REFUGEE HEALTH MATTERS.

A newsletter brought to you by the Victorian Refugee Health fellows. Edition 1, 2014

SCREENING IN REFUGEE-BACKGROUND AND ASYLUM SEEKER CHILDREN

All refugee and asylum-seeking children should have an initial refugee health assessment after arrival in Australia.

- This should include screening tests – blood, stool, and tuberculin skin testing (TST). Include the source country on pathology forms, and note 'refugee screen'.
- It is important to explain the concepts of health assessment, screening and disease prevention; families need to understand the implications of health screening and **give informed consent**
- **Immigration detention screening is extremely limited for children** – it includes CXR for those 11 years +, blood tests for those 15 years +, and TB screening if there is known TB exposure.

Nearly all children require catch-up immunisation – usually 3 sets of needles completed over 4 months.

Blood

- **Full blood examination/film**
- **Ferritin**
- **Vitamin A**
- **Vitamin D, calcium, phosphate, ALP**
- **Malaria screen** (RDT and thick/thin film) if arrival date < 3 months from endemic area, or later if suggestive symptoms
- **Hepatitis B serology** (HBsAg, HBsAb, and HBcAb)
- **Hepatitis C serology** (Hepatitis C virus (HCV) antibodies)
- **Schistosoma serology**
- **Strongyloides serology**
- **Syphilis screening -** consider in all children to exclude congenital infection, should be completed if STI screening done, or where parents have positive serology
- **HIV testing**

Stool

- **Faecal specimen** - ideally a fixed specimen to improve detect parasites

TB Screen

- **TST–** the TST is the first line for TB screening in children < 14 years, and can be used at all ages. It is less reliable in infants < 6 months. Do not perform within 4-6 weeks of live viral vaccines, e.g. MMR.

Other tests to consider

- **STI screen** (*N. gonorrhoea* and *C. trachomatis* urine nucleic acid detection) in sexually active adolescents, or if there is a history of sexual violence.
- **B12 and folate** in children who have had restricted food access pre-arrival, and in children from Bhutan, Afghanistan, Iran and Iraq.
- **Blood lead levels** in children with pica, developmental delay or where there is a history suggesting exposure

SCREENING IS IMPORTANT. Most children have at least one issue detected that will require follow-up. Many children have several issues identified.

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PREVALENCE OF HEALTH CONDITIONS FROM INITIAL SCREENING

Evidence from paediatric and mixed child/adult refugee cohorts in Australia suggest the following prevalence figures:

Condition	Prevalence	Comments
Anaemia	10 – 20 %	Higher prevalence in younger children (< 5 years)
Iron deficiency	11 – 34 %	Higher prevalence in younger children (< 5 years)
Low vitamin D	60 - 90%	African
	33 - 37%	Karen
Low vitamin A	40%	African
Hepatitis B	3 – 21%	South Asian and African cohorts
Schistosoma	7 – 24%	African and South Asian cohorts, higher prevalence in African cohorts
Strongyloides	2 – 21%	Higher prevalence South Asian cohorts
Malaria	4 – 10%	Predominantly African cohorts
Active TB Infection	3.3%	Only one study
Latent TB infection (LTBI)	20 – 55%	African, South Asian and Middle Eastern Cohorts
Pathogenic faecal parasites	16 – 40% all groups	
Inadequate immunisation	100%	
STI, syphilis, hepatitis C, HIV	Limited data available	

FURTHER INFORMATION

- RCH: Initial Refugee health assessment (children) http://www.rch.org.au/immigranthealth/clinical/Initial_assessment/
- RCH: Tuberculosis screening http://www.rch.org.au/immigranthealth/clinical/Tuberculosis_screening/
- RCH: Immunisation catch-up (all ages) http://www.rch.org.au/immigranthealth/clinical/Catchup_immunisation_in_refugees/
- Foundation House: Caring for Refugees in General Practice (Children and Adults) http://www.foundationhouse.org.au/LiteratureRetrieve.aspx?ID=105005

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