Fifteen-minute consultation: What do paediatricians need to know about child refugee and migrant health needs?

Aoife Ryan ,[1] Alison Kelly[2]

[1]Department of General Paediatrics, Royal Hospital for Children, Glasgow, UK
[2]Department of Community Paediatrics, Skylark Child Development Centre, Inverclyde Royal Hospital, Greenock, UK

Correspondence to
Dr Aoife Ryan, Department of General Paediatrics, Royal Hospital for Children, Glasgow, G51 4TF, UK; aoife.ryan2@nhs.scot

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Increasing numbers of refugees have entered Europe over recent years, reflective of international crises caused by conflict in Afghanistan, Syria and the Horn of Africa. Approximately one-third are children and young people aged under 18 years, many unaccompanied. These individuals often arrive at their most vulnerable following hazardous journeys with complex healthcare needs.[1 2]

In 2019, more than two-thirds of the global refugee population originated from just five countries: Syria, Venezuela, Afghanistan, South Sudan and Myanmar. In the same year, only 0.5% of the world's refugees had successfully resettled elsewhere.[3]

By 2020, around 82.4 million people worldwide were forcibly displaced from their homes. Of these, 26.4 million were refugees, while 48 million were internally displaced within their country of origin. Eighty-six per cent of the world's refugees are hosted within low-income countries. The UK is home to roughly 1% of global refugees.[4]

Nearly 7.7 million Ukrainians (ie, one in six) have been internally displaced since the Russian invasion of the country began in February 2022. As of October 2022, almost 14 million refugees have fled Ukraine, two-thirds of whom are children.[4]

Unaccompanied children arriving in the UK should be offered an initial health assessment through the statutory requirement for looked-after children. However, accompanied children and young people may present to a range of services (including general, community or acute paediatric services); it is therefore imperative that all paediatricians are equipped to identify and manage the unmet health needs of these children and young people. Table 1 delineates the terminology used to describe such individuals.

This article aims to highlight the important initial issues to consider when assessing a child or young person with unmet health needs while directing them to useful resources and appropriate services. A comprehensive health assessment is a lengthy process which is usually undertaken by paediatricians with expertise in reviewing health needs in vulnerable children; however, any paediatrician may be presented with issues related to refugee and migrant health.

BARRIERS TO ACCESSING HEALTHCARE FOR NEWCOMERS

Common challenges include:

- Language barriers.
- Lack of knowledge regarding how to access services.
- Administrative difficulties, for example, lack of identification or proof of address.
- Healthcare debts/fear of arrest.
- Aversion to official registration during transit through a 'safe' country.
- Costs associated with attending appointments can be prohibitive—both direct (eg, National Health Service (NHS) overseas visitor charges/healthcare user fees) and indirect (eg, travel) costs.[2 5]

RefuNET, a cross-sectional survey study among 148 respondents from 23 European countries, demonstrated a lack of preparedness for looking after refugee children and young people in urgent and emergency care. Obstacles to care were identified as language barriers, poor mental health and safeguarding issues, alongside insufficient information regarding medical history.[1]

PAEDIATRIC HEALTH ASSESSMENT

- Adopting a trauma-informed approach to history taking is recommended.[2]

Table 1 Glossary of useful terms for health professionals[2 4 5]

Refugees	Persons who have left their country of origin (usually due to war or persecution, eg, because of ethnicity, sexuality, religion or political beliefs) and have crossed international borders in order to find safety in another country. Refugees are protected by international law under 'The 1951 United Nations convention relating to the status of refugees' (of which the UK is a signatory)—this states that the persons must not be returned to their country of origin if they are deemed to be at risk. By default within the UK, individuals are granted refugee status for 5 years and are eligible for family reunion (one spouse and any child of that marriage <18 years). Thereafter, refugees can apply for ILR.
Persons seeking asylum ('asylum seekers')	Persons who have left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded. In the UK, these persons have applied for protection under the Geneva Convention and are awaiting a decision from the Home Office.
Refused asylum applicants	Persons whose asylum application has been unsuccessful. Some will voluntarily return home; others are forcibly returned. These individuals are at high risk of homelessness and destitution. Over two-thirds of all UK asylum applications are rejected, while nearly 40% of appeals are successful (often involving a lengthy process).
Unaccompanied asylum-seeking child	Young persons deemed to be <18 years of age with no adult to care for them; entitled to the same rights as other looked-after children and young people (including support for accommodation, finance, education, statutory health assessments and reviews).
Family reunion	Incorporates spouses and children aged under 18 years of a person who is given refugee status; these individuals are given 'ILR', that is, permanent residence within the UK.
Migrant	A person who has moved to another country for other reasons, for example, to find work. Of note, when using the term 'child migrant' in this article, we are referring to both forced and economic migrants.
Undocumented migrants	Refers to people who do not have any formal immigration status/leave to remain (ie, persons who have not entered the UK through an official border entry point). These individuals do not have recourse to public funds.

ILR, indefinite leave to remain.

- Gather a comprehensive set of information at the initial meeting with the child or young person (thus mitigating the possibility of repetitively reliving trauma and loss).
- Include consideration of what has happened to the child, young persons±their family prior to UK arrival, from their country of origin through any countries of transit to their final destination.
- Use a structured proforma to avoid missing health needs (eg, the Royal College of Paediatrics and Child Health (RCPCH) 'checklist for refugee and unaccompanied asylum-seeking children').[6]
- Be aware of cultural differences in the significance of any identified health concerns.
- Use professionally trained interpreters, either in-person or via telephone, to help establish rapport and o communicate effectively with families (avoid using family members).[2 6]

Following history attainment, perform a 'head-to-toe' functional enquiry of any symptoms that have not been addressed. For physical examination, first gain consent and explain to the child what is happening throughout (see table 2 for full details of what to focus on in both history and examination).

- Does the child look well versus acutely or chronically ill?
- What is their overall demeanour? (happy, depressed, anxious or fearful).
- Any visible signs of congenital infections (eg, microcephaly or dysmorphic features).
- Inspect hair and scalp for fungal infection or presence of infestation such as lice.
- Check for skin lesions (including areas of hypopigmentation or hyperpigmentation, impetigo or scabies).
- Note evidence of oral candidiasis, herpetic ulcers or nasal polyps (suggestive of cystic fibrosis).
- Examine for lymphadenopathy.[6 7]

AGE ASSESSMENT

Age assessment is an issue specifically for asylum-seeking young people; because many asylum seekers lack official documentation of their birth date, other methods of age assessment are therefore being undertaken across the UK to ascertain whether they are under 18 years of age. This will have implications for their asylum claim outcome, along with their ability to access health services, education and welfare support.[2 6]

The RCPCH does not endorse paediatrician involvement in age assessments of asylum-seeking young people due to concerns regarding the poor evidence base for the use of radiology in age investigation, alongside ethical considerations relating to the adverse clinical and psychological impact on children (including ionising radiation exposure without informed consent and in the absence of any clinical benefit). Article 3 (1) of the 'Convention on the Rights of the Child' states that the 'best interests' of every child 'shall be a primary consideration' in actions undertaken regarding decisions pertaining to their care.[6]

Currently, the Home Office and the Association of Directors of Children's Services have produced joint working guidance about how UK Visas and Immigration decide asylum applications in England, while governmental age assessment guidance has also been developed in both Scotland and Wales.[6]

Table 2 Paediatric health assessment (consult RCPCH guidance)[6 7]

History/examination component	Areas of importance
Past health	► Previous illnesses, hospitalisations, operations, accidents and tropical diseases. ► Immunisation history. ► History of specific conditions, for example, HIV/AIDS, hepatitis, tuberculosis and leprosy. ► Include specific questions regarding injuries.
In preschool children*	► Document pregnancy and perinatal history (plus any antenatal screening). ► Developmental delay—do not assume issues are solely due to the refugee experience.
Family health	► Enquire routinely about consanguinity, sibling health and familial illnesses.
Social history	► Assess current housing and living conditions, including issues of crowding, safety and access to local support services. ► Ask about nursery±education provision; all children in the UK are legally entitled to an education (irrespective of their immigration status).
Physical health	► Undertake a complete systems examination. ► Include overall appearance, vision and hearing, dentition, nutritional assessment, skin conditions and puberty.
Dietary history	► Current and past diet (at home, in transit and in refugee camps). ► Has the child ever exhibited pica or consumed unpasteurised milk?
Development	► Document developmental milestones (play and learning, schooling and learning difficulties). ► Refer preschool children for formal community paediatrics developmental assessment and follow-up if any concerns. ► Consider evidence of regression/undiagnosed neurodevelopmental disorders.
Migration/displacement history	► Assess characteristics of where a child was born and raised (if different from birthplace). – Climate (arid, seasonally dry and wet, tropical or temperate). – Setting (rural or urban). – Housing conditions. – Water and food sources. – Predominant insects and animals (determine arthropod-borne infections/zoonoses risk). ► History of travel from their country of origin. ► If living in a refugee camp, where/how long?
Safeguarding and child protection	► Assess a young person's vulnerabilities to sexual exploitation, risk of modern slavery and trafficking. ► Sensitively explore exposure to violence, rape and other potential traumas. ► Document any injuries on a body map (via the RCPCH Child Protection Companion).
Other considerations	► Note presence of tattoos and consider risk of blood-borne diseases (eg, hepatitis B or HIV). ► Ask about any near drowning/resuscitation episodes if travel involved a sea journey. ► Exposure to contaminated freshwater (risk of helminth infection or schistosomiasis).

*If there is no history of neonatal screening, be aware that treatable conditions, for example, hypothyroidism, could be missed.

AIDS, Acquired immunodeficiency syndrome ; HIV, Human immunodeficiency virus; RCPCH, Royal College of Paediatrics and Child Health.

MALNUTRITION ASSESSMENT

Rates of malnutrition are high in refugee children from resource-poor areas. In many countries in sub-Saharan Africa, for example, one in four children are underweight and undernutrition is a leading contributor to childhood morbidity and mortality. Malnutrition (including vitamin and micronutrient deficiencies) may not manifest any clinical symptoms or may present as failure to thrive, muscle wasting or stunted growth.[7]

Assess for physical evidence of malnutrition: document weight, height and head circumference; plot measurements on age and sex-appropriate UK WHO growth charts available via the RCPCH website. If malnutrition is suspected, measure mid-upper arm circumference.[6 8]

Encourage those eligible for the NHS 'Healthy Start' scheme ('Best Start Foods' in Scotland) to apply: pregnant women/those with children under 4 years; monthly free vouchers or financial support to purchase cow's milk, fruits and vegetables, infant formula milk and pulses, in addition to supplementary vitamins.[2 6] See table 3 for further information on prevention, detection and treatment of prevalent vitamin and micronutrient deficiencies among migrant children.

COMMUNICABLE DISEASES

Many migrants come from countries with high infection burdens: in the UK, 70% of cases of HIV, tuberculosis (TB) and malaria are diagnosed in individuals born abroad.[9] The Office for Health Improvement and Disparities (OHID) has an online A–Z list of countries with links to specific health needs/infectious diseases to consider.[2 9]

The European Centre for Disease Prevention and Control published public health guidance for screening and vaccination for infectious diseases in newly arrived migrants within the European Union/European Economic Area in 2018; this recommends offering

Table 3 Vitamin and micronutrient deficiencies prevalent among migrant children

Deficiency	Symptoms	Detection	Treatment	Prevention/control
Vitamin A: Required for normal functioning of the visual system, cell growth and development, epithelial integrity, red blood cell production, immunity and reproduction.	Clinical deficiency has numerous health consequences: xerophthalmia, night blindness, anaemia, increased susceptibility to infections and failure to thrive.	Serum retinol concentrations below 0.70 µmol/L are used as being indicative of vitamin A deficiency (with levels <0.35 µmol/L equating to severe deficiency).	Generally dietary-based with occasional supplement use.	Daily supplementary vitamin drops, for example, Healthy Start vitamin drops, contain a combination of vitamins A, C and D (available free of charge from age 6 months to 4 years).[2 17 18]
Vitamin D: Calcium and phosphate homeostasis; facilitates rapid growth and skeletal development in childhood; at-risk individuals: diet (vegetarian, vegan and non-fish eating), skin colour (non-caucasian children), lack of sun exposure, infants of vitamin D-deficient mothers, exclusively breast fed for >6 months of age.	Failure to thrive; bone weakness. Severe deficiency can lead to hypocalcaemic seizures or cardiomyopathy. Check vitamin D levels if children present with musculoskeletal symptoms (suspected rickets, osteomalacia or persistent unexplained bone pain), have radiological features of these/ pathological fractures or have a chronic medical condition.	Serum 25-hydroxyvitamin D; <25 nmol/L (10 µg/L) is classified as deficiency; insufficiency is between 25 nmol/L and 50 nmol/L. Assessing a disorder of bone mineralisation: take blood for bone profile and parathyroid hormone; long bone x-ray (if rickets is suspected). X-ray the affected area (if osteomalacia is suspected).	Colecalciferol (oral vitamin D_3) is the preparation of choice. For rapid correction in symptomatic children: prescribe a fixed loading dose for 8–12 weeks, followed by regular maintenance therapy 1 month after completion of the loading dose.	Maintain adequate vitamin D levels through safe sunlight exposure (ultraviolet B radiation is the most important source worldwide) and diet (oily fish, eggs, meat, fortified UK fat spreads and breakfast cereals). Advise daily vitamin D supplement for all children (free of charge from birth to 4 years via the NHS Healthy Start scheme for eligible families).[2 7 19]
Iodine: Iodine deficiency affects one-third of school-aged children globally; prevalence is greatest in regions where soil has low iodine content (central and mountainous areas of Europe, Asia, South America, Africa and floodplains such as those in Bangladesh).	Deficiency while pregnant results in increased perinatal mortality (miscarriage, stillbirths, congenital anomalies, eg, cretinism). Impairs neurological development in children, stunts physical growth, causes goitre formation±hypothyroidism or hyperthyroidism.	Serum thyroid stimulating hormone, free T3 and T4 help to facilitate diagnosis; serum thyroglobulin (reflects iodine intake over weeks to months); urinary iodine (reflects recent iodine intake); ultrasound of the thyroid (to detect goitre).	If iodine deficiency is suspected, seek expert paediatric endocrine advice on the interpretation of thyroid function tests and subsequent additional investigations±appropriate treatment.	Good dietary iodine sources: sea fish, shellfish, milk and dairy products Iodine can also be found in some vegetables and plant foods, for example, cereals and grains (levels vary, depending on iodine levels in the soil where they are grown).[7]
Iron: Essential for neural myelination; children exposed to extreme poverty are at increased risk of IDA due to the complex interaction of malnutrition, alongside chronic/recurrent gastrointestinal parasitic infestations.	Consequences of IDA: fatigue, pallor, dyspnoea, poor appetite, pica, higher infection risk, delayed cognitive and motor development. Haemoglobinopathy screen (sickle cell disease and thalassaemia), advised with microcytic/normocytic anaemia, normal iron studies, consistent clinical±family history, at-risk ethnicity.	Full blood count (low Hb, MCV and MCH). Blood film (typically hypochromic, microcytic picture in IDA). Serum ferritin (reflects body iron stores but is an acute-phase reactant and thus may be elevated in inflammatory diseases, masking iron deficiency).Iron studies, that is, total iron binding capacity (transport iron) and transferrin saturations (functional iron).	Dietary modification (promote iron-rich foods: meat, fish, pulses, green vegetables and dried fruits); limit cow's milk to 500 mL/ day. Prescribe iron supplements (ferrous salts), usually a 3-month course initially.	Consider iron supplementation for premature/growth-restricted infants. Introduce iron-fortified cereals in children's diets. Advise taking vitamin C with iron-rich foods to improve absorption. Avoid giving tea to infants and young children (contains tannins, which reduce gut iron absorption) and cow's milk before 12 months of age.[2 7]

Hb, haemoglobin; IDA, iron deficiency anaemia; MCH, mean corpuscular haemoglobin; MCV, mean corpuscular volume.

screening for TB, blood-borne viruses (including HIV and hepatitis B and C), and for schistosomiasis and strongyloidiasis for those from high-risk areas.[10]

Routine screening for TB is recommended for arrivals from high-prevalence areas (incidence >40/100 000 people): these countries include Afghanistan, Eritrea and Somalia. Children from these countries should be automatically referred to a paediatric TB clinic.[2 5]

IMMUNISATIONS

Childhood immunisation schedules differ considerably, depending on the country of origin. The WHO's 'Vaccine-Preventable Diseases: Monitoring System' is a useful online resource listing immunisation schedules via region, country and vaccine, alongside estimated coverage levels by country.[9 10]

The UK Health Security Agency provides guidance for those with uncertain or incomplete immunisation status:

- Assume individuals are unimmunised and plan for administration of a complete course of vaccinations (unless a documented or reliable verbal immunisation history is provided).
- Newcomers arriving to the UK midway through an immunisation schedule should be transferred onto the UK schedule and subsequently immunised as appropriate for age.
- If the primary course has been started but not completed, continue from the point of interruption (ie, there is no need to repeat doses or restart the course).
- Plan to administer the catch-up immunisation schedule with the minimum number of visits and within

Box 1 Useful resources for healthcare professionals[20 21]

Refugee Council: provides support to and empowers refugees and asylum seekers.

Includes Family Key Work Service for families with children 0–8 years of age, Refugee Integration Service and Destitute Asylum Seeker Service for asylum seekers refused leave to remain.

Website: refugeecouncil.org.uk

Freedom from Torture: Medical Foundation for the Care of Victims of Torture.

Provides specialist psychological therapy to help asylum seekers and refugees who have survived torture recover and rebuild their lives in the UK, also raises awareness and influences decision makers about torture and its impact.

Website: www.freedomfromtorture.org

Helen Bamber Foundation: working with survivors of cruelty.

Provides therapeutic care, medical consultation, legal protection, counter-trafficking support and practical support, including welfare and community integration work.

Website: www.helenbamber.org

Doctors of the World UK: an independent humanitarian movement empowering refugees to access healthcare.

Contains a wealth of translated health information including guidance for refugees on how to navigate the NHS and how to register with a general practitioner (plus a freephone advice line via 0808 1647 686). Health and well-being information leaflets for young refugees and asylum seekers are also available (entitled 'Keeping Young People Healthy').

Website: doctorsoftheworld.org.uk

English to Speakers of Other Languages: English language classes for reading, writing, speaking and listening.

the shortest possible timescale (aiming to expedite protection).[11]

LEAD TOXICITY

Migrant children may have elevated serum lead levels as malnourishment increases its absorption. Sources of lead include environmental (soil, air and water contamination) and consumer products (leaded gasoline, used batteries, leaded paint, cooking utensils and cosmetics). Lead exposure may present with acute poisoning or a chronic and variable course, or may be entirely asymptomatic; a high index of suspicion is required. Primary prevention in children is imperative because harmful effects on neurodevelopment and cardiovascular, immunological and endocrine function may be irreversible.[7]

HEARING

The WHO estimates 278 million people worldwide have moderate-to-profound bilateral hearing loss.[2] Nearly 80% of individuals with disabling hearing loss inhabit low-income and middle-income countries.[12] Approximately 50% of the total global hearing loss burden is preventable; causes include chronic otitis media, intrauterine infections (rubella and cytomegalovirus), perinatal complications (birth asphyxia, low birth weight and hyperbilirubinaemia) and vaccine-preventable infections (measles and meningitis).[12]

Availability of audiology services is variable across the globe. Furthermore, hearing-impaired children can be stigmatised and socially isolated within their country of origin. Correctly fitted hearing aids can improve communication in up to 90% with hearing impairment; however, in low-income countries, fewer than 1 in 40 individuals who require a hearing aid have one.[2 12]

Exclude hearing impairment in migrant children with communication difficulties; do not assume this is only a language barrier. Detecting and responding to hearing impairment in infants and young children promptly are important to optimise cognition, educational attainment and socialisation.[7 12]

VISION

According to the WHO, around 2.2 billion people globally have a near or distance vision impairment.[13] At least half of these cases are potentially preventable. Correction of refractive errors with spectacles could provide normal vision to >12 million children, but this option is unavailable to many.[7] Moreover, around 87% of the world's visually impaired reside in low-income countries; common causes of blindness include trachoma (*Chlamydia trachomatis*) and xerophthalmia (secondary to vitamin A deficiency).[13]

Undiagnosed eye disease and vision loss are more common among migrants from low-income countries. Visual acuity is the most important indicator of ocular health. Direct to an NHS optician for visual acuity assessment. Immediately necessary ophthalmology treatment is exempt from charge under the 'National Health Service (Charges to Overseas Visitors) Regulations 2011'.[2]

ORAL HEALTH

Oral disease poses a major health burden for many countries, causing pain, discomfort, disfigurement and even death. Newcomer status is in itself a risk factor for early childhood caries; many migrants may not have received dental care prior to their arrival or learnt about oral hygiene in their country of origin.[7] Review dental health and refer for dental assessment within the first month of arrival. Migrant children should access preventive dental interventions (eg, fluoride varnish) free of charge.[6 7]

Take an oral case history, clarifying the following:

- Previous history of dental examinations or treatment
- Current dental or oral symptoms
- Oral hygiene practices.
- Dietary sugar intake

Test your knowledge

1. Fadi is a 3-year-old Syrian refugee who has recently arrived in the UK. His childhood immunisation schedule was disrupted following familial displacement due to civil war. His parents think he has received some vaccinations but are unsure which ones. How would you manage this child? Please select all that apply.
   A. Consult published guidance from the 'Oxford Vaccine Group' on child refugees with uncertain or incomplete immunisation status.
   B. Assume Fadi is unimmunised and plan for administration of a complete course of childhood vaccinations.
   C. Given this child's primary immunisation course has been started, continue from the point of interruption, estimating which vaccines Fadi has already received based on the rough timings provided by his parents.
   D. Plan to administer Fadi's catch-up vaccinations using the Syrian immunisation schedule as a basis.
2. Mariam, a 2-year-old Eritrean girl, attends A&E coryzal with a febrile illness; you diagnose a likely viral upper respiratory tract infection. However, you are concerned that Mariam looks pale, thin and small for her age. The family are currently seeking asylum in the UK. Her mother is dependent on governmental support and struggles to feed her children. How might you approach this situation? Please select all that apply.
   A. If malnutrition is suspected, measure the child's mid-upper leg circumference.
   B. Take a comprehensive dietary history (including current, in country of origin, in transit/refugee camps) while considering screening for vitamin D and iron deficiencies (±haemoglobinopathies as appropriate).
   C. Encourage Mariam's mother to apply for the NHS 'Healthy Start' scheme, providing monthly food vouchers or financial support to purchase cow's milk, fruit, vegetables, infant formula milk and supplementary vitamins.
   D. Accept that, given one in four children are underweight and undernourished in many countries in sub-Saharan Africa, Mariam's growth is appropriate for an Eritrean native.
3. As the paediatric registrar on-call in the acute assessment unit, you receive a phone call from a local general practitioner (GP) asking for advice regarding a 13-year-old girl who has recently arrived in the UK from Sudan; during an appointment for menstrual irregularities, she has disclosed she is a victim of female genital mutilation (FGM). What advice would you give to this GP regarding the next most appropriate actions? Please select all that apply.
   A. Advise the GP that they have a mandatory duty as a healthcare professional to report cases of FGM in girls aged under 18 years (in England and Wales); this will involve contacting the police in the first instance.
   B. Discussion with their local designated safeguarding lead is only warranted if the GP confirms evidence of FGM via genital examination of the child in question.
   C. The GP should, wherever possible, explain to both this patient and her family that a report of FGM is being made and what it means (unless the GP believes that reporting would lead to risk of serious harm to this girl or anyone else; in this circumstance, they should discuss with their local safeguarding lead in the first instance).
   D. The GP suspects that this child's age may be closer to 16 years; therefore, the mandatory reporting duty does not apply, and it would be acceptable to simply signpost this girl to FGM support services.
4. Which of the following statements pertaining to refugees are false?
   A. Approximately two-thirds of refugees entering the European Union over recent years are children and young people aged under 18 years.
   B. In 2019, more than two-thirds of the global refugee population originated from just five countries: Syria, Venezuela, Afghanistan, South Sudan and Myanmar.
   C. By 2020, around 82.4 million people worldwide were forcibly displaced from their homes; 48 million of these were internally displaced within their country of origin.
   D. Eighty-six per cent of the world's refugees are hosted within high-income countries.
5. Which of the following are considered barriers to accessing healthcare for migrants? Select all that apply.
   A. Language barriers with a lack of face-to-face±culturally appropriate interpreting services.
   B. Lack of knowledge regarding how to access healthcare services.
   C. Administrative difficulties, for example, lack of identification or proof of address.
   D. Healthcare debts±fear of arrest or prosecution.

Answers to the quiz are at the end of the references.

- Tobacco usage±alcohol consumption.

SEXUAL AND REPRODUCTIVE HEALTH

Complete a full sexual health review ascertaining whether a young person is currently or has previously been sexually active, pregnant or vulnerable to sexually transmitted infections. Discuss contraceptive options,

ideally in association with a local genitourinary medicine service. Information should be shared with other health professionals to avoid repetition for the child or young person (particularly in the context of traumatic events such as rape or torture).[2 6 7]

An awareness of the practice of female genital mutilation (FGM) is paramount; this is defined as partial or total excision of the external female genitalia for non-medical purposes. Typically performed between infancy and 15 years of age, it is primarily carried out as a cultural practice among African and Asian children (the highest prevalence being within Egypt, Sudan, Somalia, Mali, Sierra Leone and Indonesia). FGM is illegal in the majority of the high-income world (including the UK, Australia, Canada and New Zealand).[2 7]

Clinicians should appreciate the profound psychosocial consequences of FGM (eg, depression and post-traumatic stress disorder (PTSD)) and should also be aware of potential complications (difficulties with micturition, menstruation, intercourse and childbirth).[2 7]

UK-based charities offering support include

- Foundation of Women's Health Research and Development UK), an African women-led women's rights organisation working to end violence against women and girls (forwarduk.org.uk).
- The Dahlia Project, a specialist holistic service providing both psychological and physical support to survivors of FGM (dahliaproject.org).

Consider local safeguarding procedures if concerned that a child is at risk of FGM and refer to a local specialist unit (see the RCPCH FGM web page for further information, including mandatory reporting and recording requirements).[6]

MENTAL HEALTH

Health professionals caring for migrants must consider mental health problems, being aware that they may present unusually; for example, some might express psychological distress in a physical manner ('somatisation') rather than directly discussing their feelings. Varying sociocultural constructs will additionally influence presentations.[7]

Existing literature suggests the prevalence of PTSD among child refugees is approximately 11%.[7] The underlying pathology consists of re-experiencing, avoidance and hyperarousal. Symptoms can emerge up to years after the event.[2] Psychiatric disorders may coexist, for example, major depression (in up to 50% of cases), substance abuse, anxiety disorders, externalising disorders (attention-deficit hyperactivity or conduct disorder) and sleep disturbance.[2 7] For more information on PTSD recognition and management guidelines, see the National Institute for Health and Care Excellence (NICE) guidance.[14]

ACCESS TO NHS CARE

Children aged <16 years and those aged 16–19 years in full-time education are entitled to exemption from charges for prescription items, free dental services and free eyesight tests following completion of an HC2 certificate. Support migrant families to register all infants and children with a general practitioner (GP) as soon as possible.[2] Other informative sources, for healthcare professionals and migrant families alike, are listed as follows:

- The RCPCH Migrant Health flowchart: to help health professionals support vulnerable migrant children and families to understand NHS charging regulations and exemptions.[15]
- NHS entitlement page of the OHID migrant health guide for additional information.[16]
- The Refugee Council fact sheet in a variety of languages containing information on healthcare eligibility and access for people seeking asylum in the UK.[4]

AVAILABLE SUPPORT

Signpost the child's family to local charities, such as those listed in box 1. Where appropriate, refer families to the British Red Cross International family tracing and message service.[2 6]

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ORCID iD
Aoife Ryan http://orcid.org/0000-0002-1958-0004

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Answers to the multiple choice questions

1. (A) False; (B) True; (C) False; (D) False.
2. (A) False; (B) True; (C) True; (D) False.
3. (A) True; (B) False; (C) True; (D) False.
4. (A) True; (B) False; (C) False; (D) True.
5. (A) True; (B) True; (C) True; (D) True.