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¹ Section 5 has been added in February 2007. Sections 3.4 and 3.5 were updated in December 2006. The majority of the remaining content of this instruction dates back to 2001 and will be updated in the near future.

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CHAPTER 1
SECTION 8

MEDICAL

1. INTRODUCTION

This section provides the following guidance:

- * **"on entry"** - the referral of passengers, by the immigration officer, to a port medical inspector for medical examination (including advice about persons suffering from AIDS or HIV infection);
- * **"after entry/referred entry clearance"** - AIDS/HIV infection cases; and
- * **"after entry"** - advice about power under the Mental Health Acts, and procedures to remove from the United Kingdom overseas nationals who are receiving in-patient treatment for mental illness.

Guidance relating to "Assistance from the Department of Health with Medical aspects of cases at ports" is provided in Chapter 25, "Liaison with other Government Departments etc."

For guidance relating to persons seeking leave to enter or remain for private medical treatment, see Chapter 2, Section 3, "Visitors for private medical treatment"

2. ON ENTRY - REFERRAL OF PASSENGERS BY THE IMMIGRATION OFFICER TO THE PORT MEDICAL INSPECTOR

Paragraph 36 of HC 395 specifies certain categories of passengers who should normally be referred to the medical inspector.

Please note - in 1979 the Home Secretary gave instructions that medical inspectors should not be asked to examine passengers with a view to establishing whether they have borne children or have had sexual relations. In 1982 the Home Secretary gave further instructions that medical inspectors should not be asked to X-ray persons for the purpose of assessing their age. It is essential that all these instructions should be strictly observed.

² Section 5 has been added in February 2007. Sections 3.4 and 3.5 were updated in December 2006. The majority of remaining content within this instruction dates back to 2001, and will be revised in the near future.

2.1. **Circumstances in which a medical inspector would issue a medical certificate**

The medical inspector would normally certify that it is undesirable for medical reasons to admit a passenger if the person were found or suspected to be suffering from pulmonary tuberculosis, venereal disease, leprosy or trachoma, or if he were heavily infested with lice, bodily dirty or suffering from scabies. A certificate would also be issued if the nature of the person's condition would interfere with his ability to support himself or his dependants.

2.2. **Classes of persons to be medically examined**

The classes of persons who should normally be referred to the medical inspector include all persons subject to control who intend to remain in the United Kingdom for more than six months. A passenger who is referred to the medical inspector should be told, as far as possible, the reason for the examination. A limited discretion is also given to refer cases not specifically mentioned. This could be exercised, for example, where a person is obviously unwell or appears bodily dirty. It should be noted, however, that since October 1989 and following legal advice, medical inspectors only certify that it is undesirable to admit a passenger to the United Kingdom, when satisfied that a passenger's condition represents **a significant risk to public health**.

The medical inspector will report on the passenger's condition and may offer advice on its consequences. In these cases the immigration officer should take account of the report on the passenger's condition and any supplementary advice given in deciding whether or not the passenger meets the overall criteria for admission to the United Kingdom as set out in the Immigration Rules. Any practical difficulties experienced by ports should be reported to Passenger Casework Section. The immigration officer has discretion to waive the medical examination requirement (see **paragraph 2.10.** below).

2.3. **Passengers proceeding to other parts of the common travel area**

The instructions relevant to medical inspection should be applied to persons coming from outside the common travel area and travelling to the Channel Islands, Isle of Man, or Irish Republic in the same way as if they had intended to remain in the United Kingdom.

2.4. **Persons requiring further medical examination**

Where the medical inspector requires further tests on, or further examination of a person and if the examination is to be carried out in a hospital, the immigration officer should grant the person temporary admission to **the hospital address**. The same will apply if the medical inspector does not issue a certificate in respect of a person found to be suffering from an **infectious or contagious disease**. If a stay in

hospital is not necessary the immigration officer should consider whether detention or temporary admission would be appropriate. When the further medical examination has been completed the immigration officer's examination should be resumed and the person refused or given leave to enter as appropriate (see **ANNEX Z** below for additional advice about the further examination of passengers where a medical officer is required **and** the service of form IS 81).

2.5. **Persons suffering from AIDS, HIV infection or other serious illness**

If a passenger is diagnosed as suffering from AIDS, HIV or any other serious illness this will not, in itself, be sufficient to justify refusal on public health grounds alone. However, port medical inspectors will continue to provide estimates of the cost of any treatment which may be required and thereafter it will be for the immigration officer to consider applications under the appropriate paragraph of the Rules. Any case involving particularly compelling or compassionate circumstances may be referred to Passenger Casework Section (PCS) for guidance. Normally, it will only be necessary to refer those cases where ports are minded to accede to a request for ELTE on the basis that a person is suffering from AIDS, HIV infection or any other serious illness.

Should a port medical inspector decide that the particular circumstances of an individual merit exclusion on medical grounds then, on receipt of such advice, the port should follow the usual procedures for such cases. PCS should be advised as soon as practicable that the port medical inspector has departed from the "normal" practice so that decisions of this kind can be monitored.

Paragraph 3 (below) deals with **entry clearance** applications referred to ICD by the entry clearance officer, **after entry** applications for leave to remain and our obligations under the **Human Rights Act** in respect of persons suffering from AIDS, HIV infection or any other serious illness.

2.6. **Examination for pregnancy**

Reference of a woman to a medical inspector for confirmation of a suspected pregnancy should be made **only** where there is strong evidence that the purpose of the passenger's visit is to take advantage of National Health Service facilities. See also paragraph 2 above.

2.7. **Handicapped children**

Handicapped children who arrive for treatment or education at a special school should be referred to the medical inspector if it is intended that the stay should exceed 6 months. If the medical inspector decides that the child is incapable of education or issues a certificate that it is undesirable that the child should be given leave to enter, leave should be refused.

2.8. Suicide threat from a person refused entry

- ***If a person refused entry or detained pending further examination threatens or attempts suicide, the opinion of the port medical inspector of the person's state of mind should be sought immediately.***
- ***Once the opinion of the port medical inspector has been obtained, details of the threatened or attempted suicide should be passed to PCS.***
- ***Removal should not be effected in the case of a person refused entry without reference to PCS if he gives any indication that he may attempt suicide.***

NB: See also Chapter 9, Section 6 "Refusal of leave to enter (Procedure)", paragraph 5. entitled "Persons refused entry who threaten suicide".

2.9. Exemption from medical examination

Persons exempt from control, including persons with the right of abode under the Immigration Act, may **not** be referred to the medical inspector by the immigration officer.

2.10. Immigration officer's discretion to waive medical examination at the immigration officer's request

An immigration officer may waive the requirement for medical examination even where he is entitled to refer a person to the medical inspector under Paragraph 36 of HC 395. Examination should normally be waived in respect of:

- * passengers intending to remain for longer than 6 months if they are returning from short visits abroad; or
- * passengers of international repute or good standing;
- * teachers coming for authorised employment;
- * students sponsored by the British Council (who have to undergo a medical and X-ray in their own country before being granted a scholarship);
- * dependants of members of US Forces (who are obliged to undergo a medical in their own country before being allowed to travel abroad as dependants); or
- * where the medical inspector is not immediately available, or in any other cases where the immigration officer feels it unnecessary to refer.

Examination may also be waived in respect of:

- * passengers who give their reasons for coming to the United Kingdom as private medical treatment **where this is sponsored by the passenger's government**,
- * where an entry clearance endorsed "Medical treatment" is held; or
- * where the nature of the treatment proposed makes it clear that the medical inspector would not issue a certificate under Paragraph 37 of HC 395 (see **paragraph 2.1** above).

2.11. **Medical examination after entry**

Under Paragraph 7 of Schedule 2 of the Immigration Act 1971 a person may be required by an immigration officer, on the advice of a medical inspector or other fully qualified medical practitioner, to report his arrival to such medical officer of health as may be specified and to submit to further tests or examination by that officer. In practice, the officer so specified will be the "Medical Officer of Environmental Health".

The classes of persons on whom the notice is to be served are set out in Paragraph 38 of HC 395. This requirement may be imposed on persons given either limited or indefinite leave to enter (the "requirement" to report to a "Medical Officer of Health" is **not a condition**).

The medical inspector will complete 5 copies of the appropriate port medical form and will give all copies to the immigration officer for endorsement. The immigration officer should hand the top copy to the passenger and explain it to him. He should retain copy 2 and return copies 3, 4 and 5 to the medical inspector; the immigration officer should then endorse the passport under the date stamp and any other endorsements "Served with notice under Paragraph 7 of Schedule 2 to the Immigration Act 1971 (Medical examination after entry)". A report setting out the details should be submitted to Port Liaison Unit (PLU).

2.12. **Further guidance**

ANNEX Z (below) *provides additional advice about medical inspectors; further examination of passengers including the service of form IS 81; and the power to require production of a vaccination certificate.*

Chapter 25, Section 2 *provides guidance for requesting assistance from the Department of Health or the Scottish Home and Health Department with medical aspects of cases at ports*

2.13. **Refusal of entry on medical grounds/confidential nature of medical certificates**

Where the medical inspector has issued a certificate advising that it is undesirable for medical reasons that a person should be admitted, the immigration officer should normally refuse leave to enter on that ground alone. Refusal would be under Paragraph 320 of HC 395 and further guidance will be found at **Chapter 9, Section 2** of these instructions.

As passengers refused entry are entitled to be informed of the grounds for refusal, the immigration officer must advise a passenger refused entry on medical grounds of the contents of the medical certificate. However, the medical inspector should be consulted **before** this is done.

Disclosure of the content of the certificate to any other person must not be made without the consent of the medical inspector and the passenger.

3. AFTER ENTRY/REFERRED ENTRY CLEARANCE - PERSONS SUFFERING FROM SERIOUS ILLNESS

The following provides guidance to staff on how to proceed in cases involving persons who suffer from a serious illness or medical condition. Serious illness means any seriously debilitating, terminal or life threatening medical conditions including AIDS/HIV and serious mental conditions such as Post Traumatic Stress Disorder (PTSD).

This guidance also applies to EEA and Swiss nationals and their family members.

Paragraph 2.5 (above) provides guidance concerning passengers on entry who are diagnosed as suffering from a serious illness.

3.1. Policy

The fact that a person is suffering from a serious illness is not in itself grounds for refusing entry clearance or leave to remain if the person concerned otherwise qualifies under the Immigration Rules.

Equally, the fact that an applicant is suffering from a serious illness is not in itself sufficient grounds on which to justify the grant of Discretionary Leave in accordance with API Chapter 5, section 5 where the requirements of the Rules are not met.

3.2. Referred entry clearance cases

Applications made at a post abroad for entry clearance from persons who are suffering from a serious illness should normally be referred by the entry clearance officer to the Home Office via UK Visas if the applicant meets the requirements of the Immigration Rules for the category specified. Evidence should also be forthcoming of the applicant's ability to meet the costs of any

medical treatment that may be required during their stay in accordance with paragraph 37 together with paragraph 26 of Immigration Rules (HC 395). This is in addition to the usual requirements as regards maintenance, accommodation and intention to return.

A person who is seriously ill and is seeking an entry clearance to travel to the United Kingdom for medical treatment should meet the usual requirements of the Visitors for Private Medical Treatment Rules (Paragraph 51 of HC 395). As explained in paragraph 3.1 above the fact that a person suffers from a serious illness is not in itself grounds for refusing entry clearance. However, where in any case it appears that public health may be at risk because of the infectious nature of the disease (e.g. TB or hepatitis B or C), advice should be sought from the Department of Health.

3.3. **After entry**

Any application for leave to remain where there is evidence to suggest that the person is suffering from a serious illness will require careful individual consideration of its particular merits.

Leave to remain under the medical visitor provisions of the Rules should not be granted where treatment is to be on the NHS.

Where UK obligations under the Human Rights Act are engaged (see para 3.4 below) leave may be granted in accordance with the API on Discretionary Leave. In view of the fact that persons granted leave on human rights grounds on the basis of their medical condition are unlikely to be in a position to support themselves Code 1A, enabling recourse to public funds, is appropriate. All non-asylum applications for Discretionary Leave on medical grounds under ECHR Article 3 are dealt with by specialist caseworkers in CMU NCC5.

A person claiming that their removal would be in breach of Article 3 of the ECHR is entitled to apply for NASS support in the same way as a person who is seeking asylum. This is because Section 94(1) of the Immigration and Asylum Act 1999 defines a "claim for asylum" as a claim that it would be contrary to the UK's obligations under the Refugee Convention, or under Article 3 of the Human Rights Convention for the claimant to be removed from, or required to leave, the United Kingdom. Those seeking NASS support on the basis of an Article 3 claim would similarly be subject to the requirements of section 55 of the Nationality, Immigration and Asylum Act 2002.

Where an applicant seeks leave to remain on human rights grounds relating to the fact that he is suffering from a serious illness he should be asked to provide a certificate from his doctor or consultant confirming:

- the nature of his specific medical condition;
- the treatment he has been receiving, its duration and the consequences of ceasing the treatment;
- his life expectancy if he continues to receive his current treatment and his life expectancy if he does not

- his fitness to travel if required to leave the country.

Caseworkers may on limited occasions consider that they need some expert guidance on the information doctors have provided to assist in deciding a suitable course of action. In England, such guidance can be obtained from the Department of Health (contact details to follow).

Cases where a grant of Discretionary Leave is not considered to be appropriate should be refused in the normal way. They need not be referred to Immigration Service enforcement staff.

3.4. **Human Rights Act**

This paragraph has been withdrawn for updating. Claims that removal from the UK would breach Articles 3 and/or 8 of the European Convention on Human Rights because of the claimant's medical condition should be considered in accordance with the House of Lords judgment in the case of *N v SSHD* (2005) UKHL31 and other relevant case law.

3.5. **Issues concerning children**

This paragraph is currently being updated.

4. **AFTER ENTRY - REMOVAL OF PSYCHIATRIC IN-PATIENTS**

The following guidance explains powers under the Mental Health Acts and procedures relating to the removal from the United Kingdom of persons who do not have the right of abode and who are psychiatric in-patients.

Such cases are the responsibility either of the Department of Health or the Scottish Home and Health Department or the Mental Health Unit of the Criminal Policy Directorate (CPD) (see advice concerning, respectively, **Scotland** and **England, Wales and Northern Ireland** in **paragraph 4.1.** below). This advice is provided to help caseworkers identify any such cases which may arrive in caseworking groups in order that the matter may be properly **re-directed** to the appropriate quarter.

4.1. **Powers under the Mental Health Acts**

* **Scotland**

Under Section 82 of the Mental Health (Scotland) Act 1960 as amended by Section 30 of the Immigration Act 1971, the Secretary of State may order the removal of any person who does not have the right of abode and who is receiving in-patient treatment for mental illness, provided it appears to the Secretary of State that proper arrangements have been made abroad for the care and treatment of the patient and that it is in the interests of the patient to remove him.

Cases involving the use of these powers are dealt with by the Scottish Home and Health Department in Edinburgh. Mental Health Unit will be able to advise on the names of the personnel in the Scottish Home and Health Department to whom cases should be sent: ***any such cases which have been sent to a caseworking group should be redirected to the appropriate quarter immediately.***

* ***England, Wales and Northern Ireland***

Under Section 86 of the Mental Health Act 1983, which applies to England, Wales and Northern Ireland the Secretary of State may order the removal of any person who does not have the right of abode (see ***Chapter 1, Section 1*** above) and who is receiving in-patient treatment for mental illness while detained in hospital under certain of the long term powers of detention under the Act. The Secretary of State may use this power only if it appears to him that proper arrangements have been made abroad for the care and treatment of the patient, that it is in the interests of the patient to remove him and if the approval of the Mental Health Review Tribunal has been given.

The Department of Health deals with such cases and will be able to advise on whether any particular case is likely to fall within these criteria and, if so, to whom the case should be sent: ***any cases sent to a caseworking group should, once the above noted checks have been made, be redirected to the Department of Health immediately.***

Cases involving the removal of those in-patients who have been detained in hospital under orders of a court because of criminal activities should be referred to the Mental Health and Criminal Cases Unit of the Criminal Policy Directorate (CPD).

4.2. **Repatriation by the Home Office**

The initiative for seeking the removal of a psychiatric patient lies with the hospital concerned under the direction of the case doctor. ***The Home Office should not take steps to repatriate a psychiatric patient unless first approached by the patient's medical adviser.***

4.3. **Warrant for removal**

A request for a warrant authorising removal must be made by the hospital authorities who must meet the following requirements of the relevant Mental Health Act:

- * the patient must be an in-patient;
- * specific arrangements must have been made for the care and treatment in the patient's own country;

- * the doctor in charge of the case must consider it in the interests of the patient to remove him;
- * the patient must be fit to travel;
- * a medical escort must be provided to accompany the patient to his destination;
- * the patient must have a valid passport and any necessary transit visas.

4.4. **Removal without a warrant**

An application to the Home Office will not be necessary if the patient, whether or not accompanied by an escort, is able and willing to travel without powers of detention, and suitable arrangements have been made.

Steps must be taken to ensure that the patient is capable of making such a decision, such as a consultation with a medical officer.

4.5. **Return to the United Kingdom**

Where a patient has a right to return to the United Kingdom, notwithstanding repatriation at public expense, removal under Paragraph 320(19) in Part 9 of HC 395 will not extinguish that right. The use of this procedure should therefore be avoided as far as possible where a patient (or his relatives) has expressed strong opposition to his leaving the United Kingdom.

5. INOCULATIONS AND OTHER PREVENTIVE TREATMENT (PROPHYLAXIS) FOR PERSONS BEING REMOVED FROM THE UK

5.1 British residents considering visits to countries where certain diseases are endemic are advised to have appropriate inoculations or other preventive treatment before travelling. This is advisable both for their own health and to prevent infections being brought into the UK on their return. They are normally required to pay for such treatment, although certain categories of persons may be entitled to it free of charge. Those facing removal from the UK may claim that it would be a breach of their human rights or simply unreasonable to return them to a particular country without access to preventive treatment of this kind and may attempt to delay their removal on these grounds.

5.2 When considering such claims the general principle is that individuals are responsible for safeguarding their own health and that of their children. It should also be borne in mind that medical advice given to British residents who will be returning to the UK may not necessarily apply to people returning to the countries concerned. When someone is informed that their appeal rights are exhausted and/or they are otherwise liable to be removed from the UK, caseworkers should remind them at the same time of

their responsibility for minimising any health risks to themselves or their dependants in the country of return and advise them to consult a general medical practitioner about any preventive treatment needed before travelling and that they may have to pay for it.

5.3 In some cases preventive treatment may be unnecessary because of immunity acquired before coming to the UK but a limited number of people, for example pregnant women and children under 5, may be particularly vulnerable to infection and therefore may need inoculation or other prophylaxis in preparation for their return. The time between notification that their appeal rights are exhausted and final removal should normally allow sufficient time for people to take medical advice from a general medical practitioner and arrange for and complete any recommended treatment.

5.4 If a person falling within the above vulnerable categories due to leave the UK under an assisted voluntary removal scheme requests, with the support of a doctor's letter, that inoculation or malaria prophylaxis be provided, the request should normally be granted.

5.5 A person subject to removal cannot in principle claim any entitlement to remain in the UK to benefit from medical treatment. However, requests to delay removal for a short period to allow for preventive treatment should be considered on their merits in the light of medical advice and standard operational procedures before removal. This is particularly important when pregnant women, young children or unaccompanied minors are involved. However, the presumption should be that removal will not be delayed unless a doctor has confirmed that the treatment concerned is necessary prior to removal and the person subject to removal can show good reasons why it could not have been completed earlier.

Detainees

5.6 People detained prior to removal have access to medical care and advice from healthcare professionals in immigration removal centres. Detainees are not charged for treatment.

Where removal centre medical staff consider that preventive treatment should be given, removal directions may be set but should be dependent on any pre-departure element of such treatment being completed. Medical advice on preventive measures, including advice leaflets, should be made available to detainees as soon as possible, and should if possible be given as appropriate in the initial medical examination or screening which all detainees receive within 24 hours of detention, and in any case when removal directions are set. Where removal centre medical staff consider that preventive treatment is necessary and can be completed (subject to para 5.7 below) without delay to planned removal, removal directions may be set but for a date after the treatment is completed. Caseworkers and those responsible for setting removal directions should consult the health care professionals, via the IND team at the centre, on the appropriate minimum time lag between administering medication and removal taking place.

Caseworkers, those responsible for setting removal directions and IND teams at removal centres should document case histories as thoroughly as possible. This is because, if a JR is commenced, access to a claimant's medical records cannot be guaranteed. Therefore, if staff have carefully minuted, for example, any refusal of malarial

prophylaxis after it has been offered, then that may make it easier to keep RDs in place, respond to any further representations on the point and/or defend any JR claim. These points should if possible be minuted directly on CID.

Malaria Prophylaxis

5.7 Preventive treatment for malaria is a special case in that medication must be taken shortly before travel. People detained prior to removal may not therefore be able to make the necessary arrangements for themselves. Any malaria prophylaxis recommended as appropriate by the removal centre medical staff for pregnant women and children under 5 should normally be provided and **time allowed for it to take effect before removal**. The guidance by the Advisory Committee on Malaria Prevention (at Appendix, together with a supplementary letter) should be followed and copies of it should be given to the detainees concerned. Specialist advice (according to the relevant condition or age of the detainee), which can be obtained from a helpline, should be provided for pregnant women, children under 5 and those with medical conditions which might contra-indicate the prophylaxis. In the event of adverse side-effects, time should also be allowed to obtain and follow further medical advice. Removal need not be deferred in any case where a detainee declines (on his or her own behalf or on behalf of a dependent child) to take malaria prophylaxis that has been provided on medical advice.

5.8 It should be noted that para 4.8 of the ACMP advice states that “Mefloquine [also known as Lariam] is generally started with a 2-3 week window usually to determine tolerance if it has not been used before. If removal is delayed, stopping and restarting the prophylactic regime should not be a problem.” In the case of an adverse reaction to mefloquine (which may produce psychotic side effects) or other prophylaxis, removal centre healthcare staff should seek advice about alternative medication.

5.9 It should also be noted that bed nets and other barrier protective measures are equally important in an endemic setting. However these, which are not provided free to British citizens, should be regarded as the responsibility of the detainee to obtain on return. Prophylaxis is an extra option for short-term protection, which should be provided (including sufficient medication to cover the period after arrival) to vulnerable people (pregnant women and young children) as recommended by the healthcare team to allow them to settle and arrange for future healthcare after arrival in the country of return.

5.10 There are two main types of parasite causing malaria, *P. vivax* and *P. falciparum*. Chloroquine, together with bite prevention measures, is normally adequate protection from *P. vivax* but some strains of *P. falciparum* have developed resistance to this drug. The first table below lists countries and territories with malarious areas, together with the recommended type of prevention. The second table lists the recommended regimen for particular types of medication prescribed for chloroquine-resistant falciparum malaria.

Countries and territories with malarious areas

5.11 Specific information on malaria risk for each country is provided in the table below. The recommended prevention is also indicated. The recommended prevention for each country is decided on the basis of the following factors: the risk of contracting

malaria; the prevailing species of malaria parasites in the area; the level and spread of drug resistance reported from the country; and the possible risk of serious side-effects resulting from the use of the various prophylactic drugs. Where *P. falciparum* and *P. vivax* both occur, prevention of falciparum malaria takes priority. The numbers I, II, III and IV refer to the risk (Type I is low risk, Types II, III and IV represent ascending orders of risk) and type of prevention based on the table below.

	Malaria risk	Type of prevention
Type I	Very limited risk of malaria transmission	Mosquito bite prevention only
Type II	Risk of <i>P. vivax</i> malaria or fully chloroquine-sensitive <i>P. falciparum</i> only	Mosquito bite prevention plus chloroquine chemoprophylaxis
Type III	Risk of malaria transmission and emerging chloroquine resistance	Mosquito bite prevention plus chloroquine+proguanil chemoprophylaxis
Type IV	High risk of falciparum malaria plus drug resistance, or moderate/low risk falciparum malaria but high drug resistance	Mosquito bite prevention plus either mefloquine, doxycycline or atovaquone/proguanil (take one for which no resistance is reported in the specific areas to be visited)

I	II	III	IV	
Algeria	Argentina	India	Afghanistan	Liberia
American Samoa	Belize	Mauritania	Angola	Madagascar
Azerbaijan	Costa Rica	Solomon Islands	Armenia	Malawi
Cape Verde	Dominican Republic	Sri Lanka	Benin	Malaysia
Georgia	El Salvador	Tajikistan	Bhutan	Mali
North Korea	Guatemala	Vanuatu	Bolivia	Mayotte
South Korea	Haiti		Botswana	Mozambique
Kenya	Honduras		Burkina Faso	Monogolia
Morocco	Iran		Burundi	Myanmar
Syrian Arab Republic	Iraq		Cambodia	Namibia
Turkmenistan	Mexico		Cameroon	Niger
Uzbekistan	Nepal		Central African Republic	Nigeria
	Northern Miriana Islands		Chad	Northern Miriana Islands (in

				Eastern endemic areas)
	Paraguay		China	Pakistan
	Peru		Colombia	Papua New Guinea
	Turkey		Comoros	Philippines
	Venezuela		Congo	Rwanda
			Congo Democratic Republic	Saint Helena
			Cote D'Ivoire	São Tome and Principe
			Djibouti	Saudi Arabia
			Ecuador	South Africa
			Equatorial Guinea	Somalia
			Egypt	South Africa
			Ethiopia	Sudan
			French Guiana	Suriname
			Gabon	Swaziland
			Ghana	Tanzania
			Guinea	Thailand
			Greece	Timor-L'este
			Guinea-Bissau	Togo
			Guyana	Uganda
			Indonesia	Venezuela (in <i>P.falciparum</i> risk area)
			India (in Assam)	Vietnam
			Iran (<i>P.falciparum</i> risk areas)	Yemen
			Kenya	Zambia
			Laos	Zimbabwe

Source: WHO Country list at http://whqlibdoc.who.int/publications/2005/9241580364_country_list.pdf

5.12 The following table gives the appropriate regimes for the various malaria prophylaxes:

TABLE: Features of antimalarials used in the prevention of chloroquine-resistant falciparum malaria

	Recommended regimen	Alternative regimen
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	Mefloquine	Doxycycline	Malarone	Proguanil plus chloroquine
Efficacy against Chloroquine-resistant <i>P.faliparum</i>	Very good (c. 90%)	Very good Less evidence	Very good Less evidence	Limited protection
Efficacy against <i>P. vivex</i> and other malaria species	More limited Relapses can occur	More limited relapses can occur	More limited Little information Relapses can occur	Good Relapses can occur
Most notable adverse effects	Neuropsychiatric	Gastrointestinal, photosensitisation	Relatively low	Gastrointestinal
Half-life of blood level [Note: this indicates the recommended time between prescription of medication and removal]	3 weeks	18-22 hours	A 2-3 days P 17 hours	C 30-60 days P 17 hours
Frequency of administration	250 mg/week	100 mg daily	1 tablet daily	2 tablets daily plus 2 tablets weekly
Duration of medication after leaving malarious area	4 weeks	4 weeks	1 week	4 weeks
Main contraindicators	Epilepsy, psychiatric disorders, early pregnancy	Childhood, pregnancy	Pregnancy	Present epilepsy
Adult for 3 days in a malarious area				
Cost	2.00 CU*	3.2 CU	3.6 CU	1.0 CU
Number of tablets	7	38	12	88 (76+ 12)
Adult for 2 weeks in a malarious area				
Cost	2.6 CU	4.1 CU	7.0 CU	1.3 CU
Number of tablets	9	49	23	112 (98+ 14)
Adult for 8 weeks in a malarious area				
Cost	4.4 CU	7.6 CU	Not licensed for more than 28 days use	2.4 CU
Number of tablets	15	91		212 (182 + 26)

* CU (cost units) are units of approximate relative cost based on entries in the Monthly Index of Medical Specialities (April 2000). There is little change if British National Formulary (BNF) prices for 2003 are used.

Source: Extract from ACMP guidance on HPA website (Bradley DJ, Bannister B.

Guidelines for malaria prevention in travellers from the UK for 2003. *Commun Dis Public Health* 2003; 6(3): 180-99.)

TB

5.13 The WHO guidelines "Tuberculosis and air travel: guidelines for prevention and control (second edition)" specify that "Physicians should inform all infectious TB patients that they must not travel by air until they have completed at least two weeks of adequate treatment. Patients with MDR-TB should be advised not to travel until proven by adequate laboratory confirmation (i.e. culture) to be non-infectious." Removal of those with TB should therefore not take place until these conditions have been fulfilled, but should not be delayed thereafter on medical grounds. Caseworkers should bring this information to the attention of persons liable to removal at the earliest opportunity as well as of healthcare staff.

<i>I.S. Enquiries to:</i>	BCPI
<i>ICD Enquiries (AIDS/HIV cases) to:</i>	SPU
<i>Enquiries about psychiatric patients to:</i>	Mental Health section, Criminal Policy Directorate (CPD)
<i>File Reference - AIDS/HIV cases:</i>	IMG/94 36/77/1
<i>File Reference - Psychiatric patients:</i>	IMO/85 74/98

APPENDIX

The Advisory Committee on Malaria Prevention in UK travellers (ACMP): advice when deporting individuals at risk from malaria

1. Risk

1.1 Persons returning to their original homes in malarious regions may have suffered a decline in the partial immunity to malaria that develops during childhood and is maintained by repeated exposure while living in endemic regions; they may therefore be at increased risk of suffering an acute attack of malaria after returning home.

1.2 Pregnant women and small children are at higher risk than others of suffering severe disease.

2. Risk assessment and counselling

2.1 Risk assessment and personal counselling is essential to warn individuals of the risk of suffering from malaria, emphasising avoidance measures and the need for immediate diagnosis and treatment of acute feverish illnesses (see proposed assessment and advice below).

3. Preventative measures appropriate to endemic setting

Bed nets

3.1 Bed nets and other personal barrier protective measures (e.g. suitable clothing) are very low-cost, are effective long-term, have virtually no side-effects and will also help to protect from other mosquito-borne infections.

Intermittent Preventive Therapy

3.2 If Intermittent Preventive Therapy (IPT) is local policy in their destination country to prevent malaria in pregnancy and childhood, they should be advised to seek medical advice on this immediately on arrival.

Case management of illness

3.3 People should be advised to seek medical attention immediately if either they or their children become feverish after repatriation.

Guidance

3.4 See the World Health Organization/national country guidance on the appropriate measures in endemic settings which include IPT, insecticide-treated bed nets and case-management of malarial illness with therapy^{1,2}.

4. Prophylaxis

Intended use

4.1 The ACMP prophylaxis guidance is for temporary protection for the UK traveller. This is not appropriate for individuals who will return to permanent residence in their country of origin.

Standby treatment

4.2 Offering standby treatment is inappropriate where there are likely to be health services to diagnose and manage malaria.

Exception for pregnant women and young children

4.3 An exception could be made to offer a limited period of prophylaxis for pregnant women and young children, to allow them to settle and

arrange for future healthcare after arrival in the endemic country. The benefits of this *extra option* for short term protection should be discussed with the detainees before they depart from the UK

Drug options and safety

4.4 Doxycycline is not an appropriate prophylactic for pregnant women or children under 12 years. Mefloquine would be a better option. After expert consultation, Mefloquine may be considered for use even in the first trimester of pregnancy.

4.5 For pregnant women, Chloroquine /Proguanil (C+P) is safe for use in the first trimester, however, its effectiveness is declining significantly in most areas, and it is now not appropriate in many areas of the world, particularly in sub-Saharan Africa.

4.6 Note that there is little evidence on safety of co-administering anti-malarials and anti-retrovirals during pregnancy. Mefloquine is probably safe to co-administer while the clinical significance of co-administering chloroquine/proguanil with anti-retrovirals is unclear.

4.7 Prophylaxis should not be relied on by itself and other protective anti-mosquito measures should also be used.

Timing of start of use

4.8 Malaria chemoprophylaxis (for the two high risk groups stated above) may be started shortly before departure and in general should not be a barrier to returning persons to their home country. Mefloquine is generally started with a 2-3 week window usually to determine tolerance if it has not been used before. If deportation is delayed, stopping and restarting the prophylactic regime should not be a problem.

Proposed assessment and advice

A) Determine the degree of risk the subject(s) are actually going to be exposed to in the area of the country they are returning to.

B) If there is a risk it should be ensured they are aware of this and told that they may have had some immunity but this could have declined since they have been out of the country.

C) If the risk is minimal (e.g. outside sub-Saharan Africa⁴) then general advice including the need for prompt investigation of fevers should be emphasised.

D) If the risk is substantial (e.g. sub-Saharan Africa⁴) the option of Mefloquine or C+P prophylaxis for pregnant women and children (for the first 28-42 days back in their country) should be discussed with them. It should be made clear that IPT, if available, is preferable to prophylaxis. All should be given an advice leaflet (on mosquito bite avoidance and need for prompt medical attention if febrile) and a bed net (one per person being repatriated).

E) Specialist advice should be provided for pregnant women and those with medical conditions. The Home Office may wish to contract out this advice and prescription to a single clinic/centre for consistent advice.

¹ **Standards for Maternal and Neonatal Care:**
http://www.who.int/making_pregnancy_safer/publications/Standards1.7N.pdf

² **World Health Organization Malaria topic:** <http://www.who.int/topics/malaria/en/>

³ Brentlinger *et al.* Challenges in the concurrent management of malaria and HIV in pregnancy in sub-Saharan Africa. *Lancet Infect Dis* 2006; 6:100-11

⁴ World Health Organization country data and interactive maps available at :
www.who.int/malaria/malariaendemiccountries.html and <http://globalatlas.who.int/globalatlas/default.asp>

Further Advice from Chair of ACMP dated 11 December 2006:

Advice from the health Protection Agency Advisory Committee on Malaria Prevention in UK Travellers

Regarding the age of children:

In para. 1.2, 'small children' means children up to school age, generally taken to be up to five years old.

In para. 4.3 'Young children' can be taken to mean the same as the term 'small children'. Similarly, in sub-paragraph D of the 'Proposed assessment and advice', children up to the age of five would be the most vulnerable group. Children born during their parents' stay in the UK would never have been exposed to malaria until their family's return home, and would be at high risk of contracting malaria soon after arrival in an endemic area.

The reference to children under the age of 12 years (in para. 4.4) refers to the contra-indication to the use of doxycycline in the under-12s. This is a condition of the UK license for doxycycline, which ACMP advice must take into account.

Regarding bed nets:

The Home Office may wish to consider offering bed-nets to the most vulnerable groups of returnees i.e. pregnant women and children under the age of 5 years for the following reasons.

The World Health Organization recommends that bed nets are used where sleeping quarters are not otherwise protected against the ingress of mosquitoes (such as by window screens or air conditioning).

Research has shown that, in areas of high malaria risk, bed nets provide substantial protection. In these areas, for pregnant women and children under 5, bed nets may be important in mitigating malaria exposure during the first few months after repatriation. The ACMP advises travellers from the UK to endemic areas to obtain their own bed nets if they are likely to be exposed to mosquito bites during the night. Bed nets are available for purchase in the UK and overseas. They should be impregnated with insecticide, which is also widely available, or they can be bought ready-impregnated.

At the very least, the ACMP would advise that all returnees especially children and pregnant women are educated on the use of bed nets. Information leaflets, recommended by the ACMP for those returning to malaria-endemic areas, should contain clear advice on: the risk of malaria transmission, bite avoidance- including the use of clothing, insect-repellents for personal and room protection, and on the benefits of insecticide-impregnated bed-nets.

