuals should be offered full sexual health screen and safer sex health promotion advice.
Iran	No specific risks
Kuwait	No specific risks
Sudan	Sexually active individuals should be offered full sexual health screen and safer sex health promotion advice.
Syria	No specific risk but consider countries travelled through
Vietnam	No specific risk



Vitamin deficiencies

Vitamin A deficiency

- Vitamin A deficiency is extremely rare in the indigenous UK population but is a serious public health concern in many low income countries, particularly in Africa and South East Asia.
- Young children and pregnant women from low-income countries are most likely to be affected.
- Practitioners should be alert to the possibility of vitamin A deficiency in at risk migrant patients and where they suspect it may wish to seek advice on appropriate diagnosis and management from their local endocrinology or paediatric team.
- Vitamin supplementation should be considered for all infants from one month to five years, especially in at risk groups. Low income families in the UK who receive one of a range of income related benefits and tax credits may qualify for Healthy Start [\[external link\]](#). Pregnant women, women with a child under one and children aged 6 months to their 4th birthday can get free Healthy Start vitamin supplements. The supplements for children contain vitamin A.
- Vitamin A has teratogenic effects in overdose and the Department of Health recommends that pregnant women, or women who may become pregnant should not be advised to take supplements containing vitamin A and should not eat foods rich in vitamin A such as liver and liver based products [1].

Background information

- WHO estimates that approximately one third of the world's school age population and 15% of pregnant women are biochemically vitamin A deficient. One percent of all children and 8% of all pregnant women are night blind as a result [2].
- Vitamin A is an essential nutrient needed in small amounts (0.7mg a day for men, 0.6mg a day for women [3]) for the normal functioning of the visual system, and maintenance of cell function for growth and development, epithelial integrity (skin and mucous membranes), red blood cell production, immunity and reproduction [2,4,5].
- Vitamin A is found in two forms:
 - as retinol in foods from animal sources, such as whole eggs, milk, cheese and liver. In the UK fat spreads are also fortified with retinol.
 - as carotenoids (mainly beta-carotene) in plant sources which are converted to retinol in the body e.g. green leaves, carrots, ripe mangos, and other orange-yellow vegetables and fruits.
- The main cause of vitamin A deficiency globally is a diet that is chronically deficient in the vitamin. Conditions associated with chronic diarrhoea can also reduce vitamin A absorption. Furthermore chronic or repeated infections can deplete physiological supplies. These factors may co-exist in people who are socio-economically disadvantaged.
- Some research suggests that having more than an average of 1.5mg per day of vitamin A over many years may affect bone health and make them more likely to fracture as people get older.
- Supplementation of smokers and subjects previously exposed to asbestos with beta carotene has been associated with an increased risk of lung cancer. The mechanism for this effect is unknown but it seems likely that beta-carotene has a tumour promoting effect of some type. The EVM 2003 recommends that, as a matter of prudence, smokers or those exposed to asbestos should not take β carotene supplements [6].



Symptoms

- Deficiency may be subclinical; children at risk include:
 - toddlers and preschool age children living at or below the poverty level
 - children with inadequate health care or immunisations
 - children living in areas with known nutritional deficiencies
 - recent migrants or refugees from developing countries that have a high incidence of vitamin A deficiency and/or infectious disease
 - children with diseases of the pancreas, liver, or intestines, or with inadequate fat digestion or absorption [5]
- Clinical deficiency has numerous health consequences and children and pregnant women are most at risk as demands for vitamin A are higher during growth and pregnancy [7]:
 - Xerophthalmia - the leading preventable cause of blindness in children globally
 - Night blindness, especially during pregnancy when the additional metabolic demands cannot be met by a pre-existing marginal maternal vitamin A status
 - Anaemia
 - Increased susceptibility to infections
 - Failure to thrive
- Practitioners should be alert to the possibility of vitamin A deficiency in at risk migrant patients.

Testing and treatment

Serum retinol is considered to be an insensitive measure of vitamin A status because it is buffered by retinol binding protein [6]. For the purposes of population surveys however serum retinol concentrations below 0.70 $\mu\text{mol/l}$ are used as being indicative of vitamin A deficiency with severe deficiency below 0.35 $\mu\text{mol/l}$ [2]. Although there is not yet international consensus, a serum retinol concentration below 1.05 $\mu\text{mol/l}$ has been proposed to reflect low vitamin A status among pregnant and lactating women [2].

Treatment of vitamin A deficiency is generally based on diet and sometimes use of supplements (particularly for children with deficiency or for those with severe measles under two years of age where vitamin A has been shown to be effective in preventing serious complications). Practitioners should however be aware that vitamin A has toxic effects at high serum concentrations [6], particularly in pregnant women where teratogenic effects have been noted. Treatment with supplements should therefore be carefully monitored.

Vitamin A deficiency is extremely rare in the indigenous UK population and there are no standard UK guidelines for the diagnosis and treatment of vitamin A deficiency. Primary care practitioners who suspect vitamin A deficiency in a migrant patient may wish to seek advice on appropriate diagnosis and treatment from their local endocrinology or paediatric team.

Prevention and control

The Department of Health recommends daily supplementary vitamin drops for all infants from one month to five years [8]. The Healthy Start [external link] Children's vitamin drops contain a combination of vitamins A, C and D and are available free of charge to children aged from 6 months to their 4th birthday in families who qualify for the Healthy Start Scheme [9].

NHS organisations may have local arrangements where they provide them free to those not on the scheme or at a small cost.

[Note that pregnant women or women who may become pregnant, who are not vitamin A deficient should be advised not to take supplements containing vitamin A (including fish liver oils), nor should they eat liver or liver products such as pâté because of the risks of overdose and toxicity [1].]

References

1. Department of Health, Chief Medical Officer. Department of Health Press Release no 90/507. Women cautioned: watch your vitamin A intake. Department of Health, 1990.
2. Global prevalence of vitamin A deficiency in populations at risk 1995-2005 [external link]. WHO Global Database on Vitamin A Deficiency. Geneva, World Health Organization, 2009
3. Report on Health and Social Subjects 41 'Dietary Reference Values (DRVs) for Food Energy and Nutrients for the UK', Report of the Panel on DRVs of the Committee on Medical Aspects of Food Policy (COMA) 1991. Department of Health.
4. British Nutrition Foundation: Vitamins [external link]
5. National Institutes of Health Office of Dietary Supplements. Dietary Supplement Fact Sheet: Vitamin A and Carotenoids [external link]
6. Expert group on vitamins and minerals 2003: Vitamin A (Retinol) [external link]
7. World Health Organization. Micronutrient deficiencies: Vitamin A deficiency [external link]
8. Department of Health. Birth to Five (2009 edition). Chapter 1: Feeding your baby [external link]
9. NHS Healthy Start website [external link]

Vitamin D deficiency

- In addition to the characteristic skeletal disorders resulting from vitamin D deficiency, low vitamin D status has been increasingly associated with a wide range of health problems; however the evidence is inconclusive at present.
- Sunlight is the major source of vitamin D and dark skinned individuals or those who for cultural or religious reasons cover their whole bodies when outdoors are at risk of deficiency, as are those whose diets (vegetarian/vegan) do not contain an adequate vitamin D supply.
- Low status is particularly likely during the winter months for people living in the UK, particularly among those who are dark skinned, wear concealing clothing or are housebound. In the winter months in the UK there is no sunlight of appropriate wavelength for synthesis of vitamin D via the skin and the population relies on body stores and dietary intake.
- Practitioners should be alert to the possibility of vitamin D deficiency in migrants who have the above risk factors and test and treat them appropriately.
- Supplementation is advised for pregnant and breast feeding women and for infants from one month to four years, especially in at risk groups. People of Asian origin, older people and people who rarely go outdoors or who always cover all their skin when they are outdoors, should also consider taking vitamin D supplements.
- Low income families in the UK who receive one of a range of income related benefits and tax credits may qualify for Healthy Start. Pregnant women, women with a child under one and children aged 6 months to their 4th birthday can get free Healthy Start vitamin supplements. The supplements for women and children contain vitamin D.

Background information

- Vitamin D deficiency, which when severe classically causes rickets in children and osteomalacia in adults, has also been linked to a range of other disorders including infectious and autoimmune diseases, cardiovascular disease, type I diabetes and some cancers, however, the evidence is inconclusive at present [1]. The main functions of vitamin D are related to calcium and phosphate metabolism.
- Vitamin D is a fat-soluble vitamin that is produced when ultraviolet rays from sunlight strike the skin and trigger its synthesis. It also occurs naturally in some animal products, including oily

fish (probably the best dietary source), eggs and meat. In the UK fat spreads are fortified with vitamin D and it may be added to other foods such as breakfast cereals. The vitamin D content of most vegetables is negligible. Sunlight (ultraviolet B radiation) is the most important source for the majority of people worldwide.

- People with pigmented skin require considerably greater sun exposure to get the same level of vitamin D synthesis as fair skinned people.
- Populations with inadequate exposure to sunshine, such as housebound or institutionalised people, deeply pigmented persons living in low ultraviolet radiation settings (e.g. the UK) or those who, for religious or cultural reasons cover their entire body surface when they are outdoors, are at increased risk of low vitamin D status, as are people with inadequate dietary sources e.g. non-fish eating, vegetarian and vegan diets.
- A significant proportion of the UK population have low vitamin D status. The National Diet and Nutrition Survey (2000/01) has shown that 15% of the general adult population, aged 19-64, has low vitamin D status (a plasma 25-hydroxy vitamin D concentration below 25nmol/L) which puts them at risk of vitamin D deficiency [2].
- Particularly high rates of Vitamin D deficiency have been found in certain ethnic minority groups including those of south Asian, African, Caribbean, and Middle Eastern descent [3].
- In the winter months in the UK there is no sunlight of appropriate wavelength for synthesis of vitamin D via the skin and the population relies on body stores and dietary intake.
- Infants of vitamin D deficient mothers are at risk of deficiency as are those that are exclusively breast fed beyond six months of age. Poor childhood diet also increases the risk.
- The Healthy Start [external link] scheme provides vitamin drops to children in families who qualify for the scheme from the age of 6 months to their 4th birthday. Pregnant women and those with a child under one year old on the scheme can also get Healthy Start women's tablets which contain vitamin D.
- The children's drops are available to breastfed babies on the scheme from one month on health professional advice if there is any doubt about the mothers vitamin D status during pregnancy.

Symptoms

In adults vitamin D deficiency may present with pain and muscle weakness, or as osteopaenia or low bone density indicating possible osteomalacia. In children, failure to thrive, particularly in terms of height may occur and bone and muscular weakness may lead to bony deformity and impaired respiratory function with increased susceptibility to infections. Severe deficiency can lead to hypocalcaemic seizures or cardiomyopathy and heart failure. Practitioners should be alert to the possibility of vitamin D deficiency in at risk patients with consistent symptoms.

Testing

Vitamin D deficiency is diagnosed most reliably by measuring serum 25-hydroxyvitamin D [4]:

- Less than 25nmol/l (10µg/l) is classified as deficiency and is associated with rickets and osteomalacia.

Treatment

There are no standard UK guidelines for the treatment of vitamin D deficiency, however many areas of the UK now have local guidelines. For a recent British Medical Journal clinical review please see Diagnosis and management of vitamin D deficiency [4].

Prevention and control

The Department of Health recommends daily supplementary vitamin drops for all infants from one month to five years [5]. The Healthy Start Children's vitamin drops contain a combination of vitamins A, C and D and are available free of charge to children aged 6 months to their 4th birthday in families who qualify for the Healthy Start scheme [6].

The vitamin D dietary reference value is 7 micrograms/day for children aged 1-3 years and 10 micrograms/day for adults over 65 years [7].

Pregnancy recommendations are stated in NICE guidelines for antenatal care [8] and in Royal College of Obstetrician and Gynaecologists guidance [9]. All pregnant women and breast feeding mothers should be advised to take supplements containing 10 micrograms of vitamin D each day (such as the Healthy Start women's vitamin tablets which also contain vitamin C and folic acid and are available to women who qualify for the Healthy Start scheme during pregnancy and until their baby is one year old [6]).

All pregnant under 18s qualify for Healthy Start regardless of their income or benefits.

NHS organisations may have local arrangements where they provide Healthy start vitamins free to those not on the scheme or at a small cost.

People of Asian origin, older people, and people who rarely go outdoors or who always cover all their skin when they are outdoors, should also consider taking vitamin D.

References

1. Holick M F. Vitamin D: a D-Lightful health perspective. *Nutr Rev* 2008; 66: S182-S194.
2. National Diet and Nutrition Survey [external link]: Adults aged 19 to 64, Volume 4 2004
3. Vitamin D deficiency in adults. *Drug Ther Bull* 2006;25-29.
4. Pearce S H S, Cheetham T D. Diagnosis and management of vitamin D deficiency [external link]. *BMJ* 2010; 340: b5664.
5. Department of Health. Birth to Five (2009 edition). Chapter 1: Feeding your baby [external link]
6. NHS Healthy Start website [external link]
7. Report on Health and Social Subjects 41 'Dietary Reference Values (DRVs) for Food Energy and Nutrients for the UK', Report of the Panel on DRVs of the Committee on Medical Aspects of Food Policy (COMA) 1991. Department of Health.
8. NICE guideline for antenatal care [external link]
9. RCOG issues new guidance on vitamin supplementation in pregnancy [external link]



Afghanistan	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p> <p>There is a high risk of vitamin A deficiency in this country.</p>
Eritrea	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p> <p>There is a high risk of vitamin A deficiency in this country.</p>
Ethiopia	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p> <p>There is a high risk of vitamin A deficiency in this country.</p>
Iran	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p>
Kuwait	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p>
Sudan	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p> <p>There is a high risk of vitamin A deficiency in this country.</p>
Syria	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p> <p>There is a high risk of vitamin A deficiency in this country.</p>
Vietnam	<p>Consider Vitamin D deficiency in individuals who may be at risk as a result of their diet, skin colour or lack of sun exposure.</p>



Mental health needs

- Remember that mental health problems may present in different ways in people from different cultures e.g. with physical rather than emotional symptoms.
- Always use a professional interpreter to explore mental health issues rather than a family member or friend, and familiarise yourself with both the cultural background and individual understanding of the patient.
- Be alert to the possibility of post traumatic stress disorder in both adults and children and manage according to NICE guidelines.
- Mental health is fundamental to health; mental health affects physical health and physical health affects mental health. The two are inseparable in overall wellness.
- Standard One of the National Service Framework for Mental Health [external link] (Department of Health, 1999) requires health and social services to promote mental health for all, working with both individuals and communities.
- Although most migrants will not suffer from mental health problems, some may be at increased risk as a result of their experiences prior to, during, or after migration to the UK. Milder mental health issues such as 'home sickness', anxiety or sleep disorders may arise for anyone who is separated from family and friends, or integrating into a new community or culture. For some migrants more serious problems may arise as a result of traumatic experiences in their past. The whole spectrum of mental health problems and substance misuse issues common in the indigenous UK population are also common in all regions of the world, affecting every community and age group.
- Practitioners looking after migrant patients should remain alert to the possibility of mental health problems and be aware that they may present in unfamiliar ways. For example some people may express psychological distress in a very physical manner ('somatisation') i.e. descriptions of physical symptoms rather than directly talking about feelings. It is also important for practitioners to remember that they may bring with them their own socio-cultural constructs in determining what is normal and abnormal experience and hence in diagnosing mental illness.
- Social support can be beneficial for anyone's mental health. Try to find out what groups might exist in your local area for particular communities so that you can signpost them to new arrivals.

Post traumatic stress disorder

Some migrants may be affected by post-traumatic stress disorder (PTSD), which develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD sufferers may not present for treatment for months or years after the onset of symptoms despite the considerable distress experienced, but PTSD is a treatable disorder even when problems present many years after the traumatic event. PTSD may present with a range of symptoms including re-experiencing, avoidance, hyper-arousal, depression, emotional numbing, drug or alcohol misuse and anger as well as unexplained physical symptoms. Children may present with sleep disturbance. All those suffering from PTSD should be offered the opportunity to benefit from psychological interventions. This can be achieved by the use of interpreters and bicultural therapists.

For more information on recognition and for management guidelines please see the NICE guideline on post traumatic stress disorder.



Other useful resources

Mothertongue - multiethnic counselling and listening service is a culturally sensitive, professional counselling service where people are heard with respect to their chosen language.

Refugee council

Freedom from Torture - Medical Foundation for the Care of Victims of Torture

Culture, Health and Illness, 4th edition. By Cecil G Helman. London, Arnold. 2000

Mind - mental health support for patients and information for health professionals on certain migrant groups in the UK

Diverse Minds - Black and minority ethnic mental health. Diverse Minds also works with refugee organisations and health providers across England and Wales to improve access to mental health support for refugees and asylum seeker communities.

Asian Women, Domestic Violence and Mental Health - A Toolkit for Health Professionals by EACH

Helen Bamber Foundation - working with survivors of cruelty

Rethink - mental illness charity

Chinese Mental Health Association - provides a range of services and accepts referrals from GPs and health professionals.



Vision and hearing

- Remember that communication problems may not just reflect a language barrier. Check that there is no issue with hearing impairment.
- Detecting and responding to hearing impairment in babies and young children is vital for the development of speech and language.
- Provide information to new patients about optician services in the UK.
- Immediately necessary ophthalmology treatment is exempt from charge under the National Health Service (Charges to Overseas Visitors) Regulations 2011

Hearing

- WHO report that globally, 278 million people are estimated to have moderate to profound hearing loss in both ears [1].
- Eighty percent of deaf and hearing-impaired people live in low and middle income countries and at least half of the total burden is preventable (middle ear infections, excessive noise, inappropriate use of certain drugs, problems during childbirth and vaccine-preventable infections).
- Properly fitted hearing aids can improve communication in at least 90% of people with hearing impairment but in developing countries, fewer than one in 40 people who need a hearing aid have one.
- Hearing impairment in children may delay development of language and cognitive skills, which may hinder progress in school. In adults, hearing impairment often makes it difficult to obtain, perform, and keep jobs. Hearing impaired children and adults are often stigmatized and socially isolated.
- Availability of audiology services is enormously variable between and within countries globally. It is possible that some migrants may have hearing difficulties that have not been detected/assessed/properly managed prior to arrival in the UK.

Vision

- WHO figures state that about 314 million people are visually impaired worldwide, 45 million of whom are blind [2].
- About 85% of all visual impairment is avoidable globally and about 87% of the worlds visually impaired live in developing countries.
- Most people with visual impairment are older, and females are more at risk at every age, in every part of the world.
- Although the number of people blinded by infectious diseases has been greatly reduced, age-related impairment is increasing and, other than in high income countries, cataract remains the leading cause of blindness globally.
- Correction of refractive errors with spectacles could give normal vision to more than 12 million children (ages five to 15), but this option is not available to many.
- Availability of optician/ophthalmology services is enormously variable between and within countries globally. It is possible that some migrants may have visual problems that have not previously been properly addressed prior to arrival in the UK.



References

World Health Organization. Deafness and hearing impairment factsheet

World Health Organization. Visual impairment and blindness factsheet

Safeguarding and child protection issues

- Clinicians should also assess a young person's vulnerabilities to sexual exploitation and risk of trafficking.
- Exposure to violence and rape and other trauma should be explored sensitively. Not all young people are able to disclose on first assessment if they have been raped and this will need careful inquiry, e.g. 'Some young people say that they have been injured or raped. Has that ever happened to you?' This line of questioning should apply to young women as well as young men.
- Clinicians should ask girls/young women if they have been subjected to female genital mutilation (FGM). They should be informed that FGM is illegal in the UK, including when a child is taken out of the country for the procedure, and be provided with a copy of the health passport. If they have been "cut", a referral should be made to a local specialist unit for a follow-up assessment. See the RCPCH FGM webpage for further information, including mandatory reporting and recording requirements.
- Clinicians should also be alert to the possibility of radicalisation and to consider making a Prevent referral.
- Clinicians should ask about current experiences of bullying or racism and consider whether and how a lack of social support or educational place may also increase their vulnerability.
- Safeguarding concerns may also arise following an unsafe environment for the child in temporary accommodation or due to neglect or physical abuse.
- Further information about safeguarding refugees and asylum seeking children can be found in the Child Protection Companion.

Trafficking

Trafficking is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs

For information about warning signs see:

<http://www.stopthetraffik.org/uk/page/spot-the-signs>

There may also be local guidance and policy which you will need to follow.

CSE

Please be aware of the following guideline and assessment tool:

<http://www.bashh.org/documents/Spotting-the-signs-A%20national%20proforma%20Apr2014.pdf>

There may also be local guidance, policy and tools which you will need to follow.

Prevent

Please follow your local guidance

As part of your mandatory training you will have received information on local policy and referral forms

Health Promotion

Health promotion messages are important and paediatricians play an essential role in providing early health promotion messages to young people.

Messages should concentrate on well-established areas such as healthy eating, smoking, how to stay safe and avoid danger, good sexual health (including how to access sexual health services) and when to access GP services. Health promotion messages should be continued by other health care professionals, including specialist nurses for looked-after children and school nurses.

Social Health and Wellbeing

Young people

Enquire about a young person's social networks. This should include questions about who they can talk to; have they started to make friends; do they want to access faith or cultural groups; do they know about college placement or local sports access as a way of starting to carry out normal activities to support good mental health.

Encourage and support resilience as well as addressing painful issues and ask about aspirations should the child/young person not be caught up in war.

Sometimes the views and wishes of the young person may be at odds with carers or social workers. Often there is a cultural reason or misunderstanding for this. Having an interpreter present gives an opportunity when the carer and young person are brought together (with the young person's permission) to allow some of these issues to be addressed in a way that acknowledges their needs, together with those of the carer or society, order to make their future easier.

Remember that a young person's expectations can be very different in different cultures, and they may also have had difficult experiences with people in a position of authority in the past.

It is recommended that you also talk to the child, young person or family about their past experience of education.

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Further reading

- Faculty of Public Health. 2008. The health needs of asylum seekers
- Promoting the health and wellbeing of looked-after children.
- RCPCH. Refugee Guidance. 2009.
- Nice guidance
- Refugee Council. The Children's Section.
- Save the Children. Providing emotional support to young separated refugees in the UK
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