

Refugees, asylum seekers, and general practice: room for improvement?

IN the absence of a coherent national policy on the reception of refugees and asylum seekers to the United Kingdom (UK), general practitioners (GPs) are called upon to deal with the health concerns of these individuals. In 1998, 46 000 refugees and asylum seekers entered the UK claiming political asylum.¹ They join the thousands of refugees already here, over two-thirds of whom are thought to live in London.² In 1998, the majority of applicants seeking refuge in the UK were from the former Yugoslavia, Somalia, Sri Lanka, and Afghanistan, and over 60% were men under 35 years of age.

Refugees, like many recent immigrants, present to GPs with a large number of health concerns, which places considerable strain on doctors with limited time allocated to individual patients. In particular, refugees may come from areas of war and famine, where existing medical systems have broken down. One study estimated that one in six refugees had a physical health problem severe enough to affect their way of life.²

There are many infectious diseases associated with this population. The speed of air travel means that severe tropical diseases, such as malaria, may be acquired in the home country and present in the UK. In a survey of Vietnamese refugees arriving in the United States of America, gastrointestinal parasites, such as hookworms, *Ascaris lumbricoides*, *Trichuris trichiura*, and *Strongyloides stercoralis*, were identified in 40% of cases.³ Protozoal infection with *Cryptosporidium*, *Giardia lamblia*, and *Entamoeba histolytica* are also common in developing countries. In addition, carriage of chronic infections, such as hepatitis B and C, is endemic in many parts of the world. It is important to identify all cases of hepatitis, since pregnant asymptomatic carriers have the potential to transmit infection vertically and infected patients present special hazards to health care workers, including GPs. Tuberculosis is of increasing public health importance in the UK and is more prevalent in foreign-born individuals, even those coming from other parts of Europe, such as the former Yugoslavia.⁴ The increasing prevalence of drug-resistant strains from many parts of the world, such as sub-Saharan Africa and the former Soviet Union, is of major concern.⁵

Infectious diseases, although important in public health terms, are certainly not the only diseases found in this group, which has high rates of smoking, hypertension, chronic heart disease, and psychiatric concerns. Psychological problems may stem from torture, imprisonment, bereavement, cultural alienation, isolation, and the separation of families; depression is a major problem in refugees and asylum seekers. Furthermore, refugees may not be included in health maintenance programmes and may be incorrectly or inadequately immunised.

Owing primarily to its public health implications, immigration regulations emphasise screening for tuberculosis to detect active disease and to identify those requiring chemoprophylaxis and vaccination. Port Health Control Units are meant to co-ordinate this programme at Gatwick and Heathrow airports; asylum seekers should be referred by immigration officials for a chest radiograph and physical examination.⁶ However, a large, unquantified number of asylum seekers are not included in this programme. Smaller ports of entry do not offer screening and there is considerable doubt as to whether systems at Gatwick and Heathrow are robust enough to cope with the number of new entrants. Subsequently, the Consultant for Communicable Disease Control (CCDC) in the health authority in which the

asylum seeker is planning to reside (sometimes an asylum seeker will give a forwarding address, or will be directed to a hostel from the ports of entry) is responsible for contacting asylum seekers. The CCDC should explain the procedure for tuberculosis follow-up and encourage registration with a GP; however, resources to enable this follow-up are limited. Community follow-up for chemoprophylaxis and vaccination is most important since new arrivals are at greatest risk of developing tuberculosis within about five years after arrival to the UK.

During the period in which individuals wait for approval or rejection of their asylum application (a process that may last years), it currently falls on GPs to provide for their health care. Surveys have pointed to serious deficiencies in primary care provision for refugees in the UK.^{7,8} The fact that most GPs are unaware that there is tuberculosis screening reflects the ineffectiveness of the programme. Few GPs routinely refer refugees for tuberculosis screening, and most appear to do little or no screening for common health conditions, infectious diseases, vaccination status, or inquire about the refugees' mental health. One reason for this is that refugees are often registered by GPs as temporary rather than permanent patients. This is possibly because this population is viewed as mobile, although this may not be the reality.² GPs may also be concerned that they will be penalised for failing to meet targets, such as those for cervical screening and vaccination, although there are no data to support this. As a result of temporary registration the refugee may be denied the basic health check and other fee-for-service items, and will not have a complete set of medical records.

All refugees, irrespective of status, have the right to register with a GP and use the full range of NHS services free of charge. Some GPs appear to be confused about this.^{7,8} Although it can be difficult for a GP to tell a legitimate refugee or asylum seeker from an illegal immigrant — and most asylum claims in the UK will be turned down eventually — this should not influence immediate care. Attitudes to asylum seekers clearly vary between GP practices; some are open to refugees while others are not so welcoming. GPs have identified language difficulties as an obstacle to accessing and fully benefiting from NHS services.⁹ The present situation results in refugees inappropriately using casualty departments and often allowing their health to deteriorate to the point where they need hospital admission.

There is an obvious need to improve the health care of refugees at a primary care level but GPs cannot be expected to take on the task single-handedly. What is the solution to this problem? In the immediate future, both refugees and asylum seekers should always be fully registered by GPs. They must be screened for common diseases, including tuberculosis, as well as for other infections and psychiatric problems.

An alternative longer term solution is the development of refugee-oriented centres for these individuals. These should be sited at districts near their residences and not at the port of entry. They should not be associated with immigration formalities but should provide services that refugees and asylum seekers would see as helpful and not threatening. These centres could be accessed via self-referral or by health care or outreach workers who often meet this group relatively soon after arrival. Such a centre should house health care professionals educated in refugee health concerns and facilitate access to infectious disease physicians, tuberculosis specialists, gynaecologists, paediatricians,

dentists, and psychiatrists. Simple but complete screening of families could be done at a single visit and it will be important for the centre to have strong links to tuberculosis services. Social services should be integrated into the system to provide advice on housing, employment, and welfare benefits. GP practices could have refugees and asylum seekers referred from such centres. A study comparing such a centre-based model with a GP-led scheme would be worthy of formal trial. In either case, it must be a priority that GPs who deal with a large number of refugees are educated effectively as to their medical and social concerns. GPs need to be aware of local interpreting services which should be improved if they are inadequate. The possibility of patient-held records would also be worth examining in a formal trial in this group of patients. Health authorities need to work closely with GPs and provide regular information on the dominant nationalities entering an area. Finally, incentives for GPs to care for these patients, possibly similar to special payments made by health authorities for managing drug misuse in the community, should be considered as there is evidence that current deprivation payments are insufficient.¹⁰ Options for management of refugee and asylum seeker health care should be reviewed urgently since the benefits of screening for certain diseases are established and cost-effective, and action now will reduce the considerable and unnecessary suffering of asylum seekers and refugees.

SALLY HARGREAVES
Researcher

ALISON HOLMES
Senior Lecturer and Honorary Consultant

JON S FRIEDLAND

Senior Lecturer and Honorary Consultant,
Department of Infectious Diseases, Hammersmith Hospital,
London

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Address for correspondence

Jon S Friedland, Department of Infectious Diseases, Hammersmith Hospital, Du Cane Road, London W12 0NN. E-mail: j.friedland@ic.ac.uk

The impact of hepatitis C in general practice

IT is becoming clear that what was previously thought to be an uncommon infection — hepatitis C — is emerging as a serious public health concern in the United Kingdom (UK). Globally, hepatitis C is 7.5 times more prevalent than HIV infection (3% versus 0.4%) and some Mediterranean and North African countries as well as those in the Far East are disproportionately affected by this infection.¹ Recent reports in the United States of America suggest 1.8% of the population is infected with hepatitis C and this amounts to approximately 2.7 million people.^{2,3} The prevalence of hepatitis C antibodies in new blood donors (a selected low risk population) in England and Wales during 1998 was 43.90 per 100 000 (0.044%).⁴ The incidence of hepatitis C in the general population is unknown but studies are underway to elucidate this.⁵ Globally, it is estimated that the incidence is 1–3 cases per 100 000.⁶

Hepatitis C is thus an emerging and important public health problem and general practitioners (GPs), among other medical personnel, ought to be aware of this. Exactly why is it so important?

Hepatitis C is a silent infection and is primarily transmitted parenterally. Moreover, it is associated with a chronic carrier state morbidity in which 20% of infected people may develop cirrhosis.⁶ In industrialised countries the virus accounts for 40% of end-stage cirrhosis and is the reason behind 30% of all liver transplants.⁶ The incidence of hepato-cellular carcinoma is 1%–4% per year in patients with cirrhosis secondary to hepatitis C.

Historically, hepatitis C emerged from what used to be called non-A, non-B hepatitis — the commonest form of transfusion-related hepatitis. It was identified in 1989 and in the same year the first generation enzyme-linked immunosorbent assays

(ELISAs) for anti-HCV antibodies became available.⁷ The routine screening of all blood donations commenced in the UK in September 1991.

The hepatitis C virus (HCV) pathogen is one of the five viruses (A, B, C, D, and E) that, together, account for the vast majority of viral hepatitis. It is a single-stranded enveloped RNA virus that has a relatively narrow host range (humans and chimpanzees). Various hepatitis C genotypes have been identified and these reflect subtle differences in viral pathogenicity, response to treatment, and overall prognosis.

HCV is spread mainly through the parenteral route. Prior to blood donation testing, many infections arose through the administration of blood and/or its products. Injecting drug use has been, and remains, the most important route of transmission.^{6,8} Among laboratory reports of hepatitis C infection in England and Wales from 1992 to 1996, 80% reported probable infection by injecting drug-use.⁹ Even among blood donors — a group from which injecting drug-users are asked to exclude themselves — 30% of people with HCV infection report 'injecting' (often many years previously) as the probable route of infection. In addition, another 26% report 'possible contact with blood' (including tattoos, acupuncture, and occupational exposure) and 15% report other blood/tissue transfer.¹⁰ Sexual transmission is relatively uncommon, as evidenced by the low rates of infection in stable homosexual or heterosexual couples with discordant infection status. Other high-risk groups for infection are prisoners, largely through injecting drug use, and infants born to mothers with chronic hepatitis C.¹¹⁻¹²

The vertical transmission of HCV is approximately 6%, though certain procedures; for example, elective caesarean section and avoidance of breast-feeding, have not been shown to reduce this figure, unlike in the case of HIV infection.⁶

Hepatitis C is undoubtedly more infective than HIV following a needle-stick injury (3% compared with 0.3%); however, in the case of HCV there is no post-exposure treatment at present.⁶ In more general terms seroconversion in hepatitis C can take up to six months; hence follow-up is mandatory for patients who may have been at risk.

Patients who test positive for hepatitis C antibody EIA tests are offered additional tests, usually recombinant immunoblot assays, in order to confirm the initial results. Viral load measurements and HCV polymerase chain reaction (PCR) will usually confirm the presence of circulating virus in much the same way as in HIV infection. In the recently published North American study, two-thirds of those infected with HCV were PCR-positive, indicating circulating virus.²

The current treatment regimes for HCV infection use a combination approach on the basis that it enhances efficacy and reduces resistance. Optimal treatment for hepatitis C infection combines subcutaneous Interferon and oral Ribavirin for six months for non-Type 1 genotype or 12 months treatment for genotype-1.⁶ Long-term viral clearance — defined as individuals who are PCR-negative six months after cessation of therapy — may be seen in 40% of patients overall. The evidence in monotherapy is that the 'cure' rates are lower and the relapse rate higher following cessation of treatment.

General practitioners who are seeing patients with hepatitis C could familiarise themselves with some of the major contraindications to this treatment; for example, Ribavirin is highly teratogenic and therefore fail-safe contraception is mandatory. Interferon, which is used in several conditions, is hampered by protracted flu-like effects, alteration in mood (irritability and depression), and haematological complications owing to myelosuppression. Primary care also has a role in supporting individuals who are using these regimes, the overall success of which is ultimately dependent on patient motivation and overall adherence to treatment.

Can the experiences of HIV infection help in this new and burgeoning public health challenge of hepatitis C?

First, in considering a diagnosis of HCV in a patient the main lesson is *not* to avoid discussing difficult issues where personal lifestyle may be relevant.¹³ An increasingly common occurrence is the asymptomatic patient who manifests as having abnormal liver function tests but with no known risk factors. Being aware of their indigenous place of birth and taking careful sexual, drug use, and transfusion histories (including blood-products), will help to identify those patients who are at risk for hepatitis C infection.¹⁴ Discussion regarding sexual transmission in discordant couples should be frank and acknowledge the incompleteness of data regarding transmission rates.^{13,14}

It goes without saying that testing for hepatitis C needs the informed consent of the patient. One vital lesson from HIV is that comprehensive counselling is not required as this is time-consuming and may be a deterrent to obtaining a working diagnosis.

General practitioners who know their practice population can provide an appropriate testing environment with a brief, focused history and individual risk assessment. This stance is fully supported by the Department of Health in their guidance from 1996, specifically about HIV infection.¹⁵

As in the case of either HIV or hepatitis C it is essential that GPs have effective communication channels with specialist centres and GPs must also be kept informed of treatment and complications as they arise.¹⁶⁻¹⁷

How should GPs, especially those working in the inner cities, respond to what may become a steady flow of patients with HCV? Clearly, patients who present to GPs need targeted information about hepatitis C and here the British Liver Trust may be a useful source of advice and help.¹⁸ Referral to recognised centres of excellence is key, since access to new tests, treatments, and clinical trials are interventions that interest some patients and where experience and expertise are at a premium.

Patients with hepatitis C live with a significant degree of uncertainty and this mirrors the early experiences of HIV infection. The greater potential for transmission of hepatitis C and its silent on-going infection, along with the implications for partner, family, and children, mean that it is essential that GPs are involved in overall care and management. For many health care professionals, the workload implications remain undetermined; however, anonymous unlinked testing is now a component of governmental strategy designed to enhance the analysis and monitoring of hepatitis C prevalence in the UK.⁵

Alongside these factors, key financial considerations are worth pondering, taking into account the spiralling costs of combination anti-retroviral therapy for HIV infection. One significant difference is that in hepatitis C the therapeutic possibility of organ transplantation exists, though re-infection rates are high.⁶

Lastly, if hepatitis C evolves in the same way as HIV infection then it may be that in 15 years' time it is regarded as another chronic but incurable infection that needs to be managed in both community and hospital settings. Hepatitis C infection represents a serious but, as yet, undefined public health challenge and one in which planning at an early stage may well pay dividends later. GPs, either directly or through their primary care groups, have a responsibility to participate in that planning as much as their specialist colleagues.

SURINDER SINGH

*Clinical Lecturer and Principal in General Practice,
Royal Free and University College Medical School
University College London*

RIVA MILLER

*Counselling Co-ordinator and Honorary Senior Lecturer, The
Haemophilia Centre and Haemostasis Unit, The Royal Free
Hospital NHS Trust*

SARA MADGE

*GP Fellow and General Practitioner, Royal Free Centre for HIV
Medicine, The Royal Free Hospital NHS Trust*

DAVID PATCH

*Consultant Physician and Honorary Senior Lecturer, Academic
Medical Unit, The Royal Free Hospital NHS Trust*

*Further information on hepatitis C is available from the Public
Health Laboratory Service (<http://phls.co.uk/cdsc>) and from the
World Health Organisation (<http://www.who.ch/>)*

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Address for correspondence

Dr Surinder Singh, Royal Free and University College Medical School, University College London, Royal Free Campus, Rowland Hill Street, London NW3 2PF. E-mail: vicars@rfhsm.ac.uk