

# Guidelines for blood borne infection testing in unaccompanied asylum seeking children and young people (UASC)

This guidance has been produced for professionals working with UASCs and is based on current evidence and recommendations from BASHH, CoramBAAF, RCPCH, RCGP, NICE and BHIVA.

Further information can be found in the British Association for Sexual Health and HIV guidelines: <http://www.bashh.org/BASHH/Guidelines/Guidelines/BASHH/Guidelines/Guidelines.aspx>

## What do we mean by the term blood borne infection (BBI)?

Blood borne infections are the blood borne viruses: Hepatitis B, Hepatitis C, HIV and the non-viral infection syphilis.

### *Hepatitis B*

Hepatitis B infection can cause both acute and chronic liver disease. Acute hepatitis B (a notifiable disease) is liver inflammation lasting one to six months, which, occasionally can lead to liver failure. Chronic hepatitis B (CHB, not a notifiable disease) comprises a lifelong infection characterized by liver inflammation and damage that can lead to morbidity and in some cases mortality from cirrhosis and liver cancer.

The risk of liver cancer is much higher in children infected at birth. Unlike individuals infected in later life, where 90–95% clear the virus completely, 90% of infants infected at birth do not clear the virus and are at risk of the long-term problems described above. HBV is much more easily transmitted by blood-borne routes than HIV. A small proportion of people with HBV are highly infectious. HBV is preventable by immunisation.

The prevalence of Hepatitis B varies markedly worldwide. High endemicity is seen in south-east Asia, sub-Saharan Africa, parts of the Middle East, the central Asian Republics, the Pacific Basin (excluding Japan, Australia and New Zealand) and some countries in Eastern Europe.

### *Hepatitis C*

HCV is a blood-borne ribonucleic acid (RNA) virus that exists as a number of different strains (genotypes) and an important cause of liver disease. The effects of the infection vary from one individual to the next. Some people will remain symptom free, some will develop cirrhosis and others will develop liver failure or hepatocellular (or primary liver) cancer.

The prevalence of Hepatitis C (HCV) varies globally. Afghanistan, Eritrea, Sudan and Vietnam are considered to have a considerably higher prevalence of infection than the UK.



## **HIV**

Human immunodeficiency virus (HIV) is a retrovirus that causes acquired immunodeficiency syndrome (AIDS), a condition in which the immune system begins to fail, leading to life-threatening opportunistic infections.

Ethiopia and Sudan have significant prevalence rates.

## **Syphilis**

Syphilis is a bacterial infection that in adults initially causes sores and then progresses to give rashes and generalised symptoms. Over many years, untreated syphilis can cause serious damage to many systems in the body and may result in death. Congenital syphilis (babies and children who acquire syphilis from their mothers during pregnancy) can result in multisystem organ damage (e.g. to the brain, bones, teeth and eyes).

## **Transmission of BBIs**

The main routes of transmission of HIV and Hepatitis B are sexual, blood- to-blood and mother-to-child

The main route of transmission of Hepatitis C is blood-to-blood, especially through injecting drug use

The main route of transmission of Syphilis is sexual contact.

## **Why are UASCs at risk of BBIs?**

The prevalence of viral infections varies in different countries and many UASC arrive from countries where blood-borne infections are highly prevalent. Some of them will have experienced rape and torture and some will have worked as commercial sex workers either before, en route to, or following arrival in the UK. Others will have been in consensual sexual relationships.

Many countries do not have universal antenatal screening for BBIs and CYP who have contracted blood-borne infections from their mothers can remain well for many years.

Please note that our UASCs may be reluctant to disclose a history of sexual assault and the issue needs to be addressed specifically in a sensitive manner.

## **Why test for BBIs?**

It is important that any test carried out on a Child or Young Person (CYP) is done in the best interests of the CYP, which should be decided in the context of a comprehensive paediatric assessment (Statutory Initial Health Assessment). Due to advances in the treatment of blood-borne infections, there are real advantages in determining the status of CYP who may have been exposed to infection.

It is recommended that all children up to 18 years of age who are at risk of blood-borne infections should be tested. In the majority of cases our UASCs are considered to be at high risk of blood borne infection and we are aware that recently, many have tested positive for Hepatitis B. Given that it is not uncommon for people to have more than one of these infections at the same time, the current recommendation is that our UASCs are tested for all four of the infections (Hepatitis B, Hepatitis C, HIV and syphilis).



## The Benefits of Testing for BBIs

- A known infected young person can receive treatment and care
- Early diagnosis and treatment is associated with better outcomes
- CYP receiving treatment are more likely to remain well and live longer than those not in treatment
- Testing can encourage CYP to change behaviours which put them at risk of infection or further illness
- Testing can allay anxiety even if the result is positive
- Diagnosed CYP are more likely to take action that will reduce the risk them infecting others
- A diagnosed CYP can inform their sexual partners and other at-risk contacts so that they may seek BBV testing as well.

### Consent

It should be within the competence of any doctor, midwife, nurse or trained healthcare worker to obtain consent for and conduct a blood test for BBIs.

HIV testing has historically been exceptionalised and treated differently to testing for other serious medical conditions. The outlook for individuals testing positive for HIV is now better than for many other serious illnesses for which clinicians routinely test. Pre HIV test counselling is no longer required.

However, it is vital that the CYP gives consent to the blood test for BBIs. It is good practice to have a pre-test discussion to establish informed consent for BBI testing. Lengthy pre-test HIV counselling is not a requirement, unless a patient requests or needs this.

The essential elements that the pre-test discussion should cover are:

- the benefits of testing to the individual
- details of how the result will be given
- the implications of a “positive test”

As with any other medical investigation the discussion should address any other issues, which may be raised by the CYP as it is important that CYP are given the opportunity to make a decision with adequate information about the test and the virus. A leaflet has been created: Blood Borne Infection Information Leaflet for Young People and a podcast explaining this is available. CYP should also be given the opportunity to raise additional queries and/or discuss concerns with a clinician via an interpreter. In most cases informed consent will have been obtained by the clinician undertaking the Initial Health Assessment but in some cases this will need to be done by the clinician taking the blood. It is good practice for signed consent to be obtained and this has been added to the information leaflet (Appendix 1).

If the CYP refuses a test the reasons why they have made that choice should be explored to ensure that these are not due to incorrect beliefs about the infections or the consequences of testing.

It is essential to ensure that the CYP have understood what is proposed, and why. It is also important to establish that the CYP understands what a positive and a negative result mean in terms of infection as some CYP could interpret 'positive' as good news.

### Who can consent?

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.

A child or young person with capacity to consent, who refuses, should have their decision respected unless there are exceptional circumstances. As with any other investigation the offer of BBI testing should be documented in the CYP's case record together with any relevant discussion. If the CYP refuses a test the reasons for this should be documented.

Children and young people under the age of 16 should still be involved in the pre-test discussion and be given all the necessary information to consent but consent is required by a senior social work manager (not the same as the child's social worker).

### ***BBI Results***

The result of BBI tests (if positive) should be given directly by the testing clinician (or team) to the patient and not via any third party, including social worker, personal adviser or other clinical teams unless the patient has specifically agreed to this.

As with any medical investigation it is essential that clear procedures are established as to how the CYP will receive the result, with particular attention paid to the means by which a positive result will be delivered.

Arrangements for communicating the results should always be discussed and agreed with the CYP at the time of testing, particularly if the test is being performed in an outpatient or emergency care setting.

Face-to-face provision of BBI test results is strongly encouraged for:

- patients more likely to have an HIV-positive result
- those with mental health issues or risk of suicide
- those for whom English is a second language
- young people under 16 years
- those who may be highly anxious or vulnerable.

As is good clinical practice for any situation where bad news is being conveyed, the result should be given face to face in a confidential environment and in a clear and direct manner with the assistance of an interpreter.

If a positive result is being given by a non-GUM/HIV specialist, it is essential, prior to giving the result, to have clarified knowledge of local specialist services and have established a clear pathway for onward referral.

If any of the results are positive, the information should be given in a clear and sympathetic way. Allow time for the young person or carers to react to the news. Listen to their response and help them talk through what it means.

In the case of HIV, it is very important to explain that HIV is a treatable disease now, and not a death sentence as many people still believe.

It is important to identify who will support the young person and help them to think about who else they would like to be told. Contact numbers should be given and an early follow-up arranged with the appropriate specialist.

### ***Non-attendance for positive results***

It is recommended to have an agreed recall process following failure of a patient to return for a positive result as with any other medical condition.

As with all other medical investigations it is the responsibility of the healthcare professional requesting the test to ensure that all results of investigations requested are received and acted upon where necessary.



If there is no means of contacting the patient or if attempts are unsuccessful, it is recommended that advice be sought from the local GUM/HIV team who are likely to have experience and resources to deal with this issue.

### **Confidentiality**

There are many circumstances where those involved in caring for a child (e.g. social worker, personal adviser, foster carer, college staff and other support services) do not require knowledge that the CYP has a blood-borne infection. However, sometimes knowledge of blood-borne infections is important for the child's medical or emotional wellbeing. The Data Protection Act 1998 and guidance recognises that there are circumstances where persons involved with the CYP may need that information for the purpose of the CYP's care.

Before disclosing information about blood-borne infections to any agency or individual, the following matters need to be taken into account in reaching a decision.

- Is disclosure in the best interests of the child, and if so, why?
- What information needs to be disclosed and to whom?
- Do those with parental responsibility/ies or the competent CYP consent to the disclosure?
- Are there risks to the carers/agency staff if the information is not disclosed?
- What are those risks?
- What is the ability of those receiving the information to maintain confidentiality?

In the event that there is objection on the part of the competent child and, having taken such information into account, the local authority is still of the view that the information should be disclosed, then the objecting party should be given adequate opportunity to seek legal advice before the information is disclosed. In all such cases, the local authority should seek legal advice before disclosure.

Whilst there remains stigma associated with HIV infection, this can be minimised by following the general principles of confidentiality for any medical condition as laid down by the GMC in its guidance *Confidentiality: protecting and providing information* [20]. 'Patients have a right to expect that information about them will be held in confidence by their doctors. Confidentiality is central to trust between doctors and patients. Without assurances about confidentiality, patients may be reluctant to give doctors the information they need in order to provide good care.'

## **Taking the Blood Tests**

The clinician undertaking the CYP's IHA may have already completed a microbiology blood test request form. If not this needs to be completed. An EDTA sample can be used for all the tests.

### **What to Request?**

- HIV and HCV antibody (serology) tests
- HBV – full clinical details including the reason for testing and any previous HBV immunisation history will allow the lab to determine the correct antibody and antigen tests to run
- HCV PCR –the lab will usually run this test on all new HCV antibody positive tests to see if there is evidence of active infection
- Syphilis – VDRL test

