

# Refugee and unaccompanied asylum seeking children and young people

## [Health Policy team](#)

?Child Protection Standing Committee and Advocacy Committee

This information aims to support paediatricians in the assessment and management of children and young people of refugee background, with links to key external information and resources. It was developed in partnership with the Child Protection Standing Committee and the Advocacy Committee.

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## **General information**

In 2014, there were just over 5,000 applications by dependent asylum seeking children less than 18 years old in the UK. The number of applications from unaccompanied children, excluding dependents, was 3,043 in 2015 - a 56% increase compared with 2014.

The largest number of applications from unaccompanied asylum seeking children in 2015 was from Eritrea, with 694 applications, and the second largest was from Afghanistan, with 656 applications.

In 2015, 62% of unaccompanied asylum seeking children were aged between 16-17 years, 26% between the ages of 14-15, 8% under 14 years of age, and 4% with an unknown age (unrelated to age disputes).

Although unaccompanied asylum seeking children represent a small percentage of the total number of looked-after children in the UK, it is important that local data on the number of them are captured in annual reports so that services can be adequately commissioned to meet the often complex health care needs of this vulnerable group of people.

## **Current UK asylum processes**

A refugee wishing to stay in the UK must apply for asylum on the basis of the Refugee Convention (or Article 3 of the European Convention on Human Rights). To be eligible, they must have left their country and be unable to go back because of fear of persecution.

If a person is granted refugee status the Government recognises that they fit the 1951 Refugee Convention definition of a refugee (or Article 3 of the European Convention on Human Rights).

Article one of the 1951 Convention outlines the position of refugees as, "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 to or, owing to such fear, is unwilling to avail himself of the protection of that country".

Refugees should apply for asylum when they arrive in the UK or as soon as they think it would be unsafe to return to their own country. After applying, refugees will have a meeting with an immigration officer (known as a 'screening') and then an asylum interview with a caseworker.

Decisions about applications are usually made within six months.

## **Current processes for asylum seeking children and young people**

A young person judged to be under 18 years of age, without an adult to care for them, is entitled to the same rights as other looked-after children and young people. This includes, accommodation, some finance, education, statutory health assessments, support and reviews.

This group of young people will most likely be given discretionary leave to remain until 17 and 1/2 years old, leaving detailed processing of an asylum application for when they are older.

Children and young people are entitled to legal aid. As much information as possible should be gathered using an appropriate interpreter at an early stage as this will be relevant to their application.

Specific statutory guidance is provided for England, Scotland and Wales.

## **Access to healthcare**

Refugee and unaccompanied asylum seeking children and young people have the same rights to care as UK nationals.

The Refugee Council provides a factsheet in a variety of languages which contains information on healthcare eligibility and access for people seeking asylum in the UK. They have also developed an information pack for refugees, which provides information about accessing health services.

For babies, children and young people born outside the UK, the usual route for obtaining an NHS number is to have one allocated through GP registration. In England, there is not set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services. Therefore, everyone is eligible to register with a GP practice. NHS England provide further information for patient registration.

Specific guidance on accessing NHS services is available for Scotland and Wales. In 2015, new regulations were introduced in Northern Ireland, meaning that all refugees and asylum seekers (including refused asylum seekers) are not required to pay for their healthcare treatment, including primary and secondary care.

Specialist referral should be made in the usual way. However, paediatricians should be aware of factors which may impact on a child or family being able to make appointments, such as language barriers and transport.

Where appropriate, a Personal Child Health Record (PCHR / 'red book') should be issued. These are available online from the health visitor, local health clinics and for some local authorities.

## **Key practice considerations**

### **Language, communication and interpreters**

For children and young people with English as a second language, any assessment should be undertaken with the support of a culturally appropriate, registered interpreter (considering ethnic and gender issues).

It is not appropriate for other children or young people to act as interpreters, or for people not trained as interpreters to perform this role. An interpreter telephone service can be used where access to a face-to-face interpreter is not possible.

It is important to remember that a health assessment may be the first opportunity that a child or young person has had to talk about their needs with a registered interpreter.

Remember to look at the young person, not the interpreter, when speaking and use positive, friendly, non-verbal communication.

It is important to explain to the young person and their carer that you will see them both individually, and then together. It is useful to discuss the care plan and any other issues (together with the family and social worker, if present) at the end of the assessment, particularly if there is an interpreter present (provided consent and confidentiality issues are considered).

## Consent

Paediatricians should refer to GMC guidance regarding information about obtaining consent and what to do if consent is refused. Further information is also provided by the BMA and the [Child Protection Companion](#).

You must have consent or other authority before examining, investigating or treating a child or young person. Unaccompanied minors may be able to consent to their own treatment, however, it is always good practice to attempt to contact their parents / guardians for a history and to communicate follow-up management.

In the UK, children and young people (including unaccompanied minors) can consent to treatment if they are deemed Gillick Competent. This means that they can:

- Understand the nature, purpose, benefits, risks and consequences of not proceeding
- Retain the information discussed
- Use and weigh this information
- Communicate their decisions to others.

A child or young person with capacity to consent, or who refuses, should have their decision respected unless there are exceptional circumstances.

Young people over 16 years of age should be assumed to have capacity unless there is reason to believe that they have an impairment of mind or brain that affects their capacity for the specific decision at the specific time. If there is doubt about capacity, an assessment of capacity should be undertaken.

Young people over 16 years of age who are assessed to lack mental capacity for a specific decision at a specific time should have an Independent Mental Capacity Advocate appointed, with the best interests decision-making process of the Mental Capacity Act (2005) followed. More information on Mental Capacity and best interests can be found in the Disability Matters eLearning Package.

## Confidentiality

As for all children and young people, it should be explained that in the UK, health information is recorded on a computer health system and shared with other health professionals (ie GP and health visitor). Health information may also be shared with other agencies (ie education and social services). It should also be explained that details will not be shared with outside agencies (ie legal or immigration officials) unless the young person and their family consent to this.

A copy of the care plan and information shared with other professionals should be sent to the young person / family in the usual way.

More detailed information on confidentiality is provided by the GMC and within the Child Protection Companion. The Caldicott principles on recording, keeping and sharing information should be followed.

## Paediatric health assessment

The health assessment of refugee children and young people - whether undertaken as part of a statutory initial health assessment for looked-after children, or as part of an initial general health assessment - should be a thorough and rounded assessment, commencing with a detailed history, as is expected for any child seen by a well-trained paediatrician.

Please note that an initial health assessment may be conducted by other health professionals. See '[Looked after children: Knowledge, skills and competence of healthcare staff](#)' for further information.

It is important to allow sufficient time to gather a comprehensive set of information at the initial meeting. This prevents the possibility that a child, young person or family may have to relive trauma and loss repeatedly.

Paediatricians should aim to understand the political circumstances of the child, young person or family's country of origin and countries of transit. A brief discussion will provide useful information as well as information about the processing of their asylum claims and any age determination issues.

Any assessment should include consideration of what has happened to the child, young person and / or family before entering the UK, en route and their final destination.

Paediatricians should use a structured proforma to avoid missing any health needs. This can help guide the conversation, to first discuss straightforward issues (ie demographics) and then dealing with subjects which may potentially cause distress.

Please note that there should be a minimal use of jargon and paediatricians should also be aware of cultural differences in the significance of a health concern.

[CoramBAAF's 'Promoting the Health of Children in Public Care'](#) provides an essential guide for health and social work professionals and commissioners.

### Past health

- Ask about surgery, illnesses requiring treatment, jaundice and fevers.
- Include specific questions regarding injuries.

### Pre-school children:

- Document perinatal history and any perinatal screening in the home country.
- If there is no history of neonatal screening (ie Guthrie or hearing screening) be aware that treatable conditions, such as hypothyroidism, could be missed.

- It should not be assumed that developmental problems are solely due to the displaced and traumatic refugee experience.

## **Family health**

- Ask routine history on consanguinity, siblings and family illnesses.
- Siblings and parents may be in detention centres or placed with other families. It is helpful for the young person to know their location and contact details.
- You can raise the question of family members in the context of possibility of family tracing.

## **Physical health**

- Undertake a complete systems examination.
- Include overall appearance, vision, hearing, chest, gut, skin, neurology, co-ordination, gait, cardiac, dental care, assessment of puberty (if indicated) and nutrition.

## **Growth and nutrition**

- Document height and weight and head circumference, using RCPCH centiles.
- If malnutrition is suspected, document Mid-Upper Arm Circumference.
- Look for signs of anemia and vitamin deficiency, including scurvy / thiamine and Vitamin D.
- Ask about diet and consumption.
- For younger children, weaning practices may vary due to unfamiliarity with local shopping and food insecurity. Some families may be dependent on food banks, which can have unsuitable food for children.
- Some young people may have experiences extremely poor diets in transfer to the UK, and often do not know how to cook for themselves.
- Nutrition should be documented, health visitor informed (where appropriate) and follow-up arranged with the local GP.
- See 'Food with TLC' by the Children's Trust and Fostering Network for more information.

## **Development**

- Document developmental milestones within play and learning. Include: schooling, learning difficulties, outstanding achievements and talents.
- Pre-school children should be referred for developmental assessment and further follow-up if there are any concerns. It may also be appropriate to refer school-aged children for further follow-up if there are any concerns.
- Signs of conditions (ie scabies, lice, eczema, infected acne) should be sought and documented.
- Presence of tattoos and risk of blood-borne disease (ie Hepatitis B and HIV) should be noted.
- Injuries should be documented carefully using a body map. Sample body maps are provided in the Child Protection Companion.
- If a sea journey was involved, ask about any near drowning / resuscitation episodes.
- Consider evidence of regression.

## Communicable diseases

- A significant number of refugees and asylum seekers arrive from countries where blood-borne infections are highly prevalent, and / or they may have been exposed to diseases on route to the UK. Please see the [Migrant Health Guide](#) for more information.
- Paediatricians should consider the possibility of: TB (document the presence of a BCG scar), hepatitis, scarlet fever, malaria, measles, typhus and enterovirus. Appropriate referrals should be made.
- TB should be considered in any child presenting with suggestive symptoms (including, but not exclusive to: fever, persistent, non-remitting cough, weight loss, failure to thrive, lethargy). An urgent referral to TB services should be made if symptomatic.
- Any child presenting from a country with a TB incidence of 40/100,000 or greater - including Afghanistan, Eritrea and Somalia - should be automatically referred to paediatric TB services for assessment (as per NICE guidance).
- Children from countries with lower rates of TB may have been brought into close contact with active pulmonary TB on their journeys (eg overcrowding) and these children should be referred for TB screening.
- Unaccompanied asylum seeking children are an especially vulnerable group. They should be assessed at Looked After Children (LAC) review for evidence of symptoms compatible with TB disease and screened proactively for latent TB Infection (TBI) either by the LAC team or through pre-existing referral pathways to TB services. They should not wait for IGRA screening through the current GP programme (available in some GP surgeries for those under 16 years of age from countries with TB incidence of 150/100,000).
- Children with blood-borne viruses such as Hepatitis B, C and HIV may be entirely asymptomatic. Children fleeing regions of conflict may not have benefited from ante-natal screening and they or their mothers may have been victims of sexual violence. Screening for Hepatitis B, C and HIV should be strongly considered.
- Paediatricians should be aware of the risk of soil transmitted (ie Ascaris and hookworm) and should send stool samples for ova, cysts and parasites, or consider empiric treatment with albendazole.
- Paediatricians should be aware of the risk of schistosomiasis and leishmania in children coming from endemic regions and consider testing.
- Paediatricians should consider testing for malaria parasitaemia in children from endemic areas. Please note that in Afghanistan, the risk of P. Vivax is higher than falciparum.
- Be aware of the risk of vaccine preventable diseases (ie cholera and typhoid) in child refugees and unaccompanied asylum seekers.

The information provided on TB and latent TB has been agreed by the London TB clinical leadership group (including adult physicians and public health specialists), the national paediatric TB network and the national TB nursing network.

## Immunisations

Many children and young people of refugee background will have unknown vaccination status, and paediatricians will need to assess the likelihood that standard immunisation protocols / WHO Immunisation Schedules would have been followed in the child or young person's country of origin.

For individuals with uncertain or incomplete immunisation status, these Public Health England (PHE) principles should be followed:

- Unless there is a reliable vaccine history, individuals should be assumed to be unimmunised and a full course of immunisations planned.
- Individuals coming to the UK part-way through their immunisation schedule should be transferred onto the UK schedule and immunised as appropriate for their age.
- If the primary course has been started but not completed, continue where left off. There is no need to repeat doses or restart the course.
- Plan catch-up immunisation schedule with minimum number of visits and within a minimum possible timescale. Aim to protect the individual in the shortest time possible.

## Sexual and reproductive health

- Asylum seeking children may have experienced rape and torture. Some may have worked as commercial sex workers either before, en route to, or following arrival in the UK. Others may have been in consensual relationships.
- Paediatricians should carry out a full sexual health review, including questions about whether a young person is sexually active and whether they are pregnant, as well as discussing contraceptive options.
- Ideally, this should be carried out in the context of a comprehensive assessment and in association with the local GUM (genitourinary medicine) service.
- Please see [BAAF Practice Note 53](#) for guidelines for the testing of looked after children.

## Mental health and emotional well-being

- Sleep and behaviour disturbances may be common in younger children.
- Some young people may have been trafficked to the UK and / or experienced past traumas (ie acting as a child soldier). This group may suffer a range of psychological morbidities related to their experiences in their country of origin, their journey to the UK and entering the country.
- It is recommended that mental health screening tools - such as the Strength and Difficulties Questionnaire - is completed for all young people. This may give insight into other difficulties - for looked after children in England, this is the responsibility of the local authority. If a child or young person is deemed high risk of behavioural difficulties, an appropriate referral should be made to looked after children's CAMHS or CAMHS (depending on service provision).
- Paediatricians should ask questions about past experiences - including bereavement from war, torture and trafficking - as asylum seeking children are at risk of Post-Traumatic Stress Disorder (PTSD) and may require monitoring for up to 12 months.
- Mental health screening can be useful to identify PTSD and other difficulties, such as problems with sleeping, anger, or self-harm. It is essential that these questions are asked sensitively. NICE guidance on management of PTSD in adults and children provides further details on screening of individuals involved in a major disaster, refugees and asylum seekers.

- On arrival in a new country, children, young people and their families may experience bullying or racism, lack of social support and / or a lack of access to education, which increases vulnerability.
- Follow-up should be arranged with the local GP if there are concerns about any aspect of a child or young person's developmental physical or emotional well-being.

## **Safeguarding and child protection issues**

- If an unaccompanied child is presenting, having not previously been known to social services, an immediate referral needs to be made to the local authority's children's social care. In these settings, there is a significant concern about their vulnerability to being trafficked - though they will need to make an asylum application as soon as possible, the primal concern is safeguarding and ensuring that they are taken into the care of the local authority who then have a duty to care for them, including help with legal representation. When there are concerns around trafficking, they should also be referred to the NSPCC, who have statutory powers to intervene on behalf of children.
- Paediatricians should also assess a young person's vulnerabilities to sexual exploitation and risk of trafficking.
- Exposure to violence, rape and / or other trauma should be explored sensitively. Not all young people are able to disclose on first assessment if they have been raped and this will need careful inquiry. The same line of questioning should apply to young men and women.
- Paediatricians should ask girls / young women if they have ever been subjected to Female Genital Mutilation (FGM). They should be informed that FGM is illegal in the UK, including when a child is taken out of the country for the procedure. They should be provided with a copy of the health passport. If they have been 'cut', a referral should be made to a local specialist unit for a follow-up assessment.
- Paediatricians should also be alert to the possibility of radicalisation and should consider making a prevent referral.
- Paediatricians should ask about current experiences of bullying or racism and consider whether and how a lack of social support or educational place may also increase their vulnerability.
- Safeguarding concerns may also arise following an unsafe environment for the child in temporary accommodation or due to neglect or physical abuse.
- Please see the [Child Protection Companion](#) for further information.

## **Health promotion**

- Health promotion messages are important and paediatricians should play an essential role in providing early health promotion messages to young people.
- Messages should concentrate on well-established areas, such as healthy eating, smoking, how to stay safe and avoid danger, good sexual health (including how to access sexual health services), and when to access GP services.
- Health promotion messages should be continued by other healthcare professionals, including specialist nurses for looked after children and school nurses.

## **Social health and well-being**

### **Pre-school children**

- Families may be in serious poverty with little access to play opportunities - particularly for younger children.

## **Young people**

- Inquire about a young person's social networks. This should include questions about who they can talk to, whether they have started to make friends, whether they want to access faith or cultural groups, whether they know about college placement or local sports access. These are ways of starting to carry out normal activities to support good mental health.
- Encourage and support resilience, as well as addressing painful issues. Ask about aspirations should the young person not be caught up in war.
- Sometimes the views and wishes of the young person may be at odds with carers or social workers. Often there is a cultural reason or misunderstanding for this. Having an interpreter present gives an opportunity when the carer and young person are brought together (with the young person's consent) to allow some of these issues to be addressed in a way that acknowledges their needs, together with those of the carer or society, in order to make their future easier.
- Remember that a young person's expectations can be very different in different cultures. They may have also had difficult experiences with people in a position of authority in the past.
- It is recommended that you also talk to the child, young person or family about their past experience of education.

## **Care planning and follow-up**

Please download the checklist of actions below.

## **Age assessment**

Most refugee children and young people will not have a passport, although some may have been given a passport to help them to leave a situation where they are at risk. Sometimes the child's stated age may be disputed, with serious implications for the outcome of their asylum claim and for their ability to access health services, education and welfare support.

Adults indicating that they are children present a risk to younger children if they are placed into accommodation together. However, the converse is also true and young people should not be placed with adults.

The Home Office and the Association of Directors of Children's Services have produced joint working guidance about how UK Visas and Immigration decide applications.

The Association of Directors of Children's Services have produced age assessment guidance for assisting English social workers in conducting age assessments of unaccompanied children seeking asylum. This states that the process for age determination by the local authority should take place in the presence of an appropriate adult, by two qualified and one senior social worker, taking into account a number of social and other factors. If in doubt, the local authority should give the young person the benefit of the doubt as to their age. Age assessment guidance has also been developed in Scotland and Wales.

In these situations, remember that there is no single reliable method for making precise age estimates. The most appropriate approach is to use a holistic evaluation, incorporating narrative accounts, physical assessment of teeth, puberty and growth, and cognitive behaviour and emotional assessment.

The use of radiological assessment is extremely imprecise and can only give an estimate of within two years in either direction, and the use of ionising radiation for this purpose is inappropriate. The British Society for Paediatric Endocrinology and Diabetes are clear that it is not possible to accurately assess a child's age based on physical examination or bone age assessment. It is therefore important for paediatricians, when contacted, to explain to social workers that dental x-rays, bone age and genital examination will currently not add any further information to the assessment process. However, this may change in the future if there is new evidence.

Some age assessments carried out by the Home Office have been subject to dispute with some young people subsequently assessed to be minors. Further information about age disputes is available from the Coram Children's Legal Centre.

## **Children in detention**

Children and young people may be placed in detention centres.

The Refugee Council have produced an information briefing, which includes statistics on the number of children entering detention.

There are significant safeguarding issues for children housed in detention centres. If a professional becomes aware of a minor in a detention centre, social services should be notified as soon as possible.

## **Useful definitions**

### **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 (United Nations Convention, 1951).

## **Asylum seeker**

An asylum seeker is someone who says he or she is a refugee and has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention of Human Rights, but their application has not yet been definitively evaluated (UNHCR).

## **Unaccompanied Asylum Seeking Child (UASC)**

An Unaccompanied Asylum Seeking Child (UASC) is a child or young person seeking asylum without the presence of a legal guardian. The definition for immigration purposes of an unaccompanied asylum seeking child is given by the Home Office as "a person under 18 years of age or who, in the absence of documentary evidence establishing age, appears to be under that age" who "is applying for asylum in their own right; and is separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so". Children in this situation are also known as separated children or Unaccompanied Minors (UAM).

## **Age-disputed child or young person**

An age-disputed child or young person is a child or young person whose age has been disputed and has not had their claimed date of birth accepted by the Home Office and / or by the local authority that he or she has approached to provide support or protection. This term is usually used to refer to people who claim to be children, but who are treated as adults by the Home Office and / or the local authority.

## **Separated child**

A separated child is a child who has been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. The Home Office definition of unaccompanied children does not include children who arrived in the UK in the care of a parent or other adult (eg a relative or family friend) who by law has responsibility for the child, even if the child is no longer living with such an adult due to the subsequent breakdown of such an arrangement.

## **Trafficking**

Trafficking is the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs (UNODC).

## **External links**

[Refugee Council - statistics](#)

[Home Office - claiming asylum in the UK](#)

[Statutory guidance in England](#)

[Statutory guidance in Scotland \(Scottish Guardianship Service\)](#)

[Statutory guidance in Wales](#)  
[Refugee Council - multilingual information and fact sheets](#)  
[NHS England - Standard Operating Principles for Patient Registration](#)  
[Welsh Refugee Council - Access to Healthcare for Migrants in Wales](#)  
[Scotland - Healthcare for refugees and asylum seekers](#)  
[Northern Ireland - Access to healthcare for migrants](#)  
[GMC guidance - consent](#)  
[BMA - seeking consent](#)  
[Gillick Competency](#)  
[Social Care Institute for Excellence - making 'best interest' decisions](#)  
[Mental Capacity Act \(2005\)](#)  
[Disability Matters - Mental Capacity](#)  
[GMC guidance - confidentiality](#)  
[CoramBAAF - Promoting the Health of Children in Public Care](#)  
[Food with TLC - supporting children in care to eat well](#)  
[Migrant Health Guide](#)  
[Simmonds & Merredew - Health Needs of Unaccompanied Asylum Seeking Children](#)  
[PHE - Vaccination of uncertain / incomplete individuals](#)  
[BAAF Practice Note 53](#)  
[Strength and Difficulties Questionnaire](#)  
[NICE Guidance - PTSD](#)  
[NSPCC - child trafficking](#)  
[FGM- Health Passport](#)  
[Radicalisation - prevent strategy](#)  
[Home Office and ADCS guidance on VISA applications](#)  
[ADCS - England age assessment guidance](#)  
[Scotland age assessment guidance](#)  
[Wales age assessment guidance](#)  
[Coram Children's Legal Centre](#)  
[Refugee Council - detention of children](#)  
[UNCHR - asylum seeker](#)  
[UNOCD - trafficking](#)  
[Anderson & Blinder - 'Who counts as a migrant? Definitions and their consequenc...](#)  
[Craig - 'Mental distress and psychological interventions in refugee populations'](#)  
[Department for Health & Department for Education - 'Promoting the health and we...](#)  
[Devakumar et al. - 'The intergenerational effects of war on the health of child...](#)  
[Devakumar et al. - 'Child health in Syria: recognising the lasting effect of wa...](#)  
[Faculty of Public Health - 'The health needs of asylum seekers'](#)  
[Fazel et al. - 'Mental health of displaced and refugee children resettled in hi...](#)  
[Home Office - 'Asylum policy instruction discretionary leave'](#)  
[Home Office - 'National statistics: asylum'](#)  
[Lorek - 'Promoting the health of children in public care'](#)  
[Merredew & Simmonds - 'The health needs of unaccompanied asylum seeking childre...](#)  
[O'Donnell et al. - 'They think we're OK and we know we're not'. A qualitative s...](#)  
[Refugee Council - 'The Children's Section'](#)  
[Ritz et al. - 'Tuberculosis in young refugees'](#)  
[Smith - 'Statement of Good Practice'](#)  
[UKBA - 'Assessing Age'](#)  
[UNHCR - 'Guidelines on the applicable criteria and standards relating to the de...](#)  
[UNHCR - 'Asylum-seekers'](#)

[UNHCR - 'Global trends - forced displacement in 2014'](#)

Downloads

[Checklist for refugee and unaccompanied asylum seeking children.pdf](#)98.94 KB

[Looked After Children - Knowledge skills and competences of health care staff.pdf](#)558.73 KB

[X rays and asylum seeking children policy statement.pdf](#)7.85 KB