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Ros Levenson
Anna Sharma

Foreword

Since the dawn of civilization, there have been refugees, individuals and families fleeing from the aftermath of conflicts and war, or from cultural or religious persecution. This century has seen an unprecedented rise in such conflicts, genocide and the disruption of civilizations. As a result there has been a burgeoning in numbers of refugees world-wide, both within and outside their countries of origin. The United Kingdom has a long experience of receiving refugees from all parts of the world. The most recent influx following the conflicts in the Balkans, has resulted in plans to disperse refugees throughout the country. While this may reduce local resentment, it does mean that experience at managing the very specific problems refugees face is not easily acquired. This guide, produced jointly for the King's Fund and the Royal College of Paediatrics and Child Health, gives welcome and timely advice on the physical, psychological and cultural needs of refugee children in the UK, and explains their entitlements and rights under law here. The role and addresses of relevant non-governmental organisations are also provided. We hope that it will assist in improving the health care and education received by refugees from health professionals and others while in this country.

Professor Richard Cooke
Acting President
Royal College of Paediatrics and Child Health

Message from the Chair of the Refugee Council

Young refugees and asylum seekers are a diverse group who have wide ranging health, social and educational needs. Our most recent experience of caring for Kosovan families and children has highlighted the need for effective management of the health of these vulnerable and frequently traumatised individuals.

The impact of changes in asylum legislation may cause additional stress for families and children. For example, asylum seekers (including children and their families) will, in future, be offered housing outside London in areas where there may be insufficient expertise in offering appropriate services to refugee children.

Many refugee children and young people will have suffered overwhelming trauma in their home countries, will have had interrupted education, may not be cared for by their parents or usual carers and be experiencing isolation and/or bullying in school. This may be compounded by communication problems and poverty. Furthermore, unaccompanied children present an additional complexity of issues and needs.

The Refugee Council manages and administers the 'Panel of Advisers for Unaccompanied Refugee Children' whose key task is to uphold the rights of these children and ensure that they are offered appropriate access to services and benefits. The Refugee Council is aware of the continuing interest of paediatricians and the Royal College of Paediatrics and Child Health in responding to the needs of refugee children. The Council warmly welcomes this publication and commends it to all clinicians who may be required to care for refugee children and young people.

Naaz Coker

Introduction

These guidelines have been produced to assist paediatricians who are caring for refugee children. There is a considerable amount of documentation about the problems faced by refugees in terms of poor health[1,2,3] and problems in accessing health services[4,5]. Many paediatricians also have a great deal of experience and expertise in looking after the health of refugee children. However, the need to extend this expertise more widely to include paediatricians who may not have treated and cared for large numbers of refugee children has become more urgent for two reasons.

First, the recent arrival of considerable numbers of Kosovan families and children has sharpened awareness of the need for support in offering appropriate services to this group. Second, the introduction of the Immigration and Asylum Bill (due to become law in 1999) heralds important changes, including plans to disperse asylum seekers and give them only one offer of accommodation. This system is likely to result in asylum seekers (including children) being housed in parts of the country that may lack the cumulative expertise of the districts that have traditionally received asylum seekers. Therefore, all paediatricians may need support in offering appropriate services to refugee children. These children share difficulties experienced by many minority ethnic communities in accessing appropriate services, but, additionally, they may be traumatised by the circumstances that have made them leave their homes.

Whether paediatricians work in hospitals or community settings, they will, of course, be aware of the importance of access to health care, including primary care, for refugee children and their families. Information about entitlements to health care generally and access to primary care, in particular, is provided in Appendix 2. In addition, further information on refugees and primary care can be found in another publication, which has been published by the King's Fund and which is aimed at general practitioners[6].

Executive summary

1 The Immigration and Asylum Bill includes plans to disperse asylum seekers and give them only one offer of accommodation. This may result in asylum seekers being housed in parts of the country where there is little experience of providing care for these families.

2 Adults and children may apply for asylum at the port of entry or once they are already in the UK. Adults may be detained under certain circumstances but children should not generally be placed in detention (section 2).

3 Refugee children are entitled to routine child health surveillance and health promotion. They may not have undergone neonatal screening for congenital abnormalities or inborn errors of metabolism (section 5.3).

4 Routine appointments for immunisations will not be sent unless the child is permanently registered with a GP. The country of origin will determine whether a course of primary immunisations should be restarted (section 5.4).

5 Caution should be exercised in making an assessment of a child's age for legal purposes. Anthropometric measurements can be misleading and there is little, if any, justification for the use of radiographs in this context (section 5.6).

6 Mental health problems may arise from the problems of adjustment and, less commonly, as a persisting reaction to trauma. These may be manifest as physical symptoms. However, the resilience, as well as the vulnerability, of refugees should be acknowledged (section 5.7).

7 Children may suffer from malnutrition and a dietary history is important. The UK growth charts may not always be appropriate, particularly where the age is uncertain, and measurements of growth velocity should be made where there is concern or doubt (section 5.8).

8 The possibility of HIV/AIDS, tropical and infectious diseases should be considered, and the incidence will differ according to the country of origin. Particular conditions to consider are tuberculosis, hepatitis B and C, malaria and schistosomiasis (section 5.9).

9 Female genital mutilation is illegal in most countries, including those where the practice is traditional. Despite this it is still seen in girls from parts of Africa (section 5.10).

10 Language problems should be recognised and arrangements put in place for early access to an interpreter through local interpreting services telephone interpreting services (section 6).

11 Refugees need reassurance that they are entitled to confidentiality. Paediatricians are under no obligation to divulge information to other agencies unless it is in the best interests of the child to do so (section 7).

12 Guidelines have been produced for GPs (referenced in appendix 5). There are a number of non-governmental organisations which are active in projects to assist young refugees and contact details are given in Appendix 1.

13 All refugees and asylum seekers are entitled to NHS care, including routine ante-natal care, and do not have to pay to see a GP or a hospital doctor. They are entitled to help with prescription costs if they lack means and are not receiving benefits (Appendix 2).

1 Definitions

In this section, definitions of some key terms are given. However, much of the material in these guidelines applies not only to children who are actually refugees or asylum seekers, but also to children in the following groups[7]:

- Those applying for asylum (refugee status) in the UK
- Those who have been given Exceptional Leave to Remain (ELR) or Exceptional Leave to Enter (ELE), who are required to renew their status with the Home Office at periodic intervals
- Those given refugee status, who gain the right to stay in this country indefinitely
- Those who have had their application refused and are going through the appeals process
- Dependants of the above groups
- Other individuals or groups who may fall outside this definition but who face similar problems, eg those entering the country under "family reunion" regulations.

Therefore, in this document the term "refugee" is sometimes used to cover people who are not actually refugees, but may be asylum seekers or fall within one of the other categories listed above. However, it is important to understand what is meant by the terms refugee, asylum seeker and unaccompanied child, and these are defined below.

What is a refugee?

A refugee is a person who:

"owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, as a result of such events, is unable to or, owing to such fear, is unwilling to return to it."

Source: United Nations Convention, 1951

What is an asylum seeker?

An asylum seeker is someone who has applied for refugee status - in order to be recognised as a refugee in the UK, it is necessary to first apply for asylum.

What is a child and what is an unaccompanied child?

The term "child" and "minor" tend to be used interchangeably. The Home Office defines a child as a person under the age of 18 years. This is very important for paediatricians to bear in mind.

Two definitions of an unaccompanied child are given below.

An unaccompanied child is a person who is under the age of 18, unless, under the law applicable to the child, majority is attained earlier and who is separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so.

Source: Guidelines on policies and procedures in dealing with unaccompanied children seeking asylum. United Nation High Commissioner for Refugees. Geneva. February 1997.

The above definition differs slightly from the one that is used in the Asylum Directorate Instructions, which is as follows:

An unaccompanied child is a person who, at the time of making his 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 own right; and***
- ***without adult family members or guardians to turn to in this country.***

- ***Although children may not be with their parents we would not consider them to be unaccompanied if they are being cared for by an adult who is responsible for them.***

Source: Asylum Directorate Instructions, Chapter 2, section 5 (available on the internet at www.homeoffice.gov.uk\ind\hpg.htm)

2 What happens after a child applies for asylum?

People - both adults and children - who apply for asylum may do so at the port of entry (port applicants), or they may do so once they are already in the UK (in-country applicants). Children who are with their families will be considered as part of the adults' application, but unaccompanied children will be applying on their own behalf. The procedures for adults and their families differ in some respects from those for unaccompanied children, eg adults may be interviewed as part of the process of determining their claim. Also, adults may be detained under s.16 of the Immigration Act 1971 if the immigration officer thinks they will not comply with certain conditions, whereas children are not generally supposed to be detained. The guidance by United Nations High Commissioner for Refugees (UNHCR)[8], accepted in principle by the Home Office, states that children seeking asylum should not be held in detention (section 7.6 of UNHCR guidance). It also states that children should be given the benefit of the doubt if the exact age is uncertain (section 5.11c of UNHCR guidance). It is unusual for acknowledged children to be detained, but there is a power to detain children on the same basis as adults in exceptional circumstances. In practice, those who are detained are usually where there is a dispute about age. Children may also sometimes be detained as part of a family group.

The following sections give a brief account of the procedures for unaccompanied children who seek asylum.

2.1 Unaccompanied children - applying at the port of entry

On arrival at the port, the child is taken to an immigration officer. The claim for asylum can be implicit or explicit. In other words, it may be sufficient for a child to say that it is not safe for him or her to return to his or her country. The immigration officer carries out a brief proforma interview to obtain essential details to establish identity and, where known, date of birth etc. While immigration officers must pay attention to the welfare of the child, not all officers are trained in child-friendly practice, and those who are have usually had only brief training.

Usually, the child is granted temporary admission, though the immigration service reserves the right to call the child back for a substantive interview. In practice children are rarely interviewed, and immigration rules (HC395, Rule 352) state that children should not be interviewed if it is possible for information to determine the claim to be obtained in other ways. Any decision to interview must be taken by a senior caseworker.

The child is given a self completion questionnaire (SCQ) and is then referred to the Refugee Council's Children's Panel (see section 3). Applications can take a year or more to decide, although children's applications are supposed be prioritised. There is an appeal procedure after refusal.

2.2 Applying when already in the country

In-country applications are made to the Asylum Screening Unit (ASU) of the Immigration and Nationality Department (IND) of the Home Office. A similar procedure of self completion questionnaire follows.

2.3 Appeals against refusal of asylum

There is an appeals process which is very complex. There are specialist advisers and lawyers who can help with this.

3 Role of the Refugee Council Children's panel in the UK

Since the 1930s, many unaccompanied children have arrived in the UK to seek asylum. Recent UK government statistics note that the numbers of unaccompanied children seeking asylum in the UK are as follows[9]:

1992	190
1993	275
1994	416
1995	597
1996	633
1997	1105
1998	2833
1999 (Jan - June)	1237

Figures from the Refugee Council[10] confirm a sharp increase in the numbers of unaccompanied children, due, in large part, to the Kosovan crisis. They recorded the arrival of 1643 unaccompanied children between 1 January 1999 and 28 July 1999.

Children may be unaccompanied for a variety of reasons, eg

- They may have been sent out of their country by relatives for safety
- They may be children of asylum seekers who have died
- Their parents may have died in their country of origin
- They may have been dependants of asylum seeking parents who have abused them or been unable to care for them
- They may be young people making their own way to seek asylum
- They may be young people in search of lost parents or other relatives.

Whatever their individual experience, they will have felt the trauma leading to exile and the separation and loss from all that is familiar to them. They also face a very uncertain future, particularly with respect to their asylum claim, and also in relation to the different language, customs and lifestyle in an unfamiliar country. In recognition of these problems, the Home Office funds a project, known as the Panel of Advisers for Unaccompanied Refugee Children, which is managed and administered by the Refugee Council, and is placed within the Refugee Council's Children's Section.

The Refugee Council's Panel of Advisers for Unaccompanied Children - key principles

1. *Unaccompanied refugee children are children first and have an absolute right to care and protection.*
2. *The unique considerations of each unaccompanied child must be respected and must inform the care that is given to them.*
3. *Unaccompanied refugee children must receive equality of opportunity.*

The Refugee Council's Panel of Advisers comprises approximately 29 people who work on a sessional basis with children and young people, regardless of whether their claim for asylum was made at the port of entry or when they were already in this country. Broadly speaking, children can be matched with an adviser who shares their culture, language and background. Panel members work directly with young asylum seekers offering independent advice and, where appropriate, acting as advocates to ensure that children receive adequate access to the services to which they are entitled, eg legal representation, care and accommodation, education and contact with their own communities. A major role of the advisers is to ascertain the views of the child/young person and help develop awareness of the options that are open to them. Once the adviser has assisted the child to find accommodation, legal representation etc they cease to be involved.

Since becoming operational the panel of advisers has received 6770 referrals. Of these, 3981 children and young people were allocated to a member of the panel of advisers. The work of the Panel of Advisers was evaluated by the National Institute of Social Work in 1995 and was shown to be offering a very valuable service.

4 Legal framework

One of the key documents in setting out the legal framework for meeting the health needs of refugee children is the UN Convention on the Rights of the Child (1989). Some of the relevant articles are as follows:

Article 2 - A state must ensure the rights of "each child within its jurisdiction without discrimination of any kind".

Article 3 - On all actions concerning children …… the best interests of the child shall be the primary consideration.

Article 39 - A child "victim of … torture or any form of cruel, inhuman or degrading treatment or punishment, or armed conflicts" has a right to "physical and psychological recovery and social integration".

Other relevant international documents are listed in Appendix 5.

> ***Excerpt from Guidelines on Policies and Procedures in dealing with unaccompanied children seeking asylum (UNHCR, February 1997)***
>
> "The basic guiding principle in any child care and protection action is the principle of 'the best interests of the child'.
>
> *Effective protection and assistance should be delivered to unaccompanied children in a systematic, comprehensive and integrated manner*."

The fundamental domestic legislation governing immigration law is the Immigration Act 1971, the Asylum and Immigration Appeals Act 1993 and the Asylum and Immigration Act 1996. There are also immigration rules and various statutory instruments. A new Immigration and Asylum Bill will be enacted, probably during 1999.

Other relevant domestic legislation includes:

- The Children Act (1989)
- The NHS and Community Care Act (1990)
- The Education Act (1991)

Paediatricians should not attempt to give advice on matters of law, but should refer patients to the appropriate sources of help and advice (see Appendix 1 National Resources and Contacts).

4.1 The Home Office

The Home Office publishes some useful material on the internet. This includes the Asylum Directorate Instructions, available on the internet on <www.homeofice.gov.uk\ind\hpg.htm>.

Chapter 2, section 5 of the above instructions gives guidance to asylum directorate caseworkers on the procedures to follow when considering asylum applications from unaccompanied and accompanied children.

The instructions point out that particular priority and care should be given to the handling of the cases of unaccompanied children. Paragraph 1.2 states:

When considering asylum applications from children - whether accompanied or not - close attention must be given to the welfare of the child at all times.

5 Guidance for paediatricians

As with all children, paediatricians will ensure that the health of refugees is managed in a holistic and non-discriminatory way. This section aims to give paediatricians brief information on a number of issues and conditions that may particularly affect refugees, or where the experiences of refugee children and their families may require a particular sensitivity and level of awareness of their needs.

5.1 Consent to treatment

Consent to a health assessment should follow the General Medical Council's Guidance.[11] In the case of unaccompanied refugee children, care should be taken to ensure that valid consent has been obtained to any invasive procedures. If a child is considered too young to be able to give valid consent, the assistance of the local authority social services department should be sought as care proceedings or wardship may be required.

Suitable interpreters should be used, where necessary, to ensure that a valid consent is obtained.

5.2 Ante-natal care and birth

The paediatrician's interest in looking after children begins with care in utero. Therefore, it is well worth while liaising with obstetric and other colleagues to ensure that the following aspects of ante-natal care are addressed.

5.2.1 Encouraging access to ante-natal care

Refugee and asylum seeking women may not realise that they are entitled to routine ante-natal care on the NHS. The paediatrician should explain this to mothers of children who may be seen as they could be pregnant.

Doctors in reception centres need to be particularly aware that women may be pregnant and refer those who are to confidential ante-natal care. Counselling for ante-natal screening for malformation, hepatitis B, HIV and haemoglobinopathies should proceed as for other women with particular regard to the need for interpreters.

The paediatrician should be aware of the risk of teenage pregnancy in post-pubertal girls and make a sensitive enquiry.

5.2.2 Nutrition in pregnancy

Mothers suffering from poor nutrition may give birth to babies with intrauterine growth retardation and/or low birth weight. Spina bifida associated with inadequate folate intake ante-natally may be undiagnosed ante-natally due to lack of ante-natal screening[12] (see also section 5.8 on Nutrition).

5.2.3 Ante-natal records

A personally held ante-natal record is recommended for refugees and asylum seekers, as for everyone. This is particularly helpful where patients may be geographically mobile.

5.2.4 Confidentiality in ante-natal care

The patient's right to confidentiality is paramount, particularly with young teenagers or women in detention. Women attending clinic from a detention centre are entitled to a consultation without the presence of the detaining officer. Detaining officers may try to insist on remaining present, but the doctor can tell the officer to leave, and it is then a medical decision, rather than a personal wish on the part of the woman (see also section 7, Confidentiality).

5.2.5 Terminations of pregnancy

Counselling around terminations should be sensitive and remain confidential.

5.2.6 Screening and counselling

Counselling for hepatitis B and HIV testing should take place in the usual way. Ante-natal screening for HIV is now universal.

5.3 Child health surveillance and screening

5.3.1 Routine child health surveillance and screening

- Refugee children are entitled to routine child health surveillance and health promotion, as recommended nationally[13]. The programme should be co-ordinated by the geographical or practice based health visitor in the same way as for the indigenous population.

- Health visitors should be allocated to reception and detention centres usually on a geographical basis.
- All new arrivals who are children should have a "movement in" visit within a week of arrival if possible. This visit, which would be family centred, would form the basis of the health visitor's assessment of the initial and ongoing health needs of the children and the family. Children should be given a personal health care record (PCHR).
- Children needing medical attention should be brought to the general practitioner. Those needing emergency care, for example children with gastroenteritis, should be brought to the attention of the general practitioner without delay, in the first instance.
- Children needing routine health promotion such as immunisation should be seen within the health visitor's caseload.
- Many children will come from countries which do not have a policy for neonatal screening for phenylketonuria, hypothyroidism, cataracts, congenital cardiac disease or congenital dislocation of the hip. For this reason it is helpful to ensure that children have an initial examination by a doctor, with a low threshold for referral to a paediatrician if any of these conditions are suspected.
- Developmental delay, delay in walking, poor visual fixation or uncertainty about response to sound should be referred immediately as the cause may be treatable, and the referral should make quite clear whether or not the child has had access to routine child health surveillance and in particular whether neonatal screening has occurred.

5.3.2 Record keeping

- The health visitor should ensure that the children are placed within the relevant computer or manual system for appointments for subsequent routine health checks, the timing of which should be in line with district policy.

5.3.3 Accident prevention

- Children from refugee families, especially boys, are particularly likely to suffer accidents. The reasons are likely to be related to factors including social class, family size, overcrowding, poor housing and lack of urban street knowledge.
- Accident prevention advice is easily forgotten yet this particular group of children is extremely susceptible. Reception centres or temporary accommodation may suffer from a lack of electrical socket covers, coiled flexes on kettles, smoke alarms, stair gates, lockable cupboards, window bars and the like, and the visiting paediatrician and or health visitor should bring this to the notice of the centre manager. Parents should be given the same advice that one might give to the indigenous population together with advice on where to obtain relevant equipment. Local voluntary organisations can be contacted to help with obtaining such equipment.
- Accident advice should also be directed towards the highway code and street safety particularly for families with young boys, who may have been brought up in semi rural areas with little or no traffic where playing on the street might be common.

5.4 Immunisation[14,15]

Routine immunisations can best be carried out when a child is permanently registered with a general practitioner. Sadly, some general practitioners continue to offer only temporary registration and this is strongly to be discouraged. GPs may think that refugee families are likely to move on, making it unlikely that it will be possible to record a completed course of primary immunisation, although this reputation for high mobility may have been exaggerated[16]. This leaves the health visitor with an added load of having to remember to send out the appointments due for routine immunisations (see also Appendix 2, Entitlement to NHS services).

In some districts, clinics have been set up to run services specially for refugee families. This may be beneficial in terms of making effective use of interpreters and health advocates, and can also help to put families in touch with one another. However, the need to help families access appropriate mainstream services remains important.

5.4.1 Should refugee children re-start a course of primary immunisation?

- Older children arriving from areas where war is of recent and sudden origin such as Kosovo or Iraq are likely to be fully immunised according to the WHO schedule which usually includes primary immunisation against diphtheria, tetanus, pertussis, polio in the first year of life and measles in the second year of life. Such children need to catch up with Hib, MMR and meningitis C vaccines and the pre-school booster.

- However, young children or children arriving from areas of chronic conflict such as Bosnia or Angola may not be immunised and should commence and complete a full primary course of DTP, polio Hib and meningitis C vaccines with an accelerated schedule for MMR if there is no previous record. Children from Asia tend to be well immunised against DTP, polio TB and measles. However, children from Asia may need to be given a booster dose of polio with further boosters according to age.
- Children should be skin tested routinely for tuberculosis if over three months of age, and either given a BCG or referred to a chest clinic depending on the results. As skin testing is often done at port entry care should be taken not to repeat this unnecessarily. However, many refugees will not have identified themselves as such at the port of entry, so will not have been screened in this way.
- Hepatitis B should be screened for if the family come from a high-risk group, eg those from Eastern Europe, South East Asia and South America, where there is a high prevalence of carriage. If the mother is hepatitis B antigen positive the new-born child should commence and complete a course of vaccination against hepatitis B. If the child tests hepatitis B positive there could be grounds for referring the child for a specialist opinion.

5.5 The health of school age children

The health of school age children is a key concern and one where paediatricians can play an important part. It is important to think inclusively about this issue as some refugee children may have difficulty in accessing a school place or be poor attenders at school, (in spite of the value placed on education by many refugee families) or may experience changes in the schools they attend, due to changes in housing etc. Thus, while school health is very important, some refugee children may be hard to reach through schools and some outreach work may also be useful to ensure that the health of all school age children is managed as well as possible. However, for most refugee children, school is an important environment where they can be seen, and where their needs can be considered holistically.

School is very important in the life of refugee children, not least because the establishment of a routine can do much to make their lives feel more predictable.

Schools can play a major role in ensuring that they have a named member of staff to co-ordinate issues that relate to the well-being of refugee children. They can help to ensure that refugee children have access to school medical services as soon as possible after admission to school. They can also play a major part in ensuring that refugee parents and carers are fully informed of the school health service and about access to interpreting services during their initial induction. The role of the school nurse is also very important in ensuring access to sensitive health care for refugee children.

A useful checklist was compiled by a multidisciplinary group of professionals for all staff working with refugee children in Camden and Islington[17] and much of the material in this section is based on that document.

5.5.1 What paediatricians can do

There is much that paediatricians can do to promote and improve the health of school-age refugee children, in partnership with the school. In considering the mental and physical health needs of the school age child, there are a number of questions to consider.

a Is the child and their family aware of all medical and social services available in this country?

- Has the child/family been assured of the importance the health service attaches to confidentiality?
- Are they registered with a GP, and with a dentist?
- Do they know how to access health care services?
- Do they know their health care rights, including free treatment and, in certain circumstances, free prescriptions?
- Do they know about access to free school meals?
- Do the child and family have an understanding of preventative health measures?
- Does the school nurse/doctor have an understanding of the health beliefs of the child and child's family?
- Has consent been obtained for the school medical?
- Does the child/parent/carer appreciate the importance of the school medical and the need to attend, particularly when an interpreter or advocate will be attending?

b Has the child had a school medical?

- Is the child/family aware of what is being offered by way of school health surveillance?
- Is the carer the legal guardian and who has parental responsibility?
- Was the parent/carer present?
- For unaccompanied refugee children, is the school nurse/doctor aware that there should be a low threshold for referral?
- Is the child the correct height and weight for their age and growing normally?
- Is the child eating a balanced diet (taking note of cultural and religious factors)?
- If the child is unaccompanied and living independently is he or she supported in acquiring necessary food hygiene and nutritional skills?
- Does the school have the name of each unaccompanied child's social worker?
- Has each unaccompanied child been "allocated" to a responsible person within the school?

c The child's medical history

- What was the child's medical history before arrival in the UK?
- Are the child's medical records available?
- Is the child receiving any medical treatment?
- Has the child ever had a health problems that needed to be treated by a health worker?
- Does the child have a condition for which there is routine screening in the UK (eg hypothyroidism, phenylketonuria)?

d Specific health issues

- Does the child and family know the importance of immunisations?
- Has the child had all his or her immunisations? What immunisations are still needed?
- Does the child suffer from any tropical diseases or recurrent conditions eg malaria?
- Does the child have a long term medical condition?
- Does the child suffer from sickle cell anaemia or thalassaemia?
- Has the child been subjected to female genital mutilation (FGM)?

e Physical development

- Is the child's development within an appropriate range for their age?
- Does the child have physical or sensory disabilities or learning difficulties?

f Physical injuries

- Does the child have any physical injuries eg war injuries?
- If so, are they being treated?
- Would the child benefit from any specific therapies or regular check ups?
- Are the emotional consequences of such injuries being addressed?

g Signs of abuse

- Is the child being bullied at school?
- Is the child abusing himself/herself?
- Does the child suffer from erratic mood swings?
- Is the child or family subject to racial attacks?
- Has the child been subjected to sexual abuse?
- Has the child or family been subjected to torture or rape?

h Sexual health and sex education

- Does the child know about sexual health issues appropriate to their development, eg changes at puberty, conception, contraception, sexually transmitted diseases?
- Has the school considered how these issues can be addressed in a culturally sensitive way?
- Is the child aware of child protection rights and how to assert them?

Note: This list of issues and questions to consider has been adapted from *Meeting the needs of refugee children - Camden and Islington Community Health Services NHS Trust/Health promotion Service/Camden Education. 1996.*

5.5.2 Learning difficulties

Poor educational performance is often taken to be due to difficulties experienced with English as a spoken language. Children's comprehension is in advance of their expression and they understand more than they appear to. Two years is said to be the time it takes for the expression of language to reach the equivalent of the indigenous population. However this is too long to wait to detect learning difficulty due to, say, hearing, vision or developmental problems. The school nurse should screen children in the first instance. Pertinent questions are whether or nor there has been disruption of schooling in the home country and if not, whether the child's attainments in school were age equivalent or whether he/she was put back a year in the home country. Children who have had schooling disrupted may have difficulties concentrating initially but if treated with firm consistent boundaries soon settle.

5.6 Puberty and the assessment of age

Paediatricians may be asked to give their opinions on whether a young person is a child under the age of 18. This request may be made by the child's legal representative, who may be seeking to show that the young person in question is under the age of 18, as those accepted as such should not normally be held in detention. The paediatrician's assessment should only be done in the context of a holistic examination of the child. When making their assessments, paediatricians may find it useful to be aware of the Asylum Casework Instructions used by the Immigration and Nationality Department of the Home Office. An excerpt from these is given at the end of this section of the guidelines (see page 14).

In practice, age determination is extremely difficult to do with certainty, and no single approach to this is can be relied on. Moreover, for young people aged 15-18, it is even less possible to be certain about age. There may also be difficulties in determining whether a young person who might be as old as 23 could, in fact, be under the age of 18. Age determination is an inexact science and the margin of error can sometimes be as much as 5 years either side. Assessments of age measure maturity, not chronological age. However, in making an assessment of age, the following issues should be taken into account.

5.6.1 Puberty and anthropometric measures

It is virtually impossible to deduce the age of an individual from anthropometric measures. There are clearly defined methods for rating puberty as described by Tanner and colleagues in 1962[18]. These give the ages of various stages of attainment of pubertal appearances, commencing on average at 11 years in both males and females and going through to the final stages acquired two or three years later. The process involves the acquisition of these stages in a carefully defined order. However, the timing of the onset of puberty is extremely variable. Girls may have the first signs at about the age of 8 or 9 years and boys at about 9 or 10 years of age. Equally, pubertal delay can also take place and the first signs may be significantly delayed to 14 or 15 years in boys. Accordingly, therefore, it is not possible to give a precise age of an individual from these stages.

The situation is complicated in refugees where alterations in nutritional status and illness compound the problem delaying puberty so that a person may actually be older than they appear from pubertal development. Further, there are ethnic differences in the onset of puberty. In particular, in the Indian subcontinent a slightly earlier onset puberty is quite common, so that, for example, a boy with extensive facial and body hair may appear to be older than he actually is, according to Caucasian developmental norms. For these reasons it is simply not possible to deduce the age of an individual from an assessment of puberty, although pubertal assessment should be considered as part of good clinical practice in the assessment of these individuals.

The issue of whether the chronological age can be determined from the estimate of bone age has been discussed at great length in the literature. The answer is that it cannot. The problem is that an adult bone age may be acquired at a range of ages in childhood, although it commonly takes place around the child's 16th or 17th birthday in males and the 15th or 16th birthday in females. These averages are influenced by a range of factors that may affect the timing of the onset of puberty and the whole process of skeletal maturation.[19]

Overall, it is not possible to actually predict the age of an individual from any anthropometric measure, and this should not be attempted. Any assessments that are made should also take into account relevant factors from the child's medical, family and social history.

5.6.2 Assessment of bone age

In 1996, The Royal College of Radiologists[20] gave useful advice to its members about the use of X-rays in the assessment of age. They advised that if an immigration official requests an applicant to have a radiograph obtained to confirm their alleged chronological age, the College would regard it as unjustified. They argue strongly that

ionising radiation should be used only in cases of clinical need. However, if an individual seeking entry wishes to support their case, an X-ray of the hand presents negligible risk of radiation. However, they add that the accuracy of estimation of age from hand radiography amongst groups that have not been studied in detail remains in doubt. The Board of Faculty expressed reservations about advising on bone age for other than personal health issues or research projects approved by appropriate ethics committees.

5.6.3 Dental age

The dental age of the human from birth to 18 years can be judged by a consideration of the emergence and development of the primary and secondary dentitions. Thereafter estimates have to be based on wear of the dentition and are much less accurate.[21] There is not an absolute correlation between dental and physical age of children[22] but estimates of a child's physical age from his or her dental development are accurate to within + or - 2 years for 95% of the population and form the basis of most forensic estimates of age. For older children, this margin of uncertainty makes it unwise to rely wholly on dental age.

5.6.4 How paediatricians' reports on age determination may be received

While some paediatricians have extensive experience in undertaking assessments of age and in writing reports, they seldom have the benefit of seeing how these reports are received by immigration authorities or appellate bodies. Great care should be taken by paediatricians in how reports are presented, and as the BMA advises, medical reports should be "factual, detailed and carefully worded".[23]

In utilising paediatricians' reports, immigration officers and adjudicators should give due weight to social and cultural factors in addition to the physical factors, in view of the difficulties inherent to age determination described above. For example, it may be relevant to relate physical attributes to the child's account of their former lifestyle, eg what responsibilities they undertook in their country of origin, what education they had experienced etc. However, it appears that immigration officers and adjudicators are sometimes more influenced by medical "facts" than by social histories, although social factors may be of the utmost importance. Therefore, paediatricians should always try to explain how and why the social history is relevant to a particular child's assessment. It may not be sufficient to describe social factors and to assume that their relevance will be appreciated and given due weight. It is also important not to take for granted any prior knowledge of variations in the onset of puberty etc. Where a child is from an ethnic group that tends towards an earlier onset of puberty, this should be made clear.

Age determination - a summary

- The determination of age is a complex and often inexact set of skills, where various types of physical, social and cultural factors all play their part, although none provide a wholly exact or reliable indication of age, especially for older children.
- Assessments of age should only be made in the context of a holistic examination of the child.
- As there can be a wide margin of error in assessing age; it may be best to word a clinical judgement in terms of whether a child is probably, likely, possibly or unlikely to be under the age of 18.

Excerpt from the Asylum Casework Instructions, Chapter 2, Section 5. (Immigration and Nationality Department) February 1999

"3.13. Medical assessments of age

If an applicant's age is in dispute and he is unable to supply any reliable documentary proof to support the claim that he is a child, it is open to him or his representatives to obtain a medical assessment of age. Any examination must be voluntary. Therefore it would not be appropriate to insist or even to request that a medical report be submitted. In most cases age assessments are conducted by paediatricians. It is not Home Office practice to commission paediatrician's (sic) reports.

Due weight must be attached to any medical assessment of age that is received, but it should be noted that age determination is an inexact science and the margin of error can be substantial, sometimes by as much as 2 years either side. As the paediatrician can only offer an estimate of age, all estimates should also refer to the margin of error associated with that particular estimate.

The Department of Health's advice is that even the most thorough medical tests cannot provide conclusive evidence of a young person's age as they measure maturity, not chronological age.

It is inappropriate for X-rays to be used merely to assist in age determination for immigration purposes. Under no circumstances should a caseworker suggest that an applicant should have X-rays taken for this purpose."

It is also important to note that estimates of age may lose credibility if they are too precise. A form of words such as "Her/his age may be in the range x-y years" or "He/she is likely to be the age that he/she claims for the following reasons …. [give reasons] may be appropriate.

Wherever possible, paediatricians should be careful in their choice of words so that they do not inadvertently undermine the child's own story. For example, it may be helpful to be wary of making stark statements such as "The child does not know his own birthweight or date of birth". While these statements may be true, they may actually cast doubt on the reliability of a child in a context where he/she may be readily disbelieved.

5.7 Mental health

There are many important factors to consider in relation to the emotional and psychological health of refugee children. Many issues are also relevant to adult refugees, but some factors are specific to children and young people. Children may also be affected by their parents' psychological state and adults pre-occupied with the implications of their refugees' status and the traumas they have suffered may not be as emotionally available to their children as they might wish.

5.7.1 The incidence of mental health problems

It is generally accepted that there is a higher rate of mental health problems in refugee communities[24] and that refugees may experience particular emotional and mental health problems related to their experiences[25,26,27]. It is also important to note that many refugees encounter racism and other forms of discrimination, and even where legal redress is possible, their vulnerability makes it difficult to challenge it effectively. The experience of encountering racism in a place that had been seen as a safe haven is all the more devastating to those who experience it. Experiences of individual and institutional racism may lead to a breakdown in trust, with adverse consequences to people's health. Other factors, such as poverty, poor housing and loss of status may also undermine a sense of emotional well-being in both adults and children. However, the resilience, as well as the vulnerability, of refugees should be acknowledged.

As a report from the Health of Londoners project[28] points out, the mental health problems of refuges can encompass both problems of adjustment and less common, persisting reactions to trauma. The former are common and need good educational and social service support, as well as some specific services such as counselling and appropriate primary care for problems such as depression. The less common persisting reactions to trauma may require specific psychological interventions, and this is discussed further below.

5.7.2 What is pathological?

One of the conundrums for paediatricians is the issue of what is pathological and what is not. Some doctors make the point that some of the common responses to the experiences of refugees should not be looked on as psychiatric conditions[29]. In this situation it is suggested that supportive listening is very valuable, and this may be best undertaken by people from the person's own culture who have become established here, where that option is available.

However, it is also important that children with severe psychological problems should not have those problems unrecognised.

"Some people may well protest that it is "pathologising" or "medicalising" these experiences to be talking about stress reactions at all, let alone talking about PTSD [Post Traumatic Stress Disorder]. ….. there are wide individual differences in response to stress and by no means all children exposed to a life threatening experience go on to develop PTSD. But many do show other stress reactions and, of course, children who have been uprooted from their homes and who may have lost a parent or other loved one during the turmoil may also have other unresolved grief reactions. While recognising that most of these reactions are "normal" in the sense of being understandable, they still require that action be taken by those in authority to alleviate the children's distress."[30]

Paediatricians will, in all cases, need to make careful and culturally sensitive judgements on how to interpret physical and psychological symptoms of stress and trauma.

5.7.3 Different cultural approaches to mental health and mental illness

Paediatricians should be aware that some refugee children will be from cultures where mental illness and psychological distress are taboo subjects, and physical symptoms such as headaches, insomnia, stomach ache etc. may be the way in which emotional distress is presented. Some cultures may have a concept of mental illness only in its most severe form, and may not conceptualise emotionally or psychologically based childhood disorders.[31] There may not be words in all languages to translate English words for various kinds of emotional distress.

5.7.4 Reactions to trauma and loss

Children affected by war and international upheaval may experience a variety of signs of stress. These may include:

- Poor concentration
- Memory impairment
- Daydreaming, or intrusive thoughts and images
- Irritability
- Tiredness or lethargy
- Sleep difficulties
- Confusion
- Loss of interest and motivation
- Being withdrawn and isolated
- Not thriving
- Interrupted or uneven emotional or physical development
- Self harm
- Unexplained headaches, stomach aches or other body pains.

Where children are experiencing such problems, or where children have regressed in their behaviour (e.g. bedwetting, or clinging inappropriately to parents) it may be helpful to enquire whether they are troubled by sounds or pictures of things that have happened to them.

Both adults and child refugees may have experienced torture or other severe trauma and loss in the events leading up to their displacement. Like adults, children may experience signs of anxiety, depression, guilt and shame as a result of what they have experienced. Even fairly young children, especially boys, may have been involved in warfare and other acts of aggression and may have to come to terms with that. Children may have experienced torture personally, or may have witnessed its infliction on others.

Torture may have physical and psychological problems. Psychological problems may include:[32]

- Nightmares
- Hallucinations (eg seeing apparitions of torture)
- Panic attacks
- Sexual problems
- Phobias
- Difficulty trusting people/making relationships
- Depressive illness/anxiety.

While a great deal can be done by GPs and their colleagues in the primary health care team and by paediatricians and their colleagues in child health teams, some children and their families will need specialist referral to psychiatric clinics that specialise in PTSD or to doctors and counsellors who have particular expertise in working with victims of torture. Paediatricians will need to familiarise themselves with local and national facilities for the treatment of children and their families, who have experienced torture. (See Appendix 1).

5.8 Nutrition

Children may be well nourished or they may suffer from chronic under nutrition with stunting of growth. The following questions may be useful:

- Does the child and/or carer know how and where to buy and prepare a nutritionally balanced diet?
- Is the child /family eating a balanced diet?
- Is nutritional advice to the child and family delivered in a way that is sensitive to religious requirements and cultural preferences?
- Is the child thriving?
- Is the child suffering from nutritional deficiencies? (rickets, scurvy and thiamine deficiency are more commonly seen.)
- Is the child the correct weight/height for age and gaining weight/height normally?
- Is the child entitled to free school meals?

The UK centiles have been put together using data from Caucasian ethnic minorities and therefore some ethnic groups, for example, Somalians, may appear to be unusually tall and others may appear to be unusually short. It is important to refer children where there is more than a two centile discrepancy between height and weight or where serial measurements of growth fail to show adequate weight or height gain. Height measurements should be not less than three months apart and at least three height measurements should be used to assess height velocity. It is inadequate to use only two measurements to look for a puberty growth spurt, even though there may be pressure to do so, in order to save time.

5.9 HIV/AIDS and tropical and infectious diseases

5.9.1 HIV in children

In sub-Saharan Africa, the rate of HIV is now very high. In many countries, eg Zimbabwe, Zaire, Uganda, Tanzania, Kenya and South Africa, the ante-natal prevalence of HIV nationally is so high that around 10%-20% of all children born will be vertically infected with HIV. The classical signs of vertical HIV infection include persistent oral candida, dental caries, widespread lymphadenopathy, recurrent chest or genito-urinary infections, hepatosplenomegaly, failure to thrive or developmental delay. However, the range of opportunistic infections and organ disease in symptomatic HIV infection is so wide that the diagnosis should be considered in almost any child from sub-Saharan Africa with any chronic medical problems. Indeed, strong consideration should be given to the possibility of HIV in all new refugee children from sub-Saharan Africa.

The diagnosis of HIV in the child always virtually always implies that the mother has HIV infection, which obviously has implications for the family. Full implications of the

diagnosis to the family should be discussed in detail, using appropriate interpreters, prior to a test being performed. A paediatrician may wish to obtain help with pre-test counselling for the family from local genito-urinary medicine or adult infectious disease HIV services, but if these are not readily available, then the paediatrician should proceed with counselling and testing the family as they would with other infectious diseases. Should the child test positive for HIV, further specialist advice should be obtained from the Paediatric Infectious Diseases Unit at St George's Hospital, St Mary's Hospital or Great Ormond Street in London.

5.9.2 Other infections

These will vary according to the country of origin and a tropical disease expert should be contacted. Particular conditions to be aware of are gastroenteritis, tuberculosis, hepatitis B, malaria and schistosomiasis. Diphtheria has been more common in families of eastern European extraction.

Malaria needs to be considered in all children who are febrile and who have arrived within the last year from endemic malaria areas. 300-400 children per year are diagnosed with imported malaria, (increasingly falciparum) and the diagnosis is often delayed. If the child is persistently febrile and unwell and malaria films are negative then repeat blood cultures should be obtained with urgent consideration of typhoid.

Gut helminth infections are also very common in children arriving from Africa and Asia. If the child if failing to thrive, has intermittent diarrhoea, or has eosinophilia $>0.5 \times 10^9$/l on a blood film then the child should be empirically treated with albendazole irrespective of stool culture results. Hepatitis C infection is also more common in children from Asia and Africa. In any child where hepatitis B or HIV screening is undertaken, hepatitis C antibody should also be performed routinely. HIV, hepatitis B and C screening should also be considered for any child who has come from an area of conflict (eg Kosovo/Albanian refugees), as where the mother has been exposed to sexual assault there is a high chance of HIV, hepatitis B or C infection in the mother.

5.10 Female genital mutilation

Female genital mutilation (FGM) is illegal in most countries, including those where it is traditional. In Britain, The Prohibition of Female Circumcision Act 1985 makes it a criminal offence, punishable by up to 5 years imprisonment:

a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person; or

b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's body.

Although no prosecutions have been brought in the UK, a doctor was struck off in 1993 for performing multiple operations, knowing them to be against the law.

Despite illegality and considerable efforts in health education and campaigns, FGM persists among some of the women and girls who originate from countries where the practice persists (most notably across the African Sahel, extending in East Africa North into Egypt and South into Tanzania).

There are three forms of FGM[33].

a) **Circumcision** - cutting the hood of the clitoris

b) **Excision** - removal of the clitoris and all or part of the labia minora

c) **Infibulation** - removal of the clitoris, labia minora and all or part of the labia majora. The two sides of the vulva are then stitched together, leaving a small opening for the passage of urine or blood. Scar tissue forms, which usually must be cut to allow sexual intercourse to take place and for childbirth.

FGM presents immediate and long term health risks, of which paediatricians should be aware. Immediately after FGM there may be pain and a risk of haemorrhage, infection, urethral damage, anal sphincter damage, psychological trauma and even death. In the longer term, health risks include urinary obstruction, renal failure, obstruction in menstrual flow, haemosalpinx, pyelosalpinx, keloid, neuroma of dorsal clitoral nerve, vulval abscess, dyspareunia, infertility and psycho-sexual problems.

For paediatricians, FGM has been described as "a dilemma in child protection."[34] The paediatrician may face a situation where the child's parents have procured FGM but in other respects are caring and able parents. While being clear and uncompromising about the illegality and the harmful effects of FGM, a sensitive approach is required in order to work with families and communities for change.

6 Language and communication

The lack of a common language is one of the most fundamental obstacles to accessing healthcare. Paediatricians need to ensure that they and their colleagues are fully aware of local resources to assist with translation and interpreting, although as Jones and Gill[35] point out in the context of primary care, these local resources may be inadequate. As with any minority ethnic patients, the use of children and other family members as interpreters for child patients should be avoided, for all the usual reasons, but also because deeply distressing material may be disclosed. Children may wish to communicate about distressing events which they could not disclose if a family member was acting as interpreter. Equally, children should not be asked to interpret for adults except in cases of unavoidable urgency.

While emergency consultations may pose particular problems, it should be possible to book face-to-face or telephone interpreters for planned appointments. The importance of positive non verbal communication cannot be over emphasised as non-English speakers will rely on this to assess whether the doctor is friendly and trustworthy or not. It may be preferable to sit at right angles to the family as face to face confrontation may remind them of interviews with officials, and may make them feel uncomfortable.

Face-to-face interpreters should be asked whether they come from a sympathetic cultural background to the family to avoid choosing one from a rival group in a civil war. The family should be asked whether or not the interpreter is acceptable to them. Consideration should also be given to appropriate gender.

It is important to be aware of local sources of language support. Questions to ask include:

- *What interpreting sessions are available through the Health Authority?*
- *Does the local health authority have a contract with Language Line (a commercial provider of telephone interpreting) or access to other telephone interpreting services?*
- *Is there a local interpreting service in appropriate languages available to paediatricians in the community and in hospital settings?*
- *Does the local authority offer any access to interpreting services?*

7 Confidentiality

Like all NHS patients, refugee children have a right to be treated in a confidential manner by the attending doctor and any other healthcare staff. Paediatricians are under no obligation to divulge a consultation to other agencies unless it is in the best interests of the child to do so (eg where there is an issue of child protection). However, experience of healthcare systems in regimes where confidentiality is not observed as rigorously as in the UK may have undermined trust in the confidentiality of the NHS. Indeed, refugee children may think that undergoing a medical examination and divulging the outcome is an essential part of the asylum seeking process, which it is not. Reassurance and explanations of the right to confidentiality may need to be given on a number of occasions.

Excerpts from Principles of Confidentiality - the General Medical Council[36]

para 1 Patients have a right to expect that you will not disclose any personal information which you learn during the course of your professional duties, unless they give permission. Without assurances about confidentiality patients may be reluctant to give doctors the information they need in order to provide good care. For these reasons:

- When you are responsible for confidential information you must make sure that the information is effectively protected against improper disclosure when it is disposed of, stored, transmitted or received;
- When patients give consent to disclosure of information about them, you must make sure they understand what will be disclosed, the reasons for disclosure and the likely consequences;
- You must make sure that patients are informed whenever information about them is likely to be disclosed to others involved in their health care, and that they have the opportunity to withhold permission;
- You must respect requests by patients that information should not be disclosed to third parties, save in exceptional circumstances (for example, where the health or safety of others would otherwise be at serious risk);
- If you disclose confidential information you should release only as much information as is necessary for the purpose;
- You must make sure that health workers to whom you disclose information understand that it is given to them in confidence which they must respect;
- If you decide to disclose confidential information, you must be prepared to explain and justify your decision.

Disclosure in connection with judicial or other statutory proceedings

para 21 In the absence of a court order, a request for disclosure by a third party, for example, a solicitor, police officer, or officer of a court, is not sufficient justification for disclosure without a patient's consent.

Appendix 1
National resources and contacts

A number of non governmental organisations are active in projects to assist young refugees. The summary below should not be considered to be exhaustive, and projects vary from time to time. The details given below are included to give an idea of the kinds of help which may be available from key voluntary organisations in the UK. A list of useful addresses of advice and other agencies follows.

Barnardos

Barnardos works with children seeking asylum, both unaccompanied and in families, within a number of its services in London. There are two services which have a particular focus on this work:

Families in temporary accommodation

This project provides outreach services to children and families in temporary accommodation within Tower Hamlets, Westminster, Lambeth and Wandsworth. It also provides welfare and housing advice.

Refugee scheme

This service provides casework and befriending services to unaccompanied asylum seeking children aged 15-17 years. It is based near the Oval in London.

For further information on these services, contact Linda Howarth on 0181-551 0011.

Save the Children

Save the Children works with refugee children and young people in a number of different settings in England. A key principle is to work with them as with any groups of children or young people. This means thinking about wider issues – eg educational, economic and family concerns – and not only focusing on specific problems such as those related to health. Above all, it means listening to what young refugees have to say for themselves.

More specific examples of Save the Children's work and some contact information follow.

Younger refugee children

Save the Children London Younger Children's team aims to:

- equip early years practitioners with practical ways to support young refugee children;
- raise awareness of the rights of young children from asylum-seeking and refugee families;
- ensure that service development and delivery is co-ordinated to meet the needs of young refugee children and their families.

Current work in London includes lobbying and awareness raising through training based on 'Refugee Children in the Early Years', a report produced by Save the Children in partnership with the Refugee Council. The report covers practice development and provides a brief guide to the general health care issues that early years practitioners may need to be aware of when working with asylum seeking and refugee children and their families.

In South East London

Save the Children has worked with the Vietnamese refugees in Deptford, South London for almost 10 years - developing, managing and handing on work. Evaluations and/or project reports document all this work.

- Health Project 1992-5 (now managed by Community Health South London NHS Trust). Research into needs of refugees and developing services in response to major health issues they faced.
- Parent Support Project 1995-6/Family Support Project 1997-2000. Part of the Department of Health Parenting Initiative focusing on support for Vietnamese families with children with behavioural, emotional and developmental problems and disabilities. Follow-on work being considered.
- Children's and Young People's Participation Project – being developed in response to new research/needs analysis. Will engage refugee children and young people directly in devising projects to influence service provision by health providers/the local authority and to address exclusion issues.

In Oxfordshire

Save the Children works in Oxford with a group of young refugees aged 11-18 years. They have identified health and health care issues as important concerns that Save the Children is taking forward in two main ways. One is to help young refugees express their own views to health service providers about the treatment and services that they receive. Save the Children also works with social services (the lead agency) to influence their practice, and in turn that of health and other local authority providers, to develop their capacities to work better with refugee children and young people. From this work and connecting both these approaches, Save the Children is advocating nationally for

suitably qualified paediatricians to assess the health and developmental status of unaccompanied children in appropriate and sensitive ways immediately on arrival in the UK.

Deptford Vietnamese contact information:
Sue Emerson (SCF) Tel: 0181-741 4054
Lam Tran (DVFSP) Tel: 0181-692 1191

Oxfordshire contact information:
Nicola Chapman (SCF) Tel: 01865 792662

Horn of Africa Youth Scheme (HAYS) contact information:
Kaleb Wubneh (SCF) Tel: 0181-741 4054

The Children's Society

The Children's Society has a long history of commitment to the welfare and rights of all children and their families involved in asylum proceedings, reflected in their projects working with asylum seeking children and their families. This includes projects to:

- Promote the whole development and well-being of the child by providing equal life chances and opportunities
- Provide information, advice and support to enable asylum seeking families and children to meet basic needs such as food, housing and other living expenses;
- Ensure that asylum seeking children have comprehensive access to the education and health systems;
- Advance the integration of refugee groups into wider communities;
- Provide unaccompanied children with access to an independent visitor scheme through and beyond formal asylum proceedings.

For further information, contact Naomi Chunilal, Social Policy Unit, The Children's Society. Tel: 0171-841 4409 (direct line) or 0171-841 4400 (switchboard). Fax: 0171-837 0211. Email: nbc@childsoc.org.uk

International Social Service

International Social Service (ISS) offers an inter-country social work service and has worked extensively with unaccompanied refugee children in the UK. ISS has been running a project for unaccompanied young refugees from Yugoslavia, most of whom have been ethnic Albanian minors from Kosovo and surrounding Balkan regions. This has led to the development of a new charity, Albanian Youth Action, which will assist young people by giving advice on benefits, housing, health, legal and immigration services, by running group activities and English classes, and a range of other services. (Albanian Youth Action's address is as for ISS, but note different telephone number: 0171-582 6082).

For further information, contact ISS at Cranmer House, (3rd floor), 39 Brixton Road, London SW9 6DD. Tel: 0171-735 8941

Other useful addresses

Refugee Council
3 Bondway
London SW8 1SJ
Tel: 0171-820 3000
Refugee Council Advice Line Tel: 0171-582 9929 (Monday to Friday, 10.00am to 1.00pm).
For refugees, asylum seekers and people who work with them.

Joint Council for the Welfare of Immigrants
115 Old Street
London EC1V 9JR
Tel: 0171-251 8708
Advice line telephone: 0171-251 8706 (Monday, Tuesday, Thursday, 10.00am to 12.30pm)
Advice, information, help and representation for people with immigration or nationality problems.

Refugee Legal Centre
Sussex House
39-45 Bermondsey Street
London SE1 3XF
Tel: 0171-827 9090
Free legal advice for asylum seekers on all aspects of the asylum procedure and conditions of stay

Children's Legal Centre
University of Essex
Wivenhoe Park, Colchester
Essex
Tel: 01206 873820 (advice line, Monday - Friday 10.00am to 12.20pm and 2.00 - 4.30pm)
Legal advice, other than immigration, for refugee young people and children on issues such as education, care, social security, abuse etc.

Immigration Advisory Service
County House
190 Great Dover Street
London SE1 4YB
Tel: 0171-357 6917
24-hour helpline Tel: 0181-814 1559

Immigration Law Practitioners Association
1st floor, Lindsey House
40-41 Charterhouse Street
London EC1M 4JH
Tel: 0171-251 8383
Maintains directory of solicitors, barristers and other providers of immigration advice who are members of the Association.

Medical Foundation for the Care of Victims of Torture
96-98 Grafton Road
London NW5 3EJ
Tel: 0171-813 7777
Provides services for survivors of torture and other forms of organised violence. Centre staff carry out case work, counselling, advice regarding welfare rights, medical treatment, psychiatry, psychotherapy, group therapy, complementary therapy, family therapy, and child and adolescent psychotherapy. They can also advise people on how to register with a GP. Foundation staff run training sessions and workshops for professional groups working with refugees and survivors of torture, and can discuss issues with health care workers.

The Traumatic Stress Clinic
73 Charlotte Street
London W1P 1LB
Tel: 0171-530 3666
Offers treatment to refugees experiencing serious trauma reaction; also offers advice on local services for treating traumatic stress, and advice on management

Language Line
Swallow House
11-21 Northdown Street
London N1 9BN
Tel : (enquiries) 0171-520 1400 or 0800 78 33 503
Language Line is a commercial telephone interpreting service, across a wide range of languages. A number of Health Authorities and NHS Trusts have contracts with Language Line.

Community Health Council
The local Community Health Council (CHC) may be a useful source of support and advice for patients in getting the best out of the NHS. Their address can be found in the telephone directory.

Voluntary Action Council/
Council for Voluntary Service
Titles of voluntary organisations differ from place to place, but most areas have a Voluntary Action Council that will have knowledge of local community groups and organisations that can advise and assist refugees.

NHS Direct
Tel: 0845 46 47
An NHS 24-hour nurse-led telephone advice service, which has been operating in some areas since March 1998, and which will cover the whole country by autumn 2000.

Carers National Association
20-25 Glasshouse Yard
London EC1A 4JT
Tel: 0171-490 8898
Information line Tel: 0808 808 7777 (Monday to Friday 10.00am to 12 noon and 2.00pm to 4.00pm)
Provides information and advice to carers, and brings the needs of carers to the attention of policy makers.

Appendix 2
Entitlement to NHS services

Entitlement to free treatment

There is much misunderstanding on this issue, but the facts are simple: all refugees, those with Exceptional Leave to Remain (ELR) and asylum seekers are entitled to all NHS services, both in hospital and through a GP, just like other residents of the UK. ***Unlike some other overseas visitors, refugees and asylum seekers do not have to pay to see a GP or hospital doctor.*** Refugee children and adults should have access to the full range of primary, secondary and tertiary NHS services. If there is serious doubt about someone's refugee status, advice should be sought from Trust management, while being sensitive to the health needs and feelings of the patient. Great care should be taken not to deter refugees from seeking the health care to which they are entitled.

Charges for NHS prescriptions, NHS sight tests and vouchers for glasses and NHS dental treatment

Once someone has been recognised as a refugee or has ELR, they are, to all intents and purposes, treated the same as British citizens settled in the UK for health and benefits purposes. However, for help with health costs there are particular issues that apply to asylum seekers. Asylum seekers who are not eligible for income support have no automatic exemption from NHS prescription, dental and optical charges that accompanies receipt of income support. However, asylum seekers without means can apply for help with NHS charges because they are on a low income (or no income).

Entitlement to health care for refugees and asylum seekers

Excerpt from Statutory Instrument no. 306: The National Health Service (Charges to Overseas Visitors) Regulations 1989.

"Overseas visitors exempt from charges:

4. No charge shall be made in respect of any services forming part of the health service provided for an overseas visitor, being a person, or the spouse or child of a person-
c) who has been accepted as refugee in the United Kingdom, or who has made a formal application for leave to stay as a refugee in the United Kingdom…"

Excerpt from Health Service Circular HSC 1999/018
Overseas visitors' eligibility to receive free primary care

"A refugee given leave to remain in the UK should be regarded as ordinarily resident. A refugee who is in the UK awaiting the result of his application to remain in this country should also be regarded as ordinarily resident because he or she is residing lawfully for a settled purpose."

In order to apply for help with NHS charges, asylum seekers need to complete form HC1 (formerly known as AG1) which is obtainable from many surgeries and clinics, main post offices, benefit offices etc. However, this form is quite long and complicated and is only available in English, and people may need help and advice in order to complete it. Also, it can take several weeks to process the form, so wherever possible, asylum seekers should be advised to fill in the form at the earliest possible opportunity. If they wait until they need free prescriptions, or a free sight test, or free dental treatment, they will not be able to get the help as soon as it is needed. Unfortunately, new applications have to be made every 6 months, and this is a further obstacle for asylum seekers and any other people with complex problems in their lives.

Help with health costs - how child health teams can help asylum seekers who are not entitled to benefits

- Order a supply of HC1 forms from the Health Authority to keep in the surgery, and offer them to asylum seekers who are not eligible for financial benefits.
- Find out where help is available in appropriate languages to assist patients in completing these forms.
- Remind asylum seekers to fill the forms in before they actually need help with health costs, if possible.
- Ensure that all colleagues in the child health team are aware of the need to inform asylum seekers that they will need to apply for exemption from charges for prescriptions, dental care, sight tests, travel to hospital etc.

Access to primary care

Access to primary care is of the utmost importance to refugees, and guidelines on this issue have been produced for GPs[37]. There are no statutory barriers to refugees or asylum seekers in respect of accessing primary care. However, there may be other barriers in so far as patients may be unaware of their entitlements and GPs may be unclear about what they should do. The BMA gives clear advice, as follows[38]:

All asylum seekers have the right to be registered with a NHS doctor and therefore there is no obligation or expectation for doctors to check the immigration status of people registering to join their lists.

There is strong support for the view that GPs should offer permanent registration to refugees and asylum seekers, rather than temporary registration, wherever possible. In offering permanent registration, they are more likely to be able to offer ongoing care, and to obtain previous records if they exist. Temporary registration also removes incentives to undertake cervical smear tests and immunisations. Moreover, refugees may not be as mobile as is sometimes thought. Jones and Gill[35] refer to a Home Office study[27] that found that 70% of refugees had been living in their current home for more than a year.

Appendix 3
Entitlement to financial benefits

While it is not necessary for paediatricians to have a detailed knowledge of financial benefits for refugees, it may be helpful for them to understand the basics. The bottom line is that with the exception of relatively unusual situations where asylum seekers may have sufficient means to support themselves, for the majority of asylum seekers, poverty is high on the list of daily concerns. This problem is exacerbated as asylum seekers are not allowed to work or to participate in government training schemes for 6 months, after which they can seek permission to work from the Home Office. Those with refugee status or ELR are

permitted to seek work, but often find that they cannot secure employment commensurate with their skills and experience.

The "old" system - from 1996

Major changes in entitlement to benefits were introduced by the Asylum and Immigration Act 1996, and further far-reaching changes are contained in the Immigration and Asylum Bill which will become law during 1999. Under the old system (after 1996) there were different rules about entitlements to benefits for port applicants and in country applicants. Port applicants were permitted to claim income support, (at a lower rate than normal), housing benefit and council tax benefit. In-country applicants (other than those who claimed asylum before the benefits changes were introduced), or those appealing against a refusal to grant refugee status, were not eligible for these benefits (other than housing benefit). They had to rely on assistance from local authorities, under the National Assistance Act 1948. That Act gave local councils a responsibility to care for adult asylum seekers who were destitute, by providing them with support in kind. In other words, they had to provide food and shelter, generally given through vouchers, not cash. Families with children and unaccompanied children were supported under the Children Act 1989, and this can include cash.

The "new" system, as in the Immigration and Asylum Bill 1999

New arrangements will remove from all asylum seekers any entitlements to claim income support until they receive a positive decision (ie refugee status or ELR). They will also remove the responsibilities currently held by local authorities under the National Assistance Act 1948, and under current homelessness legislation. The essence of the proposals are to move to a virtually "cashless" system (in spite of some concessions that have been made, which have increased since the original proposals about the amount of cash that an asylum seeker may receive) with a new national agency, operated by the Home Office, organising the system. The proposed national agency would contract with a variety of providers around the country, including local authorities, housing associations, voluntary organisations and the private sector, to provide packages of support for asylum seekers. (Unaccompanied children would not be covered by this scheme and would continue to be the responsibility of the local authority under the Children Act 1989 - see Appendix 4).

Appendix 4
Social Services/Children Looked After framework

Unaccompanied children

Unaccompanied children, under the age of 18, should be entitled to a social work assessment as they are almost certainly "in need" within the meaning of the Children Act 1989. The assessment should result in a care plan being drafted for the young person which is likely to result in one of the following:

- The young person being provided with accommodation and appropriate support, including social work services
- The young person being looked after by the authority and placed in residential or foster care (the term "looked after" includes children who are accommodated with parental consent and those who are in care because of a court order.)

In practice local authorities treat young people ages 16 and above as single adults and find them private rented accommodation. If the young person is not "looked after" by the local authority, services will be provided on the basis that the unaccompanied minor is in need. The care plan should consider health, social, physical, religious and other needs. Care plans should be reviewed on a six-monthly basis However, few authorities complete a comprehensive care plan and often the case will not be allocated to a social worker.

Young people aged 15 or below are dealt with under the Children Act and usually will be "looked after" by the local authority. For "looked after" children, the regulations should ensure that comprehensive health assessments are undertaken and that proper arrangements are in place to support the young person as he/she becomes an adult. All "looked after" children should have an allocated key worker. Current recommendations[39] are that "looked after" children and young people should have a regular health assessment. This should result in a clear health plan which is promptly implemented and regularly monitored.

It is difficult to be precise, but there are approximately 2000 unaccompanied children being looked after by local authorities. No data is collected on the numbers of children from refugee families.

Access to services

Children with disabilities are entitled to help from social services. Access to services are based upon definitions of need and eligibility criteria. If someone meets the eligibility

criteria, they are entitled to an assessment and the local authority owes a duty to provide services that meet identified needs.

The relevant legislation governing the provision of services is:

- National Assistance Act (1948)
- Mental Health Act (1983)
- Children Act (1989)
- NHS and Community Care Act (1990)

Asylum seekers disqualified from claiming income support and other benefits are being supported under the National Assistance Act (see Appendix 3). This legislation places a duty upon local authorities to provide accommodation and other amenities to those who would otherwise be destitute. In the main, local authorities discharge this duty by placing asylum seekers in accommodation (often in the rented sector) and providing cash, vouchers or food parcels.

The new Immigration and Asylum Bill will change responsibilities. When the Bill is enacted, local authorities will not owe a duty to provide accommodation and support to destitute asylum seekers. That responsibility will rest with the Home Office. However, local authority Social Service departments will still be responsible for supporting unaccompanied minors. They will not, however, be responsible for supporting refugee families (other than unaccompanied children).

Asylum seekers are regarded as normally resident in the authority and are entitled to receive services under other social care legislation, subject to the threshold on need being met. Typically, services may include:

- Nursery provision
- Day care
- Home care
- Residential care
- Social work support
- Mobility and daily living equipment

Many local authorities, particularly those with large minority ethnic communities, make grants to community and refugee organisations for the provision of generic support services such as counselling, money advice, domestic violence etc. Some Health Authorities also use Joint Finance to support refugee and asylum services.

Out of hours services

Local authorities owe a duty to provide out of hours services to respond to social services and housing/homelessness emergencies. Every authority has an out of hours team and contact numbers should be available in every surgery, police station etc. Therefore social services should be able to respond to newly arrived children who present outside of normal office hours.

Children as carers

Children who act as carers would be entitled to a social services assessment as they are almost certainly "in need". Therefore, paediatricians and other doctors should be encouraged to refer these cases for a social work assessment. They should also be given the address of the National Carers Association. (See Appendix 1).

Appendix 5
Useful documents

United Nations Convention on Refugees. Geneva (1951)

United Nations Protocol (Relating to the Status of Refugees) Geneva (1967)

United Nations Convention on the Rights of the Child. Geneva. (1989)

Refugee Children - Guidelines on protection and care. United Nations High Commissioner for Refugees. Geneva (1994)

Guidelines on Policies and procedures in dealing with unaccompanied children seeking asylum. United Nations High Commissioner for Refugees. Geneva. (1997)

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