## Checklist for migrant children and adolescents new to Switzerland

This checklist is a rough guide needing adaptation to individual needs according to the patients' and families' situation, as not all items may apply to all patients. None of the suggestions are binding. We recommend distributing it over different consultations with a focus on building good trust relations in the beginning; [(1)] suggested for first, [(2)] potentially delayed to follow-up consultation(s). AS/R stands for Asylum-seeker/Refugee.

Depending on needs children are often seen again after a few days (in case of Mantoux or to discuss results) (V1 b) at 1 Month (V2), 2 Month (V3) and 6 Month (V4) depending on needs.

Country of Origin: ______________________________________________

Cause for migration: ____________________________________________

Transfer: □ direct, □ via: _________________________________________

Duration of travel if not direct: ____________________________________

Date of first arrival in Switzerland: _________________________________

Stay in Federal Asylum Center: ☐ no; ☐ yes, currently; ☐ yes, previously

If yes: place ___________________

If yes: Medical file from previous medical visits in federal asylum center: ☐ no ☐ yes

Current permit: _________________________________________________

Languages and proficiency: □ no interpreter needed, □ preferable, □ necessary

Language for Interpreter if needed: ____________________________

Potential Social Worker/ Mentor/ Volunteer contact: _____________________

Lodging (condition, nr of rooms…):

_______________________________________________________________

### History

| Concerns Path. findings | | | Comments |
|---|---|---|---|
| Yes | No | | |
| □ | □ | [(1)] Acute Condition? Current Parental/Patient concerns?<br><br>(currently sick, acute complaints, immediate danger for Pt/family -> treat accordingly) | |

| | | | |
|---|---|---|---|
| ◻ | ◻ | [1] Acute complaints | |
| ◻ | ◻ | [1] Abdominal complaints, Diarrhea, Vomiting? | |
| ◻ | ◻ | [1] Cough? | |
| ◻ | ◻ | [1] Recurrent fever? | |
| ◻ | ◻ | [1] Other? | |
| ◻ | ◻ | [1] Patient medical history | |
| ◻ | ◻ | | |
| ◻ | ◻ | Development (motor, language, etc.) | |
| ◻ | ◻ | Adjusting to new situation (school, friends…) | |
| ◻ | ◻ | Psychological (Anxiety, Depression, Drugs, Sleep disturbances) | |
| ◻ | ◻ | Endured physical abuse? Sexual abuse? Psychological Violence? | |
| ◻ | ◻ | [1] Separation from close family-members: in home country or when traveling: specify | |
| | | | |
| ◻ | ◻ | [1] Family medical history/medical conditions<br><br>(depending on origin/situation (e.g. AS/R): cough? TB? HIV? Early death? | |
| | | | |
| ◻ | ◻ | Female genital cutting<br><br>◻ family ◻ mother ◻ patient | |

**Physical Examination**

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | [1] Weight: _____ kg Height: _____ cm<br>BMI: _____ kg/m2<br><2 years : head circumference:__________ | |
| ☐ | ☐ | BP _____ / ______ | |
| | | | |
| ☐ | ☐ | [1] Physical exam (general, Heart, Pulmo, Abdo/HSM, ENT) | |
| | | | |
| ☐ | ☐ | Vision/Eyes | |
| ☐ | ☐ | Hearing/Ears | |
| ☐ | ☐ | Teeth | |
| ☐ | ☐ | Skin | |
| | | | |
| ☐ | ☐ | [2] Genital (preferably not first visit, if from FGC-practicing country document presence/absence for legal reasons) | |
| ☐ | ☐ | Puberty status | |
| | | | |
| ☐ | ☐ | Musculo-sceletal (e.g., Scoliosis) | |
| ☐ | ☐ | Basic Neurological | |
| ☐ | ☐ | Normal psycho-motor development (see SSP check list) | |

**Tuberculosis risk with indication of test**

| Indicated | Tested | Not indicated | Tuberculosis Testing | Planned for |
|---|---|---|---|---|
| □ | □ | □ | • < 5 years and AS/R, High risk country (origin or transit)<br>All ages if<br>• Symptomatic<br>persistent cough (>2 weeks), unremitting cough, weight loss/failure to thrive, persistent (>1 week) unexplained fever (>38°C), persistent, unexplained lethargy or reduced playfulness: activity reported by the parent/caregiver, night sweets, Pneumonia not responding to Antibiotics, Gibbus, Meningitis, esp < 1y of age<br>• Post exposure<br>• Immuno-compromised | |
| | | | Mantoux for < 5 y, for ≥ 5 y IGRA possible,<br>Avoid Mantoux testing during the days after administrating an MMR-vaccine. Simultaneous application is feasible. | |
| RESULT IF TESTED : | | | | |

**Vaccinations**

| Yes | No | Assessment |
|---|---|---|
| □ | □ | Previously vaccinated as reported by caregiver |
| □ | □ | Vaccination records available (take a photocopy) |
| | | |
| □ | □ | For asylum-seekers: vaccines received recently (transit/ in Swiss-center) |

*Vaccinations indicated (unknown/insufficient number), up to date or not indicated for the age according to the Swiss Vaccination recommendations incl. specific ones for refugees (italic)*

Only documented vaccines or positive Serologies count

| Indicated<br>Indicate number of doses missing if known | Up-to date | Not indicated | | Vaccination planned for | |
|---|---|---|---|---|---|
| | | | | Depending on results | |
| □ ____ | □ | □ | **Tetanus (with diphtheria and pertussis)**<br>*If unknown:*<br>□ vaccinate doing a full catch-up course<br>*or*<br>□ do tetanus titer ideally 4-6 weeks after initial booster and vaccinate accordingly:<br>• ≥ 1000 IU/l: no further tetanus immunization is needed<br>• ≥ 500 and <1000 IU/L: single additional | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | dose 6 months after the first one<br>• < 500 IU/L: two further doses 2 and 6 months after the first one<br>If vaccinated within last 6 months -> titer possible<br><br>Booster use: <8y: Infanrix (ev Hexa)®, ≥8y: Boostrix® polio<br><br>Use vaccines including Di Per and for first dose Pol; Include Hib if <5 years | | |
| □ ___ | □ | □ | **Polio (to include in catch-up vaccination at least 1x if unknown)** | | |
| □ ___ | □ | □ | **Hepatitis B**<br><br>*If unknown:*<br><br>□ vaccinate directly (full course)<br><br>*or*<br><br>□ Hep B-Ab-titer ideally 4-6 weeks (up to 6 months ok) after booster and vaccinate accordingly (see below) | | |
| □ ___ | □ | □ | **MMR** | | |
| □ ___ | □ | □ | **Pneumococci** (< 5 years) | | |
| □ ___ | □ | □ | **Meningococci** (2-5 years, >11 years) | | |
| □ ___ | □ | □ | **VZV** > 11 years or AS/R in refugee-centers | | |
| □ ___ | □ | □ | **HPV > 11 years** | | |
| □ ___ | □ | □ | **Hepatitis A**: if outbreak in refugee center or travelling to high prevalence country. Serology before vaccination can be considered depending on age and origin. | | |
| | | | | | |
| □ ___ | □ | □ | **Consider FSME depending on risk** | | |
| □ ___ | □ | □ | **Consider Influenza depending on risk** | | |

**Serologies**

| Indicated | Available | Not indicated | Indication: Groups at risk, Country of Origin or Transit |
|---|---|---|---|
| ◻ | ◻ | ◻ | **Hepatitis B** (HbsAg, anti-Hbc)<br><br>All AS/R; Africa, Asia, Central/South-America and potentially Eastern Europe if > 12 years of age, for infants/newborns: if mother has negative serology: no testing; history of sexual abuse |
| ◻ | ◻ | ◻ | **HIV 1 /2**<br><br>Mother HIV +,<br><br>Clinical signs<br><br>Other risk factors: child separated from birth-mother, history of sexual abuse, history of blood product transfusion, unprotected sexual activity, > 15 y,<br><br>Origin with increased risks: Sub-Saharan Africa, Caribbean, central Asia<br><br>No general testing of children from high risk countries with known negative maternal serology<br><br>Only test if consent obtained |
| ◻ | ◻ | ◻ | **Syphilis**<br><br>Sexually active, history of abuse, suspicion of congenital infection, <2 years and no info on maternal serologies (especially if Sub Sahara Africa) |
| | | | |
| ◻ | ◻ | ◻ | **Chagas**:<br><br>>9Mte old from Latin America (esp. Bolivia/ poor conditions),<br><br>for newborns if status of mother unknown or positive: direct exam and PCR in the first month of life (umbilical cord blood or peripheric blood) + serology at 9 months of age. |
| ◻ | ◻ | ◻ | **Strongyloides**:<br><br>Africa, South-East Asia – especially if likely to become immuno-compromised immunocompromised (any origin)<br><br>For West Africans: Ivermectin may be dangerous in the presence of Loa loa -> get specialist advice |
| ◻ | ◻ | ◻ | **Schistosoma** –Serology + ev CCA in urin<br><br>all African and Middle Eastern countries; Brazil, Venezuela, Surinam,<br>Southern China, Indonesia, the Philippines, the Laos and Cambodia<br>NOT: Turkey, Iran, Afghanistan, Sri Lanka.<br>http://www.who.int/mediacentre/factsheets/fs115/en/<br><br>(especially, if bath in still or slow moving water)<br><br>-> if positiv or symptomatic: Stool/Urin test; |

| | | | |
|---|---|---|---|
| | | | Praziquantel is contraindicated in patients with Neurocysticercosis: get specialist advice, especially if neurological complaints/ seizers are present! |
| | | | |
| □ | □ | □ | **Hepatitis A**<br><br>Potentially search for immunity (especially if from Afghanistan, Sub-Saharan Africa) instead of vaccinating (AS/R; growing-up in Europe but travel low/middle income country or frequent visitors of such origin) |
| | | | |
| □ | □ | □ | **Malaria**<br><br>rapid testing/smears if febrile + from endemic area |
| | | | |
| | | | *Potentially if vaccination catch-up strategy based on serology is chosen:* |
| □ | □ | □ | **Tetanus titer up to 6 months after vaccine given ( ideally 4-6 weeks after vaccine given)** (see above) |
| □ | □ | □ | **Anti-HBS-Ab ideally 4-8 weeks after vaccine given**<br><br>If anti-HBs ≥100 IU/L immune, no further doses<br><br>If anti-HBs 10-99 IU/L: give 1-2 more doses depending on age (0-10y: 2x Engerix 10; >11 y: 1x Engerix 20 (if Hep A neg: ev 1 Twinrix + 1 Havrix after 6 months)<br><br>If anti-HBs <10 IU/L: complete vaccination and do HbsAg |

**Intestinal parasites**

| Indicated (potentially) | Results available | Not indicated | | | Planned for: |
|---|---|---|---|---|---|
| □ | □ | □ | AS/R, low and middle income countries | | |
| Options: | | | Preferable if: | | |
| □ | 1-3 x stool exams:<br><br>Gardia lamblia Ag in stool + protozoae/helmints | | | - if abdominal complaints, eosinophilia growth retardation, anemia, develop. delays<br><br>to exclude intestinal parasites it takes up to 3 stool exams | |
| □ | Albendazol 1-<2years: 200 mg po 1x:<br>>2 years and >10 kg: 400mg po 1x | | | - if asymptomatic, but exposure risk | |
| □ | Gardia Lamblia Ag in Stool + stool on protozoa/helminthes (SAF) once | | | - if asymptomatic, but exposure risk | |
| □ | no exam / no treatment<br>(await self clearance if parasites present) | | | - if asymptomatic +/- exposure risk | |
| □ | Other: | | | | |
| | Notes/Results:<br><br>PS: If stool positive in family member: consider 1x stool or treatment | | | | |

### Further Tests

| indicated | Results available | Not indicated | Blood | Planned for: |
| --- | --- | --- | --- | --- |
| ☐ | ☐ | ☐ | **Full blood count** (ideally with differential) | |
| ☐ | ☐ | ☐ | **Ferritin**<br><br>(all if AS/R, Low/Middle Income, Anemic, Fe-poor diet) | |
| ☐ | ☐ | ☐ | **Vit D:** dark skin, poor sunlight exposure (very covered clothing), alternative: direct treatment | |
| | | | | |
| | | | **Other** | |
| ☐ | ☐ | ☐ | Search for Chlamydia, Gono etc., ev. pregnancy<br><br>if sexual abuse, unprotected intercourse | |

### Other

| Yes | No | ? | **Female genital cutting** [2] | Planned for |
| --- | --- | --- | --- | --- |
| ☐ | ☐ | | Potential Female genital cutting risk<br><br>Egypt, Sub-Saharan Africa, Kurds, Indonesia, Malaysia …<br><br>http://data.unicef.org/resources/female-genital-mutilation-cutting-country-profiles/ | |
| ☐ | ☐ | ☐ | Genital Status: cut<br><br>if yes: describe/ note type : ___________________________<br><br>Write if patient/family declined exam:___________________ | |
| ☐ | ☐ | | Prevention information given:<br><br>Medical: Harmful practice even if minor forms<br><br>Legal: punishable even if performed abroad<br><br>(see guidelines) | |

**Prevention Information discussed:**

□ [2] Nutrition (no sweet beverages etc., adapting to local ingredients)

□ [2] Limitation of Screen-time, importance of physical activity

□ [2] Information on out-side activities, social activities and integration offers available

□ [2] Accidents

□ [2] Travel back to home country (e.g., malaria prophylaxis, vaccines, FGM/C) -> consult before travel

□ [2] For adolescents: sexual education, contraception, drugs, confidentiality, avoiding physical conflicts

□ Seeking medical care: where to go in an emergency [1], when to see paediatrician / family doctor [2]

□ General age-related advice (e.g., Sudden infant death etc.)

**Suggested next visits:** (e.g., write date or months):

For additional information on chatch-up vaccinations consult the recommendations of the federal officice of public health: Empfehlungen für Impfungen sowie zur Verhütung und zum Ausbruchsmanagement von übertragbaren Krankheiten in den Asylzentren des Bundes und den Kollektivunterkünften der Kantone, BAG
https://www.bag.admin.ch/bag/de/home/krankheiten/infektionskrankheiten-bekaempfen/infektionskontrolle/gesundheitsversorgung-asylsuchende.html

The checklist was developed by the Reference group migrant child health of the SSP and is based on: PIGS guidelines 2016; Klinische Betreuung von Migranten, Fokus Pädiatrie, Paediatrica, Gehri et al. 2016; Data from GE; Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA, ECDC; Empfehlungen für Impfungen sowie zur Verhütung und zum Ausbruchsmanagement von übertragbaren Krankheiten in den Asylzentren des Bundes und den Kollektivunterkünften der Kantone, BAG; www.kidsnewtocanada; Fougère Y, High coverage of hepatitis B vaccination and low prevalence of chronic hepatitis B in migrant children dictate a new chatch-up vaccination, Vaccine, 2018; We thank SwissTPH and FOPH and practicing paediatricians for Inputs/Advice received.