

Sexual health, asylum seekers and refugees

A handbook for people working with refugees and asylum seekers in England

Ruth Wilson with Marsha Sanders and Hildegard Dumper



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tandem: communications
research



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Disclaimer

The information in this book is based on the evidence and medical opinion at the time of publication. Care has been taken to ensure that the information given in this text is accurate and up to date. Medical knowledge and practice is constantly changing, as new information becomes available, and as such changes in treatment procedures and use of drugs or practice become necessary. Likewise, information on asylum legislation and services has been reviewed by the Border and Immigration Agency in order to be accurate at the time of going to print. As this is a complex and changing area, readers should check in case of any developments, especially in the area of immigration law.

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The Department of Health funded the Asylum Seekers and Refugees Sexual Health Project (both the community research and the handbook), and the following organisations helped in earlier stages of setting the project up – the Health Development Agency (Northern and Yorkshire); the Northern and Yorkshire Public Health Observatory; the Scarman Trust and several of the local authority consortia that receive dispersed asylum seekers (East Midlands; North East; South of England and Yorkshire and Humberside).

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Ruth Wilson, Director, tandem communications and research



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Abbreviations

AIDS	acquired immune deficiency syndrome
AIT	asylum and immigration tribunal
ELE/R	exceptional leave to enter or remain
ECHR	European Convention on Human Rights
FGM	female genital mutilation
GP	general practitioner
GUM	genitourinary medicine
HIV	human immunodeficiency virus
HP	humanitarian protection
ILR	indefinite leave to remain
IND	Immigration and Nationality Directorate (now renamed Border and Immigration Agency)
IUD	intrauterine device
IUS	intrauterine system
LGBT	lesbian, gay, bisexual and transgender
NASS	National Asylum Support Service
NHS	National Health Service
PCT	primary care trust
PHO	public health observatory
RCO	refugee community organisation
STI	sexually transmitted infection
TB	tuberculosis





Chapter 1

INTRODUCTION

IN THIS CHAPTER

- 1.1 Who is the handbook for?
- 1.2 Our aims
- 1.3 Why a handbook?
- 1.4 Who's behind the handbook?
- 1.5 Some basic ideas
- 1.6 A guide to the handbook

1.1 WHO IS THE HANDBOOK FOR?

This handbook is for a wide range of organisations and individuals.

We hope it will be of use to policy makers, commissioners, managers, staff, interpreters, volunteers and community activists in:

- health services and health promotion initiatives
- refugee projects and organisations
- sexual health services
- community groups and self-help initiatives
- voluntary sector organisations
- campaigns for health, equality and human rights
- mental health and counselling services
- government offices and services
- local authority asylum teams and consortia
- social services departments
- interpreting agencies
- housing agencies
- colleges and youth projects
- advice agencies



- funding bodies
- and many other organisations.

1.2 OUR AIMS

The handbook can be used in many ways. You may want to:

- know more about the sexual health issues that affect refugee and asylum seekers
- find out about a particular area of concern, and the organisations and resources that can help
- develop work on sexual health with asylum seekers and refugees, or start a new project
- develop good practice, provide training, build a library, develop skills, or create materials and resources
- form links and partnerships with other organisations.

Whatever your purpose, we hope the handbook will give you the information, ideas and inspiration you need to develop work that promotes good sexual health among asylum seekers and refugees.

1.3 WHY A HANDBOOK?

This handbook has developed from the concerns of asylum seekers and refugees. In 2001, the Joseph Rowntree Charitable Trust published *Dispersed*, a report looking at the impact in West Yorkshire of the policy of dispersing asylum seekers away from the south of England. Interviewed for the report, an Afghan refugee expressed his concerns about sexual health:

“Some asylum seekers are not aware of HIV and so on. They are not used to using condoms. So if they’re not given enough information about safe[r] sex they risk getting illnesses.”

(Wilson, 2001)

After the report was published, the North East Public Health Observatory (PHO) and the Joseph Rowntree Charitable Trust convened a meeting at which a mix of professionals discussed some of the many issues involved. The PHO, the Health Development Agency North East and the Scarman Trust then funded a short feasibility study looking into the need for materials to help a range of health and refugee workers address sexual health issues.

The main findings of this study were that:

- little research had been done on the sexual health needs and concerns of asylum seekers and refugees
- health professionals and others were concerned about a number of sexual health issues affecting asylum seekers and refugees
- some practical initiatives were being developed at a local level to promote sexual health among refugee communities, but these were isolated and lacked access to resources and links to similar projects



- many professionals felt uncertain how to start raising sexual health issues – they were concerned they might cause offence
- people were also conscious of the negative labelling of refugees and asylum seekers and of hostility fuelled by the tabloid press and the way these could combine with people's fears and prejudices concerning sexual health
- asylum seekers and refugees interviewed wanted to have greater access to sexual health information, and health professionals
- refugee workers and others interviewed wanted to do more to improve sexual health among refugee communities.

The findings of the study tally with the Government's *Sexual health and HIV strategy* (Department of Health, 2001), which identifies the importance of promoting sexual health and access to services among vulnerable groups such as asylum seekers. The Government strategy also highlights the need to work on HIV services for African communities, and to meet the needs of women and girls affected by female genital mutilation.

Ruth Wilson, of tandem communications and research, carried out the feasibility study.

1.4 WHO'S BEHIND THE HANDBOOK?

As a result of the feasibility study, three organisations – the Centre for HIV and Sexual Health, **fpa** and tandem communications and research – set up the Asylum Seekers and Refugees Sexual Health Project in 2002, in order to carry out community research, and produce a practical handbook. The handbook and community research have been funded by the Department of Health, as one of the steps being taken to meet objectives set out in the *Sexual Health and HIV Strategy*.

The Centre for HIV and Sexual Health is an NHS organisation, working in Sheffield, as well as regionally and nationally, to promote sexual health in its widest sense. For the community research component of the Asylum Seekers and Refugees Sexual Health Project, the Centre and tandem recruited and trained refugee community researchers who carried out interviews and focus groups in Yorkshire in 2004 (see Section 9.4). The community research report – *Sexual health in exile: the sexual health concerns, issues and needs of refugees and asylum seekers in South and West Yorkshire: a community research report* – can be downloaded from the websites of tandem, the Centre for HIV and Sexual Health, **fpa** and Health for Asylum Seekers and Refugees Portal (HARPWEB). Quotes and conclusions from the report are included in this handbook.

This handbook is published by **fpa**. **fpa** is the UK's leading sexual health charity. Our purpose is to enable people in the UK to make informed choices about sex and to enjoy sexual health. We run a wide range of groundbreaking projects throughout the UK from local community initiatives to partnerships with professionals – improving good practice and access to services. We also campaign on a wide range of sexual health issues, produce publications, run a sexual health helpline, deliver Speakeasy courses for parents to help them talk to their



children about sex and relationships, facilitate training courses across the UK and provide a library and information service.

tandem communications and research has played a lead role in both components of the project: the community research and the handbook. The handbook has been written by Ruth Wilson, Director of tandem, with Marsha Sanders and Hildegard Dumper. tandem is a communications and research consultancy with extensive experience of working on refugee issues.

1.5 SOME BASIC IDEAS

Asylum, refugee and sexual health are wide-ranging terms – they encompass many issues, and affect people at all stages of life. We have approached writing this handbook with some basic ideas:

Sexual health

- Sexual health is understood in its broadest sense, as defined by the World Health Organization. It is ‘a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity’.
- Sexual health is a basic human right.

Refugees and sexual health

- Asylum seekers and refugees are not sexually different to other populations.
- The sexual health issues that asylum seekers and refugees may face are not unique to people who seek asylum – nearly all are also experienced by British citizens.
- However, many factors combine to make asylum seekers and refugees vulnerable to poor health, including poor sexual health. These include:
 - experiences of persecution, oppression and flight
 - inadequate health care in the country of origin
 - insecurity, poverty and powerlessness in the UK
 - loss of community and being in an unfamiliar environment.
- All asylum seekers and refugees are individuals, and it is rarely appropriate to make broad generalisations about a culture, society or community.
- Refugee communities are not homogenous – some people are more vulnerable than others, for example because they are young, female, gay or bisexual, or because they have had little sex and relationships education in their country of origin.
- Asylum seekers and refugees bring with them experiences, skills and qualifications that can be an asset when addressing sexual health.
- Working with refugees is not just about problems and challenges – it is also about people re-establishing their lives productively and creatively in another country.



Sexual health promotion

- Effective sexual health promotion has to address inequity and powerlessness and challenge systems that oppress and discriminate.
- Sexual health promotion means working at a number of levels – international, national and local – with international agencies, national governments, UK-wide and local services, and with communities and individuals.
- It requires listening and responding to the needs, rights and concerns of asylum seekers and refugees, and working in partnership.

What can commissioners and service providers do at local level?

These recommendations were made as part of the community research carried out in 2004 by the Asylum Seekers and Refugees Sexual Health Project:

1. Multi agency approaches

A wide range of organisations, working in partnership, have parts to play in addressing the sexual health needs and concerns of asylum seekers and refugees. These include primary care trusts, sexual health professionals, health promotion units, health professionals, refugee agencies, refugee community organisations, Initial Accommodation providers, voluntary sector health organisations, housing providers, local authorities, schools, colleges and others.

2. Local sexual health strategies and local refugee and asylum strategies

Local sexual health strategies should consider the needs of asylum seekers and refugees, including the need for targeted interventions to meet their concerns. Equally, sexual health needs should be acknowledged within refugee and asylum strategies at local and national level.

3. Increased role for sexual health professionals

Sexual health professionals (including those in health promotion teams) should receive additional training and resources to enable them to work closely with refugee and asylum seeker communities, and with refugee agencies.

4. Training for health professionals and refugee workers

Health professionals, such as GPs, practice nurses, health visitors and midwives, may also need training on refugee and sexual health issues, including cultural and religious awareness. Managers, staff and volunteers in refugee agencies may benefit from training in sexual health.

5. Sexual health promotion/support workers in refugee agencies

Refugee agencies in the voluntary sector might consider using sexual health support workers who can provide support, advice and signposting to individuals and work with refugee community organisations. These staff could also campaign on key issues, contribute to policy development, and train colleagues and volunteers (such as volunteer befrienders) on sexual health issues and local services.

Wherever possible, condoms, and sexual health information in other languages and formats should be made available at refugee organisations.

**6. Building capacity in refugee and asylum seeker communities**

Community organisations can benefit from training and support, to enable them to play an active role in raising awareness of sexual health issues. Peer educator schemes should play an important role in building skills and knowledge.

7. HIV

HIV and sexually transmitted infection awareness campaigns should address the needs of refugees and asylum seekers, and encourage those at risk of HIV to seek advice and access testing services. Community members are often best placed to carry forward such campaigns, but they need support and training.

8. Education on sex and relationships

Asylum seekers and refugees can benefit from targeted sexual health promotion initiatives for men, women, young people, parents and different communities. Local health promoters should use a range of strategies, enabling people to learn about and discuss issues such as safer sex, values, sexual violence, being gay, lesbian or bisexual, their rights, and the age of consent.

9. Focus on domestic violence

Sexual violence should be acknowledged as an issue in domestic violence. Regional domestic violence workers are well placed to work with refugee communities to raise awareness of domestic violence, and to offer support and referral for those experiencing domestic violence. They could also represent this issue at policy level and advise other agencies.

10. Training for interpreters

Training and support for interpreters is needed, to protect confidentiality and give them the skills to interpret sexual health terminology and cope with interviews where sexual health or sexual violence is discussed.

11. Translated resources

Information, including leaflets, posters and videos/DVDs on different sexual health issues should be widely available, together with information on all relevant local services and where to go for help. Wherever possible, these should be translated and in other formats.

{Wilson R et al, 2007}

1.6 A GUIDE TO THE HANDBOOK

The handbook is designed so you can read it cover to cover, or go to the sections that are of particular interest or use to you.

- Each section provides lists of useful organisations, websites and publications.
- In a number of sections there are short profiles of projects working on sexual health issues with asylum seekers and refugees.
- Where appropriate, there are boxes that provide a short summary of relevant law in England – this is a complex field, currently undergoing major reform. Legal advice should always be sought before you take action.



- The main conclusions from the community research are included in boxes in the relevant sections.
- Quotes from the community research also feature throughout the handbook – any quote by an anonymous refugee or asylum seeker is taken from the community research report. The views expressed are not necessarily shared by the authors and publishers.
- There are also quotes from people we have talked to, books we have read, and websites we have visited in the course of writing this handbook.
- We are not able to name every initiative or organisation active in the area of refugees and sexual health, or every publication or website. We have tried to include the main national agencies in each section, along with publications that are accessible and useful. The websites and publications often provide a starting place to find other resources that can help.
- You will find more information about organisations in Appendix 3.

An England guide

Because of differences in legislation and service provision, it was decided that this handbook should focus on England. We hope that some of the general information will be of interest and use to service providers in Northern Ireland, Scotland and Wales, and from time to time reference is made to legislation regarding those countries.

People requiring more information about refugees and asylum seekers in Northern Ireland, Scotland and Wales should contact:

- Northern Ireland Council for Ethnic Minorities
- Scottish Refugee Council
- Welsh Refugee Council

(see Appendix 3 for contact details).

For information on sexual health services, contact **fpa** (see Appendix 3).

“Refugees aren’t different sexually, we are all human beings – biologically we are all the same. But some things – poverty, racism, persecution – mean you are vulnerable.”

(Women’s officer, refugee organisation)

“Raising awareness is essential, to remove the stigma around sexual health among refugee communities, and to make professionals more aware of people’s needs and how to meet them.”

(Health policy adviser, refugee organisation)





Chapter 2

SEXUAL HEALTH: AN INTRODUCTION

IN THIS CHAPTER

- 2.1 Definition of terms
- 2.2 Policy context
- 2.3 Local NHS services
- 2.4 National helplines
- 2.5 Voluntary sector organisations
- 2.6 For more information

This section provides a brief definition of some of the main terms relating to sexual health that are used in this handbook. It provides an overview of the Department of Health's *National strategy for sexual health and HIV* and other key policy documents, and gives a summary of sexual health services and how to find them. It also lists some national organisations that provide a starting point to find out more about sexual health.

2.1 DEFINITION OF TERMS

The vocabulary relating to sexual health is extensive. These are some of the terms most commonly used in this handbook:

Sexual health

The World Health Organization (WHO) defines sexual health as:

'a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.'

(www.who.int, accessed January 2007)

The Department of Health also provides a definition of sexual health, in *The national strategy for sexual health and HIV*:



‘Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.’

(Department of Health, 2001)

Sex

The word ‘sex’ refers to the biological characteristics which define humans as female or male. It is also used to mean sexual activity.

Gender

‘Gender’ refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. The terms ‘male’ and ‘female’ are sex categories, and the terms ‘masculine’ and ‘feminine’ are gender categories. Ideas about gender vary considerably between different societies. Gender may be evident in people’s self-image (gender identity) and in how they behave (social gender role).

Sexuality

The World Health Organization has a broad definition of sexuality:

‘Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.’

(www.who.int/en, accessed December 2006).

The WHO points out that, while sexuality can include all of these dimensions, not all of them are always experienced or expressed. A wide number of factors influence sexual experience, including biology, psychology, culture, law, religion and social, economic and political conditions.

Sexual identity

The human population is not divided simply into males and females. A person’s sexual profile has several components: their physical make up (chromosomal sex, sex organs and genitalia), their gender identity (self-image), their social gender role (how they behave), their sexual orientation (which sex they find attractive). These four components exist independently. A person may express any variation of each of these in any combination (Mackay, 2000).



Sexual orientation

This refers to a person's sexual and emotional attraction to people of the same gender (gay or lesbian orientation), another gender (heterosexual orientation) or both genders (bisexual orientation) (Amnesty International, 2001). The term 'homosexuality' is often used to describe the sexual orientation of men and women who are attracted to the same sex – in this publication we use the phrase 'gay and lesbian sexuality'.

Transgender

This term is used to describe people who have a compelling sense that their gender identity is not in conformity with the physiological characteristics of the sex they are born with. As a result, some people seek 'gender reassignment', usually involving hormones and/or surgery (known as sex reassignment surgery), to bring their physical characteristics into conformity with their gender identity (Amnesty International, 2001). In some definitions transgender includes transsexuals, intersexuals (or hermaphrodites) and eunuchs.

Transvestite (cross dresser)

A person who chooses to wear any amount of clothing normally considered belonging to the opposite sex. Transvestites may have no desire to change gender and generally do not wish to undergo gender reassignment.

Sexual violence

Sexual violence is defined as:

'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise direct, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'

(World Health Organization, 2002).

'Coercion' can cover a whole spectrum of degrees of force. In addition to physical force, it can include threats, intimidation, blackmail and actions taken when someone is unable to give consent – for example if they are drunk, drugged, asleep or unable to understand what is going on. It can include rape in and out of marriage, sexual abuse, forced marriage, the denial of the right to use contraception, forced abortion, female genital mutilation, obligatory inspections for virginity, and forced sex work and trafficking.

Sex work and prostitution

The term 'sex work' is sometimes used to include a range of roles in the sex industry, such as acting in porn films, working as a stripper, offering phone or internet sex, or offering sexual



services. 'Prostitution' entails only the offering and selling of sexual services – in particular those aspects of sex work that are illegal, such as soliciting.

The terms 'sex worker' and 'sex work' are often used in preference to 'prostitute' and 'prostitution' because they are considered less derogatory. However, they suggest choice and do not reflect the true situation of coercion and exploitation that asylum seekers and refugees experience. Asylum seekers and refugees are unlikely to identify with or use these terms. The Home Office has adopted the term 'people in prostitution' as an alternative and less value-laden term to describe people who sell sex (Home Office, 2004). We have also adopted this term in this handbook.

Useful organisations and websites

- International Planned Parenthood Federation
- World Health Organization

2.2 POLICY CONTEXT

The *NHS plan* was published in 2000 (Department of Health, 2000). It set out a vision for providing better quality services designed around the needs of patients, and delivered by a sustained programme of investment and reform.

In 2001, the Department of Health published *The national strategy for sexual health and HIV* (Department of Health, 2001), providing for the first time a national strategic approach to the maintenance of sexual health and the response to HIV in England. The strategy aims to:

- reduce the transmission of HIV and sexually transmitted infections
- reduce the prevalence of undiagnosed HIV and sexually transmitted infections
- reduce unintended pregnancy
- improve health and social care for people living with HIV
- reduce the stigma associated with HIV and sexually transmitted infections.

The national strategy for sexual health and HIV and accompanying *Implementation action plan* (Department of Health, 2002) highlighted the need for targeted sexual health promotion interventions and HIV/sexually transmitted infection preventions for some groups, including asylum seekers and refugees, because they are at higher risk or have particular access requirements.

In 2002, *Shifting the balance of power* (Department of Health, 2002) led to a radical restructuring of the NHS. Power and resources were decentralised and devolved to primary care trusts (PCTs) to ensure better delivery of health care in line with local needs.

In January 2003, the Department of Health published *Effective commissioning of sexual health and HIV services* (Department of Health, 2003) setting out detailed advice and guidance on the commissioning of sexual health services. This was complemented by the *Effective sexual health promotion toolkit* (Department of Health, 2003) which included good



practice tips for professionals working in the field of sexual health promotion that could be adapted for work with particular groups. This good practice guide also complements the Department's guidance on providing health care for asylum seekers – *Caring for dispersed asylum seekers* (Department of Health and Refugee Council, June 20).

As part of implementation of *The national strategy*, the Department of Health has supported and endorsed a number of publications relevant to the sexual health needs of asylum seekers and refugees. These include:

- *Recommended standards for NHS HIV services* (Medical Foundation for AIDS and Sexual Health (MedFASH), 2002) and *Recommended standards for sexual health services* (MedFASH, 2005) – best practice guides for planners, commissioners and service users on what people can expect from good quality HIV and sexual health services.
- *HIV and AIDS in African communities* (Department of Health et al, 2004) – a framework to improve the effectiveness of HIV prevention and care services for African communities affected by or at risk of HIV.

In 2004, the Department of Health published the White Paper, *Choosing health: making healthy choices easier* (Department of Health, 2004). This highlighted action and new investment to improve access to sexual health services, a major new information campaign, and more generally, action to maximise the positive health impact of the local community setting.

The White Paper *Our health our care our say: a new direction for community services* (Department of Health, 2006) identified a need for sexual health services to be provided in a variety of settings including general practice, community clinics and through voluntary and private sector providers.

The Department of Health has recognised the need to engage with racism and promote racial equality and has set out its plans in its *Race equality scheme* (Department of Health, 2005). This guidance endorses these moves and seeks to give practical advice that will help NHS staff to provide a better service.

Other relevant policies

Other relevant policies include:

The Health and Social Care Act (2001) – Section 11 of the Health and Social Care Act imposes a legal duty on PCTs to involve users, carers and the public in decisions affecting health care. The guidance contains suggestions for workers about how they might engage and target members of refugee communities.

Race Relations (Amendment) Act 2000 – Under the amended Race Relations Act, public authorities are required to take active steps to promote racial equality in both their employment practices and service delivery. This requirement is not optional and must be supported by measures demonstrating how this can be achieved.



Useful organisations and websites

- Commission for Racial Equality
- Department of Health

Useful publications

All Department of Health policies and reports included in this section, along with other relevant Department of Health publications, can be downloaded from www.dh.gov.uk.

2.3 LOCAL NHS SERVICES

The following offer sexual health services in most local areas:

General practices: General practices provide a range of free sexual health services including contraception, diagnosis and treatment of some sexually transmitted infections, pregnancy testing, health screening and referral to secondary services. They should help with unplanned pregnancy and referral for abortion.

“Refugees don’t realise what a GUM clinic is. You can give a false name, if you want, and a false address. You can walk in or phone – you don’t have to be referred by a GP.”

[Senior refugee health worker]

In some areas, specialist general practices (known as Personal Medical Services or PMS) have been set up. These provide specialist services in addition to general practice services. Some provide specific services to asylum seekers and other transient or particularly vulnerable groups.

Not all general practices offer a full range of contraceptive methods, but they should signpost people to a local service that does. People may also be referred on to a sexual health service or a genitourinary medicine (GUM) clinic for sexually transmitted infection testing and treatment. Most general practices provide HIV testing but if a general practice carries out a test it must be entered on medical records. A GUM or sexual health clinic will carry out tests and keep the results private – the information will not be passed on to a person’s GP and it is up to the individual whether they then inform their GP of their HIV status. However, GPs are best able to help if they are fully aware of any health problems.

GUM clinics: GUM clinics (also known as GU clinics) specialise in the investigation and treatment of all sexually transmitted infections, including HIV. They offer a full range of tests, treatments and advice on all infections and other genital conditions. Sexual health clinics provide both sexually transmitted infection and contraception services, including emergency contraception, pregnancy testing and help with psychosexual issues. They can write medico-legal reports in support of an asylum application if this is appropriate.

GUM clinics are usually based in hospitals, and can be contacted without referral by a GP. They offer a confidential service, and people do not have to give their name. Written and



computer records are kept separate from any other notes held at the hospital. Some sexual health services are provided in community-based settings by the NHS and voluntary sector organisations working together.

Contraception/family planning clinics: These clinics offer free contraception, pregnancy testing and some tests and treatment for sexually transmitted infections. Some provide counselling for psychosexual difficulties. They should provide support for unplanned pregnancy and referral. They may also offer sessions specifically for young people. If a full range of tests and treatments are not provided, they will provide details of the nearest service that does.

Young people's services: In addition to sessions run for young people by general practice and contraception clinics, there are a number of clinics specifically for young people. These will have an upper age limit. Some are run by the voluntary sector such as Brook.

Health promotion services: Health promotion services work to promote good health among the local population. They may be based in a primary care trust, or they may be a separate health promotion unit. In some areas, they go under the title of 'public health' or 'health development' or 'health improvement'.

All health promotion services offer support to professionals working on issues related to sexual health. Some also work directly with local communities. Services on offer often include training; seminars; conferences; information on policies; strategic development; building networks and encouraging partnership initiatives. Many health promotion services run free condom schemes, and provide a range of resources such as publications, videos and demonstration models and kits. Small quantities of all **fpa's** leaflets on contraception and sexually transmitted infections may be available free from health promotion units in England. Contact your local unit directly for more information. They are also available to purchase from **fpa** (see Appendix 3). Health promotion services run national sexual health campaigns at local level.

"We don't want to set up barriers. We don't want people to be scared of coming to the clinic. With asylum seekers and refugees that means explaining the right to be anonymous, protecting confidentiality, offering a language service, and respecting their perspective and needs. It also means making it clear that we are not part of the immigration system and will not pass on information."

(Consultant physician in GUM)



Community research

Awareness of sources of help and advice

Most interviewees in the community research knew of places to go for help if they needed contraception or were worried about sexually transmitted infections. General practices, sexual health clinics and hospitals were seen as important sources of help. People found it harder to think of places they could go to for help if they were worried about their son or daughter learning about sex and coping with relationships in the UK.

2.4 NATIONAL HELPLINES

For details of local sexual health services contact one of the helplines listed below. Asylum seekers and refugees –and organisations working with them – can also contact the helplines directly to discuss sexual health concerns. All contact details can be found in Appendix 3: Useful organisations and websites.

- **fpa**
- African AIDS Helpline
- Brook
- NHS Direct
- Sexual Health Line
- Terence Higgins Trust

2.5 VOLUNTARY SECTOR ORGANISATIONS

Organisations and projects working on particular issues or with particular communities are available in most areas. They include:

- London Lesbian and Gay Switchboard
- Rape and Sexual Abuse Support Centre
- Women's Aid

All contact details can be found in Appendix 3: Useful organisations and websites.

There may be other relevant initiatives at local level, such as projects working with teenage parents or people in prostitution. To find out about these, contact your nearest Council for Voluntary Service (CVS) or local council. Details of your local CVS can be obtained from the National Association for Voluntary and Community Action (www.navca.org.uk).

2.6 FOR MORE INFORMATION

There are many organisations working on sexual health issues. The following are useful starting points if you want to find out more.

- Black Health Initiative



- British Association for Sexual Health and HIV
- Brook
- Centre for HIV and Sexual Health
- Department of Health
- **fpa**
- Medical Foundation for Aids and Sexual Health
- The Society of Sexual Health Advisers

Useful publications

fpa factsheets

A series of regularly updated factsheets on the law and key sexual health topics in the UK.

Available from www.fpa.org.uk

Black Health Initiative information

Information on NHS services, in 15 different languages (including video and audio resources).

Available from www.bcathealthinitiative.co.uk

Terence Higgins Trust leaflets

Terrence Higgins Trust has free leaflets in different languages.

Available from www.tht.org.uk





Chapter 3

ASYLUM SEEKERS AND REFUGEES: AN INTRODUCTION

IN THIS CHAPTER

- 3.1 Definition of terms
- 3.2 Health issues
- 3.3 UK Government policy
- 3.4 For more information

This section provides a definition of some of the key terms used to describe people seeking asylum or granted permission to remain in the UK. It also outlines some of the main health issues facing asylum seekers and refugees, and summarises some of the ways in which immigration and asylum policy impacts on sexual health.

In May 2005, the Immigration and Nationality Directorate (IND) (now renamed the Border and Immigration Agency) began implementing its new asylum model, with the aim of replacing the existing systems and procedures for asylum determination and support by April 2007. On 1 April 2007 IND became an executive agency of the Home Office and changed its name to the Border and Immigration Agency. Asylum support now operates through regional offices but eligibility criteria and the support offered remains the same.

3.1 DEFINITION OF TERMS

Asylum seeker

An asylum seeker is a person who has requested asylum or refugee status and whose application has not yet been decided.

Asylum

If a person is recognised as a refugee, they will be granted asylum (including the right to remain in the UK). The grounds on which asylum will be granted are covered by paragraph 334 of the UK Immigration Rules. Those granted asylum between July 1998 and August 2005 were granted Indefinite Leave to Remain (see below). Since September 2005, those granted asylum have been given five years Leave to Remain or Enter (see below).



Refugee

A refugee is a person forced to leave his or her country of origin or habitual residence in search of safety in another country. The 1951 UN Convention defines a refugee as 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 or, owing to such fear, is unwilling to return to it.'

The Border and Immigration Agency of the Home Office defines the term 'refugee' as including only people who have been recognised as such by the United Nations High Commissioner for Refugees (UNHCR), or who have been granted asylum by a signatory to the 1951 UN Refugee Convention.

Indefinite Leave to Remain

Before 30 August 2005, people granted asylum were granted Indefinite Leave to Remain (also known as settlement) at the same time as the decision to recognise them as a refugee. This has now been replaced by Leave to Remain/Enter for up to five years.

Leave to Remain/Enter

Since 30 August 2005, people granted asylum no longer have an automatic right to settlement. They are allowed to stay in the country for up to five years. They will then need to make an application for Indefinite Leave to Remain, which, if granted, will mean permanent settlement.

Exceptional Leave to Enter/Remain

Exceptional Leave was granted up to April 2003. It was given for up to four years to people who could demonstrate compelling compassionate or humanitarian reasons why they should not be removed from the UK. Exceptional Leave to Remain was replaced by Humanitarian Protection and Discretionary Leave to Remain in April 2003.

Humanitarian Protection

Humanitarian Protection is available to people who are not refugees but who can establish substantial grounds for believing that their removal from the UK would expose them to a real risk of serious harm, that is:

- the death penalty or execution
- unlawful killing
- torture or inhuman or degrading treatment or punishment in the country of return; or



- serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict.

Until 30 August 2005, leave on Humanitarian Protection grounds was granted for three years in the first instance. It is now granted for five years, with the option to apply for settlement at the end of that period, as in refugee cases.

Cases in which there is a risk of a breach of Article 3 of the European Convention on Human Rights (ECHR) for non-protection reasons (such as the gravest medical cases) will not attract Humanitarian Protection, but will be considered for Discretionary Leave.

Discretionary Leave to Remain/Enter

Discretionary Leave to Remain is given for up to three years, after which a renewal application can be made for up to three years. After six years, settlement can be applied for.

Discretionary leave will be granted to an applicant who:

- has an Article 8 claim (a claim to stay based on keeping a family united and/or on other aspects of the claimant's private or family life)
- has an Article 3 claim that does not fall within the criteria for humanitarian protection (medical cases and severe humanitarian cases)
- is an unaccompanied asylum seeking child for whom adequate reception arrangements are not available in their own country (in these cases three year's leave is not always appropriate and children will be expected to leave the UK when they reach adulthood)
- would have qualified for Asylum or Humanitarian Protection but has been 'excluded' (for example, because of a serious criminal offence. In these circumstances Discretionary Leave would only be granted for six months at a time)
- is able to demonstrate other particularly compelling reasons why removal would not be appropriate.

Family Reunion

Before August 2005, only people granted Indefinite Leave to Remain could apply for family members to join them from overseas ('family' was taken to include spouse and children under the age of 18 who have not established an independent life). Since 30 August 2005, anyone granted Refugee Status or Humanitarian Protection can apply for 'family reunion'. Anyone who qualifies to join a family member in the UK will be granted leave to enter in line with the sponsor already in the UK.

Refusal

This term is used when a person's application is rejected. When a person is refused asylum they will either have a Suspensive or a Non-suspensive right of appeal (some may choose not to appeal). If someone has a Non-suspensive appeal they will be required to leave the UK in



order to exercise that right of appeal. However, most will have a Suspensive right of appeal, meaning their removal is suspended until they have exhausted all appeal rights.

The Gateway Protection Programme

The Gateway Protection Programme is a resettlement scheme, set up in April 2003. It is a partnership between the UK Government and the UNHCR and builds on similar schemes run by the UNHCR in conjunction with other countries around the world.

Refugees under this scheme are assessed by the UNHCR before they reach the UK as being exceptionally vulnerable, at risk and in need of permanent resettlement. The Government has agreed to accept up to 500 refugees a year from the UNHCR's refugee resettlement programme.

3.2 HEALTH ISSUES

Many factors have been identified as contributing to the vulnerability of asylum seekers:

- the relatively poor health care systems in some countries of origin
- the turmoil caused by war or oppression
- experiences of torture, persecution and loss
- the difficulties of travelling and claiming asylum
- cultural bereavement and alienation
- overcrowding, and accommodation in low grade housing
- isolation and lack of community
- difficulties in communication
- lack of choice, influence and status
- hostility and racism in the media and surrounding communities.

Refugees' and asylum seekers' access to health services is often limited by lack of knowledge of their rights and of what is available to them, and by communication difficulties.

“If you are vulnerable you forget about your sexual health. It's the last thing you worry about.”

(Women's officer, refugee organisation)



Community research

The UK asylum system

A number of interviewees in the community research said that the situation of asylum seekers and refugees makes it difficult for them to have good sexual health. Poverty, bureaucracy, insecurity, loss of government support and hostility are all seen as having a negative impact. For asylum seekers, not being allowed to work (for at least one year) and the boredom and depression that stem from this, were also seen as undermining sexual health.

Useful organisations and websites

- Asylum Seeker Co-ordination Team (Department of Health)
- British Medical Association
- HARPWEB
- ICAR
- Refugee Council
- Refugee Health Network

Useful publications

Meeting the health needs of refugees and asylum seekers in the UK: an information and resource pack for health workers

Burnett A and Fassil Y (NHS, 2002)

Provides a comprehensive introduction to refugee health and related areas of concern, with contact lists and examples of good practice from around the UK.

Available from www.dh.gov.uk

The sexual health and sexual educational needs of refugees in Stockton-on-Tees

Elden S and Bedding S (Stockton International Family Centre, 2003)

Examines the sexual and educational health needs of refugees living in Stockton-on-Tees.

Available from www.sifc.org

3.3 UK GOVERNMENT POLICY

Many aspects of UK immigration and asylum policy impact on sexual health. Over the last decade, several Acts of Parliament have enacted law relating to dispersal, entitlement to support, entitlement to health care and other aspects of the asylum process.

New asylum model

Under the new asylum model a case owner is allocated to each individual case, and they remain responsible for that case throughout the process. The case owners are located in



one of 25 teams across the UK. The case owner ensures the claim is processed within the stipulated time-scales, decides whether to grant or refuse status, is responsible for all support arrangements and helps integrate those granted status, or facilitates the removal of those who are refused and are unsuccessful at appeal. All new applications for asylum made on or after 5 March 2007 are allocated a case owner and subject to this end-to-end approach, as well as a more limited number of applications made prior to this date.

All applicants for asylum under the age of 18 are assessed by social services who work with case owners to confirm their age and ensure they are properly protected. They are then accommodated with their families if they applied as part of a family, or by social services if unaccompanied.

All pre-new asylum model cases are dealt with by the Asylum Case Resolution Directorate in Croydon. All other support work has been regionalised and is undertaken in the regional asylum offices. Immigration procedures in general are subject to change, and up-to-date information should be obtained from the Home Office or Refugee Council.

Entitlement to health services

A person who has formally applied for asylum in the UK is able to access NHS treatment without charge for as long as their application (including appeals) is under consideration or for as long as they have been given Leave to Remain.

Asylum seekers may apply to a general practice to register as an NHS patient. A practice must consider such an application on its merits and should decline it only if its patient list is formally closed to new registrations or if the practice has other good non-discriminatory reasons for refusing that individual.

Accommodation providers under contract to the Home Office are required to assist dispersed asylum seekers to register with a general practice. Under normal circumstances this will mean ensuring all necessary information to register is available in a language they understand. If an asylum seeker has a pre-existing medical condition (for example, a pregnant woman or someone suffering from heart problems, asthma or diabetes) the accommodation provider is required to take them physically to register with a general practice within five working days of arrival at the dispersal address. If such a person is also in need of an urgent supply of prescribed medication then the provider is required to take the person to the nearest general practice within one working day of their arrival at the address.

Asylum seekers who are being accommodated and/or supported by the Home Office will be issued with an HC2 certificate for full help with health costs, including free NHS prescriptions (on the basis of the income based assessment being carried out by the Border and Immigration Agency). These certificates are issued on behalf of the Department of Health. Asylum seekers not supported by the Home Office can complete an HC1 application form and apply for an HC2 certificate under the NHS Low Income Scheme. Arrangements are in place to ensure that such claims are given priority.



Currently, general practices are not required to ask to see official documentation when registering an asylum seeker – however, proof of address can be obtained from a Home Office letter, bill (asylum seekers who are accommodated by the Border and Immigration Agency will have their utility costs met centrally and are unlikely to have relevant bills) or other document. An HC2 certificate itself does not entitle the holder to NHS treatment – it entitles the holder to help with the cost once they have been accepted for treatment.

Contraception services are free to all regardless of immigration status. Treatment for sexually transmitted infections is also free to all, unless people go to their general practice when they may have to pay a prescription charge for treatment. However, only the initial diagnostic testing and associated counselling is free for people with HIV. Should a test prove positive, subsequent treatment will be chargeable if the patient is liable to pay overseas visitor charges (that is, if they are not an asylum seeker).

A summary table of entitlement to NHS treatment covering asylum seekers and failed asylum seekers is available at www.dh.gov.uk/asylumseekers and www.harpweb.org.uk.

See Section 7.6 for more information.

Refused asylum seekers

Any individual of any nationality who is found by the Home Office and the Asylum and Immigration Tribunal (or the higher courts in some appeal cases) not to be in need of asylum or international protection is expected to leave the UK (unless they qualify to remain on some other basis). The Government believes that voluntary returns are preferable to enforced returns, and is working to increase the numbers who wish to return to their country voluntarily through the Voluntary Assisted Return and Reintegration Programme.

If an asylum application is refused, families with children under 18 continue to receive asylum support until the youngest child reaches 18 or they leave the UK. For others, asylum support ceases once all appeal rights have been exhausted. If they are destitute and temporarily unable to leave the UK through circumstances beyond their control, they may be eligible for support under Section 4 of the 1999 Immigration and Asylum Act. The eligibility criteria are that they are:

- taking reasonable steps to leave the UK or place themselves in a position in which they can leave the UK; or
- unable to leave the UK by reason of a physical impediment to travel or some other medical reason; or
- unable to leave the UK because there is no current viable route of return to the country of origin; or
- permission has been obtained to proceed with a judicial review against a decision relating to the person's asylum claim; or



- the provision of support is otherwise necessary to avoid a breach of a person's human rights.

Schedule 3 of the Nationality, Immigration and Asylum Act, 2002 precludes support under Section 21, National Assistance Act 1948, to 'ineligible persons', including former asylum seekers who have failed to co-operate with removal directions and former asylum seekers who are unlawfully in the UK. Local authorities can, however, provide support under Section 21 to ineligible persons to the extent necessary to prevent a breach of the ECHR.

This is a complex and changing area – up-to-date summaries are available from the Home Office, Department of Health and the Refugee Council.

See Section 7.8 for more information on refused asylum seekers and primary medical services and hospital treatment.

Health screening

Asylum seekers applying on arrival at ports are normally referred to the Port Medical Inspector for examination.

Increasingly, new asylum applicants who have no resources and are unable to stay with relatives or friends are initially accommodated in Initial Accommodation by the Border and Immigration Agency, where they are offered the opportunity to have their health screened. A one-day induction process, which may include a health check, has been developed for asylum applicants who do not require accommodation. Asylum seekers who do not require accommodation, or those who have been dispersed, can register with a local general practice after dispersal, where they will go through the initial health assessment offered to all new patients.

Testing for HIV is not conducted on a routine basis. It is offered on request or where a medical history indicates the asylum seeker has been at risk. Testing is done through referral to a genitourinary (GUM) clinic, with pre- and post-test discussion and counselling. Asylum seekers may have only a few days in Initial Accommodation before being dispersed, so it is often more appropriate for them to receive the testing in the area they are dispersed to where they can build a relationship with the health professionals and receive continuity of care.

Useful organisations and websites

- Asylum Seeker Co-ordination Team (Department of Health)
- Exile
- HARPWEB
- Home Office Border and Immigration Agency
- No Recourse to Public Funds (NRPF) Network
- Refugee Council



Useful publications

First do no harm: denying healthcare to people whose asylum claims have been refused

Kelley N and Stevenson J (Oxfam and Refugee Council 2006)

Looks at the impact that the *NHS overseas visitors hospital charging regulations* has on failed asylum seekers who need hospital care.

Available from www.refugeecouncil.org.uk

3.4 FOR MORE INFORMATION

There are many sources of information about the asylum system and asylum seekers and refugees in the UK. The following organisations provide a useful starting place.

- BBC
- Home Office Border and Immigration Agency
- Refugee Council





Chapter 4

SEXUAL HEALTH AND HUMAN RIGHTS

IN THIS CHAPTER

- 4.1 Human rights and health
- 4.2 Sexual rights
- 4.3 Reproductive rights
- 4.4 Women's rights
- 4.5 Lesbian, gay, bisexual and transgender rights
- 4.6 For more information

International human rights agreements provide standards which governments sign up to, and against which their performance can be judged. They were first defined by the international community in the Universal Declaration of Human Rights adopted in 1948 as a response to the events of the Second World War, including the Holocaust. These events were a stark reminder of what may happen when states treat, or allow others to treat, some people as less human than others.

The Human Rights Act came into force in the UK in October 2000. The Act has two main aims:

- To bring most of the human rights contained in the European Convention on Human Rights into UK law. In other words, to make it possible for people to raise or claim their human rights within complaints and legal systems here in the UK (see Section 5.2).
- To bring about a new culture of respect for human rights in the UK. The Human Rights Act is about much more than compliance with the law by public authorities. The Act was intended to place human rights at the heart of public service delivery, and through this to make rights a reality for all people in the UK.

An awareness of human rights as they relate to sexual health is useful for organisations that want to adopt and promote human rights as part of their core values, or that want to scrutinise the performance of governments and campaign against human rights abuses. This section provides a summary of the main international human rights agreements relating to sexual health.



‘Prevention of and response to sexual and gender-based violence are directly linked to the protection of human rights.’

(UNHCR, 2003)

4.1 HUMAN RIGHTS AND HEALTH

The abuse or denial of human rights often has an impact on health.

Article 25 of The Universal Declaration of Human Rights (1948) states that:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

(United Nations, 1948)

4.2 SEXUAL RIGHTS

There is no one international law or treaty that deals specifically with the issue of sexual rights. However, sexual rights are recognised in a number of international human rights agreements. According to the World Health Organization (WHO), they include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services
- seek, receive and impart information in relation to sexuality
- sexuality education
- respect for bodily integrity
- choice of partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when to have children
- pursue a satisfying, safe and pleasurable sexual life.

The WHO states that for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (www.who.int/en, accessed January 2007).



4.3 REPRODUCTIVE RIGHTS

The International Conference on Population and Development (ICPD) (1994) defined reproductive rights as follows:

‘Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.’

(ICPD, 1994)

Reproductive rights are seen as basic to women’s equality and their self-determination over their bodies and sexual lives. The Center for Reproductive Rights, for example, promotes and defends the reproductive rights of women worldwide. It identifies the following as reproductive rights:

- a full range of safe and affordable contraception
- safe, accessible and legal abortion
- safe and healthy pregnancies
- comprehensive reproductive health care services provided free of discrimination, coercion and violence
- equal access to reproductive health care for women facing social and economic barriers
- freedom from practices that harm women and girls (such as female genital mutilation)
- a private and confidential doctor-patient relationship.

(www.crlp.org, accessed January 2007)

4.4 WOMEN’S RIGHTS

The UN has stated that there can be no human rights without women’s rights. The position of women in society, and the level of equality and freedom they are allowed, has a major impact on the sexual health of men, women and children. World conferences, including the Beijing conference (1995) have confirmed the gendered nature of violations of human rights.

The convention on the elimination of all forms of discrimination against women, is the main international human rights document dealing solely with the human rights of women. Article 12 calls on governments to:

‘take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.’

(UN General Assembly, 1979).



It states that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups (such as migrant, refugee and internally displaced women) and that state parties should ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services. It also states that there should be adequate protection and health services for women in especially difficult circumstances, including refugee women.

Other key agreements include the *Declaration of the elimination of violence against women* (United Nations, 1993) and the 4th *World Conference on Women, platform for action* (United Nations, 1995).

The declaration defines the term 'violence against women' and states that governments should 'condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination'.

4.5 LESBIAN, GAY, BISEXUAL AND TRANSGENDER RIGHTS

There is no separate international statement on the rights of lesbian, gay, bisexual or transgender (LGBT) people. Amnesty International advocates the following (Amnesty International, 2001):

- repeal laws criminalising homosexuality
- condemn torture, whoever the victim
- provide safeguards in custody
- prohibit forced medical 'treatment'
- end impunity
- protect LGBT people against violence in the community
- protect refugees fleeing torture based on sexual identity
- protect and support LGBT human rights defenders
- strengthen international protection
- combat discrimination.

'Sexuality and gender identity are fundamental aspects of human identity . . . they go to the core of what it means to be human. The right to freely determine your sexual orientation and gender identity, and to express them without fear, are therefore human rights in the fullest sense.'

(Saiz, 2002)



4.6 FOR MORE INFORMATION

Useful organisations and websites

- Amnesty International
- Center for Reproductive Rights
- Human Rights Watch
- International Centre for Reproductive Health
- International Gay and Lesbian Human Rights Commission
- International Lesbian and Gay Association
- International Planned Parenthood Federation
- UNICEF
- United Nations Development Fund for Women
- World Health Organization

The International Planned Parenthood Federation (IPPF) Charter on sexual and reproductive rights

The IPPF's *Charter on sexual and reproductive rights* is based on 12 rights that are grounded in core international human rights instruments. These are, the right to:

1. life
2. liberty and security of the person
3. equality, and to be free from all forms of discrimination
4. privacy
5. freedom of thought
6. information and education
7. choose whether or not to marry and to found and plan a family
8. decide whether or when to have children
9. health care and health protection
10. the benefits of scientific progress
11. freedom of assembly and political participation
12. be free from torture and ill treatment.

(IPPF, 1996)

Free copies of the IPPF *Charter*, along with posters and other information are available from www.ippf.org.





Chapter 5

SEXUAL HEALTH AND THE ASYLUM APPLICATION

IN THIS CHAPTER

- 5.1 Applications under the UN Convention
- 5.2 Applications under the European Convention on Human Rights
- 5.3 Women and persecution
- 5.4 Applicants with HIV
- 5.5 Lesbian, gay, bisexual and transgender (LGBT) applicants
- 5.6 Trafficking and asylum claims
- 5.7 Female genital mutilation and asylum claims
- 5.8 The medico-legal report
- 5.9 For more information

This section provides an overview of some of the ways in which sexual health issues may form part of the application for asylum. It is important that asylum seekers receive skilled legal advice. In more complex cases, this may need to be from companies and agencies specialising in particular aspects of immigration and asylum law. People requesting asylum in the UK should make known to their legal adviser and to the Home Office any information that will support their case, as early as possible.

5.1 APPLICATIONS UNDER THE UN CONVENTION

The 1951 UN Convention defines a refugee as someone 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 or, owing to such fear, is unwilling to return to it' (United Nations High Commissioner for Human Rights, 1951).



To secure protection under the 1951 UN Convention, asylum applicants have to demonstrate that they have a well-founded fear of persecution for a reason recognised under the Convention. They must also prove that the state is unwilling or unable to provide effective protection.

Through case law in the UK, in recent years it has become accepted that ‘membership of a particular social group’ may include being female, or having a particular sexual orientation. As a result, people can apply for asylum on the grounds that if returned to their home country they would be persecuted because of their sexual or gender identity, or because they are accused of transgressing laws or social mores governing the rights and behaviour of men and women. Cases are often contested by the Government, and may not be successful.

‘Membership of a particular social group’ is not the only basis on which a woman’s asylum claim might be based. The interpretation of the Convention has begun to be widened to include women’s experiences of persecution. For example, refusing to conform to social mores relating to dress can be interpreted as the political actions of a woman asserting her human rights [see also Section 5.3].

‘Persecution’ may include sexual violence.

5.2 APPLICATIONS UNDER THE EUROPEAN CONVENTION ON HUMAN RIGHTS (ECHR)

Since October 2000 there has been another form of protection available in the UK through the Human Rights Act. This Act forbids the UK authorities from acting in a way which is incompatible with a right under the ECHR. If someone can show that returning them to the country from which they fled would breach one of these rights unlawfully, they will be allowed to remain in the UK.

The human rights protected by the Human Rights Act are the same as those contained in the ECHR. These include Article 2, the right to life, Article 3, the right to be free from torture or inhuman or degrading treatment or punishment, and Article 8, the right to respect for private and family life.

Human rights issues must be taken into account from the outset of the application, by the asylum seeker’s legal representative and by the Home Office but it is the claimant’s duty to state the issues clearly, fully and at the earliest opportunity.

In certain circumstances, when an initial request for asylum has been refused, it may be possible to make a fresh asylum or human rights claim, but only if there is new information to submit, backed up by evidence. Specialist legal advice is likely to be necessary.

Applicants who have stopped receiving support from the Border and Immigration Agency can re-apply once the Home Office has acknowledged receipt of their human rights claim. This can take between a few weeks and several months because a decision has to be taken as to whether the claim is genuinely new in accordance with the relevant legal criteria. They may be



eligible for local authority hardship funds for people in this situation who are seriously ill with HIV. Provision varies, and you should check whether your local authority offers such support.

5.3 WOMEN AND PERSECUTION

There is an increasing awareness of the ways in which women may experience persecution differently from men (Crawley, 2001, Dumper, 2003). Women may be persecuted for the same reasons as men, such as their political activities and beliefs. However, they may be persecuted for breaking rules regulating women's behaviour – by having a sexual relationship outside marriage, for example, or for refusing to wear a veil. They may be also persecuted in ways that are gender-specific, including sexual violence, domestic violence, forced marriage, female genital mutilation (FGM), forced abortion and sterilisation, and denial of access to contraception. Some women may face honour killing as a result of perceived transgressions.

As with other forms of violence, these all constitute persecution if:

- there is a severe violation of a basic human right (that is, ECHR Article 2, 3, 4(1) and/or 7); or
- there is an accumulation of various acts, including a violation of a human right which is sufficiently severe as to affect an individual in a similar manner as a severe violation of a basic human right, as above.

Women's grounds for requesting asylum must be explored. Male heads of household often make the asylum claim on behalf of the family and may not be aware of the importance of a woman's case, or may be ashamed of the details. However, a woman's claim to refugee status may in some cases be as strong as, or stronger, than that of her male relative or partner. Home Office figures for 2005 show that asylum claims made by women as the main applicant have a slightly higher success rate than those made by men.

Women (and their families) may not realise that they have the right to request asylum in their own right. This means they are in a position of complete dependence on their husband for immigration status, benefits, housing and entitlement to a wide range of services, even if they are in a relationship that is abusive. If the relationship breaks down and the woman applies on her own at a later date, this can complicate or prolong the claim. She will be expected to explain why she did not apply in her own right at an earlier date.

Women can find the process of making an asylum claim particularly difficult. Interviews with legal representatives and immigration officials may be embarrassing or traumatic. Women may not want other family members to be present at interviews, and wherever necessary they should be provided with a case owner (or interviewer) and professional interpreter of the same sex, with guarantees of confidentiality.

For a number of reasons – including shame, fear and the need to cope with other difficulties – women often report sexual violence at a later stage in their claim. This can raise questions about credibility (Cenada, 2003). It can also be difficult for women to provide evidence of sexual violence, unless they have been medically examined soon after the event. This rarely



happens, because of practical difficulties, more urgent priorities, lack of access to health care and the stigma of rape and loss of virginity in most countries.

The Home Office has adopted guidelines to ensure that gender issues are taken into account when looking at the persecution experienced by women asylum seekers (*Home Office asylum policy instructions*, October 2006).

“Confidentiality on the part of legal advisers, health workers, interpreters and any one else involved in helping with the asylum seeker’s case is vital to enabling victims of rape and sexual torture to talk about their experiences.”

(Legal officer, refugee organisation)

5.4 APPLICANTS WITH HIV

In only very exceptional cases is it possible to make a successful claim to remain in the UK on the basis of having a serious medical condition such as HIV/AIDS. Specialist legal help should be obtained. The fact that a person has a serious medical condition including HIV/AIDS will not be counted against them in any application.

Sometimes, a claim is made under Article 3 of the ECHR that a person should not be returned to their country of origin because they have a serious illness and would face serious deterioration in their condition and possible death because of a complete lack of health care in their country. Such applications are most often made when a request for asylum has been turned down.

Each case is considered on its merits but case law in the European Court of Human Rights and in the UK has established a very high threshold for inhuman or degrading treatment in such cases. This does not enable an applicant to stay in the UK simply to benefit from treatment that is more advanced or more affordable than in their own country. In practice, such applications are frequently turned down. Such claims are unlikely to succeed unless the person concerned is in the final stages of a serious illness and faces imminent death without medical or other support if removed from the UK.

5.5 LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) APPLICANTS

In 1999, the House of Lords ruled that homosexuals could constitute a ‘particular social group’ under the 1951 UN Convention. Since then, the Home Office and Asylum and Immigration Tribunal has generally accepted that lesbians and gay men can qualify for refugee status on the basis of homophobic persecution, if it can be proved that the state in their country offers no effective protection or supports the persecution of homosexuals.

The ECHR can also provide grounds for gaining protection for LGBT asylum seekers. Article 8, which relates to the right to respect for private and family life, may be used to support the claim of someone persecuted on the grounds of sexual identity.

It can be difficult to secure the information needed to substantiate claims made on these grounds, because the ‘unmentionable’ status of gay and lesbian sexuality often means there



is almost no information about this kind of persecution. In addition LGBT asylum seekers often remain silent about this aspect of their asylum claim until late in the process, when it may be too late.

There are organisations, such as the UK Lesbian and Gay Immigration Group, Naz Project London and the International Lesbian and Gay Association, that may be able to help provide evidence of persecution and lack of state protection. See Section 7.5 and Appendix 3 for more information.

5.6 TRAFFICKING AND ASYLUM CLAIMS

People trafficked into the sex industry are often brought into the UK on false documents. However, some people do manage to escape and make asylum claims because they fear persecution from the trafficker if they return home, and the risk of being trafficked again. They may also face hostility and ostracism from their family and community in their home country.

Where a person makes an asylum claim based on being a victim of trafficking, and continues to fear being re-trafficked, or the consequences of having been trafficked, the claim will be considered on its individual merits and in the context of the country concerned. The Home Office acknowledges that trafficking is a form of harm which is serious enough to constitute persecution, though it may not always occur for one of the specific reasons set out in the Refugee Convention (that is, it is not for reasons of race, religion, nationality, membership of a particular social group or political opinion). However, where, for example, a woman who has been trafficked for sexual exploitation is able to establish that she has a well-founded fear of being trafficked for reasons other than those set out in the Refugee Convention, she will be granted Humanitarian Protection. The Home Office has produced the *UK action plan on tackling human trafficking*, which describes the mechanisms it is putting in place to ensure the safety of victims of trafficking and that their asylum claim is dealt with fairly (Home Office and Scottish Executive, 2007).

The United Nations High Commission for Refugees (UNHCR) has produced guidelines as to how and why some trafficked women and girls (whether for the purpose of sexual exploitation or domestic slavery) may be considered members of a particular social group within the terms of the Refugee Convention. The Council of Europe has produced a *Convention on action against trafficking in human beings*, which the British Government signed on 23 March 2007. The Convention is intended to prevent and combat trafficking, while providing a framework for protecting and assisting victims of trafficking. Additionally, in 2006 the European Parliament called for an action plan on trafficking in human beings (European Parliament, 2006).

5.7 FEMALE GENITAL MUTILATION AND ASYLUM CLAIMS

There are examples of women claiming asylum on the grounds of being at risk of female genital mutilation (FGM). The House of Lords held in the case of *SSHD V Fornah [2006] UKHL 46* that women from Sierra Leone who fear being subjected to FGM can be regarded as a particular social group for the purposes of the Refugee Convention. The judgment has



relevance to other societies where FGM is widespread and tolerated, or encouraged by the state. Where a woman from such a society demonstrates that her fear of being subjected to FGM is well founded, a grant of asylum is likely to be appropriate.

At the same time as the FGM Act came into force in March 2004 (see Section 8.11) the Home Office issued guidance for case workers regarding gender issues in asylum claims (revised in October 2006). These instructions give guidance on the additional considerations case workers should have in mind when assessing claims for asylum that could include gender related harm, such as marriage related harm, violence within the family or community, domestic slavery and FGM.

5.8 THE MEDICO-LEGAL REPORT

If an asylum seeker is claiming asylum based on sexual torture, rape or sexual violence, their legal adviser will need a medical report documenting any evidence of the torture and its effects. The medical report needs to be written by a doctor, preferably with credentials in the field of torture care, and the history-taking and examination need to be rigorous if they are to be considered credible by the Home Office.

Ideally, the asylum seeker should be seen by a doctor within the first few days of arrival. However, victims of sexual torture, rape and sexual violence often feel extreme levels of shame and may find it difficult to let people know about their experiences.

Some forms of sexual violence leave long-term or permanent physical and psychological scars. Sexual torture and rape may have lasting consequences, such as pregnancy, HIV, sexual problems and disability. However, some common forms of sexual violence – such as rape – do not usually leave lasting physical scars. It can be difficult to verify some cases of sexual torture and rape, especially when a significant period of time elapses between someone being raped or tortured, and their reaching the UK. Their medical care may then be delayed by the dispersal system, and it may be months before they have the confidence to disclose information.

Asylum seekers who disclose additional information at a later stage of the application process can submit this in support of their asylum claim. A medical examination can be carried out to provide a medico-legal report on the experiences raised. Psychiatric reports are often found to be useful in support of asylum claims.

5.9 FOR MORE INFORMATION

Useful organisations and websites

- Asylum Aid
- Community Legal Service Direct
- Electronic Immigration Network
- Immigration Law Practitioners' Association



- Medical Foundation for the Care of Victims of Torture
- Refugee Women's Legal Group
- UK Lesbian and Gay Immigration Group
- United Kingdom Human Trafficking Centre
- www.yourrights.org.uk

Useful publications

Asylum policy instructions on gender

[Immigration and Nationality Directorate, 2006] (now renamed the Border and Immigration Agency)]

Instructions issued by the UK Government to immigration officials on how to handle and consider claims made by female asylum seekers.

Available from www.ind.homeoffice.gov.uk

Gender guidelines for the determination of asylum claims in the UK

[Refugee Women's Legal Group, 1998]

Available from www.rwlg.org

Guidelines for the examination of survivors of torture

[Medical Foundation for the Care of Victims of Torture, 2000]

An overview of how to write a medico-legal report. Summarises different kinds of torture and their effects.

Available from www.torturecare.org.uk

Immigration controls, the family and the welfare state

Cohen S [Jessica Kingsley Publishers, 2004]

A handbook of law, theory, politics and practice for local authority, voluntary sector and welfare state workers and legal advisors.

International human rights mechanisms and women asylum seekers

[Asylum Aid, 2005]

Looks at whether the individual complaints systems of four UN human rights mechanisms could benefit women who are claiming asylum in the UK.

Available from www.asylumaid.org.uk

Lesbian, gay, bisexual and transgender (LGBT) refugees and asylum seekers: ICAR navigation guide

De Jong A [ICAR, 2003]

Provides detailed information on UK legislation and legal issues.



Available from www.icar.org.uk

Lip service or implementation? The Home Office gender guidance and women's asylum claims in the UK

Ceneda S and Palmer C (Asylum Aid, 2006)

Available from www.asylumaid.org.uk

Refugees and gender: law and process

Crawley H (Jordans publishing, 2001)

Examines how those representing asylum seekers can ensure that all gender-related aspects are considered in the determination process.

UK action plan on tackling human trafficking

Home Office and Scottish Executive (TSO, 2007)

Pulls together the work currently underway to tackle trafficking across government, and creates a platform for future work.

Available from www.homeoffice.gov.uk



Chapter 6

GENERAL GOOD PRACTICE GUIDANCE

IN THIS CHAPTER

- 6.1 Good practice guidelines
- 6.2 Language
- 6.3 Culture
- 6.4 Religion

“Good practice should be the same for anyone, wherever they come from.”

(Health adviser, health service for asylum seekers)

This section provides guidelines for building good practice. In many ways, the guidelines replicate good practice when working with any sector of the population.

Language and communication are key, and Section 6.2 looks at some of the issues that arise when people who speak different languages talk about sex and sexual health. Culture and religion can be important influences on sexual health and sexual behaviour, and many people working with different communities want to understand these areas better, so they can provide a good service and avoid causing offence. Sections 6.3 and 6.4 provide an overview of issues relating to culture and religion, with suggestions on where to go for more information.

6.1 GOOD PRACTICE GUIDELINES

Don't make assumptions

Many factors influence people's sexual health, and their attitudes and experiences around sex and sexual health. It is helpful to be aware of these as far as possible. However, you cannot predict what any one person or group of people will experience, or how they will feel about sex and sexual health issues. They may not conform to the beliefs or practices that are common in their community. Their priorities may be different to your own, or they may not feel ready to tackle a sexual health issue you consider urgent. They may consider normal a practice that causes you concern.

It is important to make people aware of their choices and the help available while respecting their decisions about what is important to them at different stages of their time in the UK.



Ask questions

Some people avoid asking questions about sexual health because they do not want to appear insensitive or cause offence. It is best to ask people what matters to them, and to find ways of opening up conversation so they can express themselves and so they can let you know what they consider appropriate or inappropriate.

People working with individual clients or with community members and groups can develop sensitive questions that help them explore areas that might be difficult. It is also important to ask representatives of refugee community organisations for advice about the sexual health issues affecting their community, and what people are concerned about. Sometimes interpreters can give information about culture and beliefs that is useful. Building these relationships will help you find out what questions to ask and how best to phrase them – but always remember that everyone is an individual with their own values and understandings.

Be clear and explicit about confidentiality

Many asylum seekers and refugees are reluctant to talk about sexual health issues because they fear that information about their experiences or behaviour will become known in their community. They may not have told close family members about what has happened to them. Some survivors of rape, for example, feel unable to tell their partners. Lesbians or gay men may fear reprisals from their community. Some people may think that information will be passed on to the Home Office, and could affect their asylum claim or entitlement to services.

Clients and service users need to be reassured regarding confidentiality. A confidentiality policy should be in place and staff, volunteers and interpreters should be aware of this. There should be a private space where people can talk without being heard by other clients. It must also be made clear that confidentiality does not mean secrecy – information may be shared within a team or management structure, and in certain cases there is a legal obligation to break confidentiality.

See also Section 7.3.

Provide information and choice

Many asylum seekers and refugees do not know their rights, entitlements or responsibilities in this country. Many are not aware of services on offer, or how to contact them. Some fear that contacting such services may jeopardise their asylum claim. Some have had little sex and relationships education in their country of origin, and may find culture, behaviour and medical treatment in the UK very different to what they are used to. Sometimes information circulates about sexual health that is confusing or false.

“You need to acknowledge the courage it takes to disclose something, and the courage it takes to hear it. People often have no training in how to deal with this, and it has a major impact on your work, so you need to have supervision and protocols in place.”

(Project manager, HIV organisation)



Accurate information should be provided in people's own language as far as possible, through working with interpreters and with staff and community representatives who speak other languages. Translated information – written or audio – is useful, though expensive to produce.

Sexual health information should be provided in different contexts using a wide variety of techniques and media. If people have access to reliable information from different sources and in different formats, they have more time and opportunity to absorb what they are finding out and understand their options.

Build trust

Trust is important to enable asylum seekers and refugees to talk about their sexual health experiences and needs. Due to persecution in their country of origin, many are suspicious of authority figures and are not sure who to trust. They may fear being judged, or that confidentiality will be broken. They may need time to decide if a service provider is reliable and able to offer the support or information they need. They may want to be sure that actions will be taken only with their consent.

For people working at community level, it is important to be reliable, and not raise expectations. Refugees and asylum seekers may be concerned that nothing really happens for their community – that funding for a community group, for example, is not forthcoming. Helping with capacity building issues can give a community more autonomy and therefore more say in what goes on. This in turn can strengthen relationships and build trust.

To be trustworthy, an organisation needs to be clear and consistent in its aims and approach, and honest about its limitations. It helps if staff and management take time out to ensure they share a vision of what they are doing and how it is achieved.

Be accessible

Outreach work, location of services, opening hours, appointment systems, types of activity on offer and provision of crèche facilities will all influence who uses your service. Awareness of the differing needs of sectors of the refugee population, such as men and women, or different age groups, can help you develop services and projects that are useful and accessible. Ensure asylum seekers and refugees know what you can offer and feel able to get in touch.

Manage disclosure

Many asylum seekers and refugees have experienced sexual violence and other forms of loss and trauma. Some are HIV positive or have AIDS. It can take considerable courage to talk about such experiences. They may choose to tell a health worker or counsellor, or they may confide in someone they have come to trust – such as a community worker, interpreter, volunteer or faith leader.

It is important that organisations and services are clear about what staff, interpreters and volunteers should do if someone discloses they are HIV positive, or that they have been raped



or have suffered other forms of abuse or persecution. Support should be available to people hearing traumatic information, and boundaries should be in place to ensure that people do not provide advice or help beyond their role and expertise.

Wherever necessary, clients should be referred on to an agency that can help them. Remember that choosing to disclose is often an enormous step to take, and the client should be told what is likely to happen as a result, for example with regard to continuity of care and confidentiality. Wherever possible, they should be consulted about the next steps and offered choice.

Work in partnership

Partnerships are essential to effective working on sexual health issues. They can involve refugee community organisations, specialist sexual health services, health promotion units, the local authority, refugee agencies, housing providers, voluntary sector projects, strategic bodies, commissioners, funders and many others.

“It works best when we have joined up care – when we are networked with other organisations and we all link what we are doing.”

(Nurse, health service for asylum seekers)

Partnership working brings a number of benefits.

It can:

- give refugee communities an active role in decision-making and delivery of sexual health promotion
- enable commissioners and services to respond to and work with local communities
- increase capacity, and ensure a wider range of skills and knowledge is available for specific initiatives to specialist organisations and services.

Involve refugees and asylum seekers

Consultation and involvement are key to running effective sexual health initiatives and providing adequate care. There are many ways in which involvement can be achieved, from community research to funding for community-led projects. Working with refugee community organisations can be very productive, though you need to bear in mind how under-resourced such groups often are. Also, not everyone is part of a community organisation. Extra efforts need to be made to reach the most marginalised people.

Raise awareness and campaign

Positive sexual health for all can only be achieved by challenging inequality and systems, policies and people who oppress and discriminate. To achieve this, sexual health needs to be promoted at a number of levels:

- with individual asylum seekers and refugees



- among refugee communities
- within services and among volunteers, interpreters, staff and management
- among policy makers and politicians at local, regional and national level
- at the level of international human rights and social, economic and environmental policy.

Client rights

The following rights have been drawn up by the International Planned Parenthood Federation (IPPF):

Every client has the right to:

Information

Know about the benefits and availability of sexual and reproductive health services and to know their rights in this regard.

Access

Obtain services regardless of race, sex or sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability.

Choice

Decide freely on whether and how to control their fertility and which method to use.

Safety

Be able to protect themselves from unwanted pregnancy, disease and from violence.

Privacy

Have a private environment during counselling and services.

Confidentiality

Be assured that any personal information will remain confidential.

Dignity

Be treated with respect, empathy, courtesy, consideration and attentiveness.

Comfort

Feel comfortable when obtaining services.

Continuity

Receive sexual and reproductive health services and supplies for as long as needed.

Opinion

Freely express views on the services provided.

(Huezo, 2003)



6.2 LANGUAGE

Every language has its own way of naming the world, and this is particularly the case when it comes to matters of sex and sexual health.

Language and interpreting are issues that always rise to the top of the list of barriers facing asylum seekers and refugees, particularly when trying to access services. All too often, organisations lack the budget – and sometimes the will or understanding – to use professional interpreters. They try to manage without, or ask clients to bring friends or family members with them.

When the topic is sexual health, communication becomes even more challenging, because of the sensitivity of the subject matter and because many languages lack the appropriate vocabulary. Below are some of the difficulties that can arise.

- The interpreter may not have had much education on sexual health.
- The language they speak may have a limited vocabulary for sex and sexual health.
- The only words available may be slang words, which may be insulting or embarrassing for the interpreter, client or both.
- Alternatively, the words available may be specialist ones (medical terms, or words taken from another language), and they may not be understood properly by the client or interpreter.
- Sometimes there are no words available for a part of the anatomy, or for particular sexual acts – the interpreter may have to find longer ways of explaining things, and this can be difficult and embarrassing.
- People can find it particularly hard to say they don't understand something when sex and sexual health are being discussed.
- Accounts of sexual violence can be deeply distressing, and may have an impact on the interpreter.
- The interpreter may have particular values around sexual behaviour which influence how they interpret and how they relate to the client.
- The interpreter may not understand the importance of confidentiality.
- They may be interpreting for a family member, friend or close contact, and this can cause tension and inhibition in the client or interpreter.
- Some people do not feel able to speak openly if the interpreter is of the opposite sex.

“Sex is a big challenge for interpreters. It can take you places where you don't know the words. It can be very tempting to push on and do your best, but it's better to stop and say you don't know the language.”

(Interpreter, organisation working with torture survivors)



The role of the interpreter

Transferring information, emotions, attitudes, assumptions, beliefs and knowledge from one language to another is not as straightforward as it may seem. Interpreting is a professional skill that requires a high level of language proficiency, excellent listening and speaking skills and an in-depth understanding of the way that public institutions and services work. It is also important that interpreters understand the issues they interpret.

A trained community interpreter is someone who is used to working in public service settings with people who are often disadvantaged by language and cultural barriers on the one hand and discrimination and displacement on the other. Using a trained interpreter helps ensure effective and accurate communication, culturally sensitive services, efficiency and, most importantly, confidentiality. However, interpreters usually work on a sessional basis across many different agencies and so cannot be expected to be specialists in all areas. They may need to have some concepts or terminology explained.

“We find telephone interpreting very helpful. We can use a speaker phone, so we’re not passing the handset to and fro. The anonymity makes it easier for the client and the interpreter.”

(Consultant physician in genitourinary medicine)

Defining good practice

Engaging and working with interpreters can also be a complex process. The choice of interpreter can be crucial. In the case of sexual health, it is important for the interpreter to be experienced, to have thought about appropriate vocabulary and to be sensitive to issues of trust, shame, fear and trauma.

As part of this, clients should feel able to express themselves openly, and have the opportunity to change interpreter if they want. It is always best to offer choice regarding the sex of the interpreter, and to provide someone who is not close to the client. There have been cases where abusive husbands have accompanied their wives to appointments to prevent them speaking out, and where pimps have acted as interpreters in order to control the women who work for them.

Sometimes, interpreters end up working with family, friends, or people they know. It should be clear whether people who interpret in these circumstances are paid (some organisations do not, but offer everyone the option of an independent, professionally-trained interpreter). Interpreters can also find themselves working with different members of the same family and

“People take a family member or friend with them to interpret, and then they hold back their real problems.”

(Woman, Europe)



knowing secrets not known to all the family. Such situations need careful management, and the interpreter may need support and guidance if they learn very private information.

Some organisations working with asylum seekers think that interpreters should be from a different country or culture altogether from the client in order to avoid problems of confidentiality or conflict. Others believe that interpreters who share a world view and cultural belief system with clients can facilitate the communication process. Training, supervision and clear protocols are needed whichever approach is taken.

Good practice: basics

- Consider the pros and cons of telephone and face-to-face interpreting – telephone interpreting can seem remote and impersonal and, therefore, inappropriate in sensitive and complex cases – on the other hand, some clients welcome its anonymity.
- If you know sexual health issues are going to be discussed, let the interpreter know this in advance.
- Tell them if you think there is particular vocabulary they will need to know.
- Explain the work of your organisation and your own role in relation to sexual health.
- If you can, talk about the key issues with the interpreter before the session – check how they feel about doing the session, and ask their advice if there are things you are unsure of (but be careful not to compromise the interpreter's independence).
- Ask people if they are interpreting for family members or very close friends.
- Match the sex of the interpreter and client if appropriate but be aware that in matters of sexual health, especially rape, men sometimes prefer a woman interpreter.
- Be aware of possible political, religious or cultural differences.
- Consider whether a significant age gap between interpreter and client might create discomfort.
- Take extra care in explaining procedures, regulations and reasons for asking sensitive questions.
- As a rule, it is best to avoid the use of jargon, slang or colloquialisms – however communicating about sex can be difficult, and you may need to check which English words the interpreter knows.
- Be sensitive to the demands and pressures on the interpreter – they may need a break during a difficult session and supervision or counselling.
- If things have gone well and trust has been established, try to use the same interpreter in follow-up appointments.
- Give as much feedback as possible to the interpreter and the interpreting service, if one is used.
- If possible, offer training to interpreters on sexual health (such as that run by Newcastle Interpreting Service or the Workers Education Association).



- In some areas, there is also training on offer to health workers and other professionals who use interpreters.

Useful organisations and websites

- Electronic Quality Information for Patients
- Ethnologue
- HARPWEB
- Multikulti
- Newcastle Interpreting Service
- Sussex Interpreting Services
- Workers Education Association

Useful publications

Sexual health training course for interpreters

Briddon D et al (Newcastle Interpreting Service, Newcastle PCT, 2005)

Student handbook, training pack and teaching materials on sexual health.

Available from www.newcastlepct.nhs.uk

Valuing diversity

Kai J (Royal College of General Practitioners, 2006)

Training pack including a video showing the problems of using a family member as an interpreter in a sexual health situation.

Available from www.rcgp.org.uk

6.3 CULTURE

“Multi-cultural sensitivity is not an excuse for moral blindness.”

**(Mike O'Brien MP, former Home Office Minister, House of Commons
Adjournment Debate on Human Rights (Women) 10 February 1999)**

Culture has been defined as ‘a shared set of norms, values, assumptions and perceptions (both explicit and implicit), and social conventions which enable members of a group, community or nation to function cohesively’ (Schott and Henley, 1996).

Culture is an important influence on sexual health. It can play a significant part in how people behave, what they expect, and how they judge the behaviour or experience of other people. It also affects what people know about sex and what they are willing or able to discuss. In most societies, sex is a taboo subject and many people have only limited access to information about sex and sexuality.



It is important that organisations working with asylum seekers and refugees on sexual health issues ensure that they are aware of and sensitive to the cultural norms of different communities, including their own. The term ‘culturally competent’ is sometimes used to describe agencies and individuals who work in this way.

It is also, however, important to bear in mind the shortcomings of relying on cultural information.

- Culture in one country can vary from one region or social group to another.
- An individual’s experience of a culture will vary according to a number of factors, including their sex, age, level of education, location, economic status and family circumstances.
- Culture will be only one part of what an individual sees as forming their identity, and other characteristics may be seen as equally or more important, such as health, immigration status, sexual orientation, religion, education, work (or lack of it), ethnicity, skin colour and personal philosophy.
- People are usually part of several ‘micro-cultures’ – places of work, families, religious groups or ethnic groups.
- A culture – or some of its practices – may be oppressive to some of its members and violate their human rights.
- All cultures change. Attitudes towards sex and sexuality are constantly challenged and levels of tolerance are never permanent. The development of the internet, for example, has altered people’s access to information about sex, and their attitudes towards it.
- Culture is only one of many factors that influence sexual health and behaviour.

“They wouldn’t understand the culture. It is too difficult for them to understand. Why should culture be a barrier – we have enough barriers with colour and age.”

(Woman, Southern Africa)

“A lot of beliefs and values are to do with controlling women, who they have sex with and when, even – if they are made to go through female genital mutilation – what they feel when having sex.”

(African communities service manager, family support organisation)

The experience of asylum seekers and refugees

For some asylum seekers and refugees, coming to the UK is an opportunity to adapt to a more liberal society – at an extreme, this can result in vulnerable people engaging in high risk and possibly criminal activity.

Others may turn to traditional values in order to cope with living in an unfamiliar country. At another extreme, this can lead to rigid and fundamentalist views which limit access to information about sexual health and cause tension in families or communities where young people adopt different values and lifestyles.



Many people operate somewhere between these two poles. They may maintain many aspects of the culture of their homeland, and will hold attitudes that were shaped by experiences in their country of origin while also adopting some of the values and practices of their new environment. Their beliefs and behaviour may not be fixed – like members of the host population, they may change over time.

Sometimes, difficulties can occur when someone fails to understand what is considered acceptable behaviour in this country – or what is legal. The roles and behaviour of men and women, and the power they may or may not have within a relationship and wider society are important areas where people can have very different perceptions of what is normal or right, and what is negotiable. This can apply to relationships between people of different cultures or the same cultural background, and to same sex and heterosexual partnerships.

“We help men understand behaviour here – some are from countries where it’s okay to follow a woman home, or it’s okay to stare. They don’t realise those things are not acceptable here.”

(Training and development worker, refugee community organisation)

Asylum seekers and refugees may be additionally vulnerable because of their experience of poverty, powerlessness and insecure immigration status, and their lack of knowledge of their rights and responsibilities. The racism and anti-asylum hostility that exist in parts of the UK media and some sectors of the UK population can also have an impact on sexual health.

Good practice: basics

Responding to and welcoming cultural difference involves becoming aware of your own culture and its attitudes to sexual behaviour. Health workers, refugee organisations and others working on sexual health issues with asylum seekers and refugees need to reflect on their own beliefs and those prevalent in the UK in order to overcome cultural barriers.

“You don’t want to do something wrong, but you also need to consider human rights. Culture can change, and sometimes it’s about finding ways that change can be comfortable.”

(Clinical psychologist, NHS hospital)

Remember that the person you are working with is the expert on their own life, wishes and needs.

However, promoting sexual health will also mean finding constructive ways of challenging some cultural norms, such as female genital mutilation.



The following two boxes give some guidelines on how to develop cultural awareness.

Cultural competence: checklist for organisations

- Make the environment more welcoming and attractive based on clients' cultural mores.
- Include community input at the planning and development stage.
- Use educational approaches and materials that will capture the attention of your intended audience.
- Find ways for the community to take the lead – understand there is no recipe.
- Hire staff that reflect the client population.
- Understand cultural competency is continually evolving.
- Be creative in finding ways to communicate with population groups that have limited English-speaking proficiency.

[Adapted from Fenton et al, 2002]

Cultural awareness: checklist for individuals

- Be aware of your own cultural assumptions and how these may affect your understanding and responses.
- Listen with respect and a genuine wish to learn.
- Find out how people see themselves and their culture, what they value, what they see as important.
- Beware of negative or pejorative 'information' – it usually indicates prejudice or incomplete understanding.
- Understand that in discussing culture we are discussing possibilities, not certainties – a framework, not a straitjacket.
- Be prepared to change your understanding as new information becomes available.
- Sort out what information is useful and helpful to your work, and what is merely exotic or personally fascinating.
- Understand the importance of factors such as age, generation, life experience, occupation, education and so on.
- Realise that culture is one factor, but not the only factor in anybody's life.

[Schott and Henley, 1996]

Useful organisations and websites

See Section 9.3 for information on finding contact details for local refugee organisations, and Section 10 for information on other countries.



Useful publications

Diversity in health and social care

[Radcliffe Publishing]

Journal covering all aspects of diversity in health and social care.

Available from www.radcliffe-oxford.com

Exploring ethnicity and sexual health. A qualitative study of the sexual attitudes and lifestyles of five ethnic minority communities in Camden and Islington

Elam G et al [National Centre for Social Research, 1999]

A qualitative study looking at sexual attitudes and behaviours among Jamaican, Black African and South Asian people living in North London.

Available from www.natcen.ac.uk

Elam G and Fenton K, 'Researching sensitive issues and ethnicity: lessons from sexual health', *Ethnicity and Health*, vol 8, no 1 (2003), 15–27.

Available from www.tandf.co.uk

The Penguin atlas of human sexual behaviour

Mackay J

See Appendix 2.

Gives an overview of human sexual behaviour worldwide.

Training manual for community health educators – the involvement of African communities in the promotion of sexual health in the north of England

Katulushi C and The African Communities Service, Barnardo's Castle Project, Leeds [Black Health Agency/Barnardo's, 2004]

Information on African cultures and religions, and guidance on the development of culturally-appropriate sexual health promotion.

Available from [Barnardo's African Community Service](#).

Transcultural health care practice: an educational resource for nurses and health care practitioners

Husband C and Torry B (eds) [Royal College of Nursing, 2004]

Training materials including modules on midwifery, the politics of diversity, transcultural communication and race equality management.

Available from www.rcn.org.uk



Community research

First impressions of the UK

For most interviewees and focus group participants, sexual behaviour in the UK is more overt and there is greater freedom than in their country of origin. Most interviewees appeared to have adapted to this or had come to accept it. Some felt that, at least in some regards, their own culture or country may have a better approach (particularly with regard to the level of sexually transmitted infections, teenage pregnancy and sex below the age of consent in the UK). A minority believed that UK laws should be made more stringent and freedoms curtailed.

Behaviour in public

This was raised by 27 people (69 per cent of interviewees) in the one-to-one interviews, and it came up in four of the focus groups. The behaviour they commented on included kissing and hugging in public, people having fewer inhibitions about showing sexual feelings, drinking, smoking and language. Two focus groups said the behaviour and freedom of young people particularly struck them as different.

Dress

In one-to-one interviews, 24 people (62 per cent of one-to-one interviewees) raised this as something they found different, and four of the focus groups commented on dress. Most talked about women exposing flesh and wearing miniskirts.

“They are almost naked and they do not feel shy. At home if you dress like that, you’re labelled a prostitute.”

[Woman, Southern Africa]

Legal situation/freedom

In one-to-one interviews 17 people (44 per cent of interviewees) talked about freedom and the law, and three focus groups also looked at this. They observed in particular that sex before or outside marriage is allowed in the UK, young people are allowed to have sexual relationships, and there is greater equality and freedom in general. Some also commented that gay and lesbian sexuality, divorce, and pregnancy outside marriage are allowed.

“Back home, a girl cannot come and spend a night at my place and if she does her family may force me to marry her. In that case, it means that the sexual issue is very special for us.”

[Man, African Great Lakes Region]



6.4 RELIGION

Most religions set down rules or guidelines around sexual behaviour, including abortion, adultery, chastity, contraception, gay and lesbian sexuality, marriage, masturbation, personal hygiene and cleanliness, sex outside marriage, the role and rights of women, and virginity.

In addition, some aspects of religious practice and belief can influence people's understanding of what causes sexually transmitted infections, and their attitudes to treatment. For example, some people may find it difficult to take medicines at certain times of the year, such as periods of fasting. Others may believe in traditional remedies, or may be advised by a spiritual guide to rely on prayer instead of medication.

Faith can be a source of hope and an important coping mechanism for many people. However, as in other areas of work with asylum seekers and refugees, it is important not to make assumptions about how people's religious beliefs will affect their sexual behaviour or attitudes. Within one faith, there may be differing perceptions or interpretations of what is right and wrong with regard to sex and relationships. Sometimes there is a divergence between the teachings of a religion and the everyday practices of its followers – the Catholic church, for example, does not support the use of artificial forms of contraception, but many Catholics use contraception.

Moreover, an individual may relate to their religion in a range of ways. Some people consider the guidance provided by their faith in all their actions. Others turn to religion only in times of particular need. Others may be atheists or agnostics, or indifferent to matters of faith. Some asylum seekers and refugees may have been persecuted because of their faith – or lack of it – and may have very strong views and beliefs.

Most parents want children and young people to have moral guidance and the knowledge and skills to enable them to cope with sex and relationships, and some turn to religion for guidance. For some refugee families this can be an area of anxiety and tension – particularly if the parents hold strong religious views and their children do not adhere to these.

Organisations that want to improve their understanding of different faiths and the ways they are practised in different countries and cultures, should talk to refugee community organisations and to refugees themselves.

“Some religions do not allow you to talk about sex. Some do not allow sex until people are married, so they are ignorant about it.”

(Woman, African Great Lakes region)

“In the UK, sex is regarded as a very trivial activity which is part of everyday life. Sex is easy to get. That is why there are more unsafe practices in the UK. In my country, religion, family members, community members do not allow someone to have sex outside marriage. That's why there are no major sexual health problems.”

(Man, Middle East)



You can also approach local faith leaders, and interfaith groups which bring together representatives of many religions.

Community research

Cultural awareness and equality

Many interviewees in the community research wanted health professionals to be aware of different cultures and backgrounds. A lesser number said that awareness of different religious beliefs is important. However, a small number of respondents said equality is more important than cultural sensitivity – “diseases have no religion”.

Useful organisations and websites

- Association for Women’s Rights in Development
- BBC
- British Humanist Association
- The InterFaith Network UK
- Multi-faith Group for Healthcare Chaplaincy
- Ontario Consultants on Religious Tolerance (see Chapter 10)
- www.whrnet.org/fundamentalisms

Useful publications

Faith, values and sex and relationships education

Blake S and Katrak Z (PSHE and citizenship spotlight series, Sex Education Forum, National Children’s Bureau, 2002)

Gives an overview of the values and perspectives of the major faiths on key sexual health topics, with a bibliography and websites for agencies in the Sex Education Forum.

Available from www.ncb.org.uk

Religion, abortion and contraception

fpa (fpa, 2004)

A factsheet summarising the position of different religions with regard to contraception.

Available from www.fpa.org.uk

Training manual for community health educators – the involvement of African communities in the promotion of sexual health in the north of England

See Useful publications, Section 6.3.



Chapter 7

REFUGEES, ASYLUM SEEKERS AND SEXUAL HEALTH

IN THIS CHAPTER

7.1	Women
7.2	Men
7.3	Young asylum seekers and refugees
7.4	Parents
7.5	Lesbian, gay, bisexual and transgender refugees
7.6	New arrivals
7.7	Detainees
7.8	Refused asylum seekers

This section provides a summary of the sexual health issues that may affect asylum seekers and refugees.

Many asylum seekers and refugees will not experience significant sexual health difficulties. Some may wait a long time before they decide to tackle certain issues. Some may decide that any problems they have are passing, or are not as important as other challenges they face. The longer someone is in the UK, and the more stable their immigration status, the more likely they are to be able to cope with sexual health issues and related difficulties.

In this section, the issues that can arise, and ideas for good practice, are summarised for different groups – men, women, young people, lesbian, gay, bisexual and transgender (LGBT) people, those who are newly arrived, refused asylum seekers and people in detention.

There are some factors that members of all these groups can face, such as:

- poverty
- insecure immigration status
- loneliness and isolation
- language barriers
- loss and bereavement



- depression and boredom
- racism and hostility.

These all need to be taken into account whether you are tackling underlying causes, or the symptoms and consequences of poor sexual health.

Community research

Powerlessness and sexual health

Overall, the experience of powerlessness ran through the findings of the community research. This operates at a number of different levels – women in relation to men and the wider community, girls in relation to their families, asylum seekers and refugees in relation to health professionals and interpreters, and refugee communities in relation to the ‘host’ country. Since so much of sex and relationships education and sexual health promotion is predicated on the notion of empowering individuals to make choices that are appropriate to them, this is a highly relevant issue.

7.1 WOMEN

Refugee and asylum seeking women are particularly vulnerable in the area of sexual health. As it is women who get pregnant and give birth, the risk factors and exposures for women and men are fundamentally different from the outset, with greater responsibility for their own and their family’s health being placed on women.

In addition, many of the health issues related to sex and sexuality depend on the nature of men’s and women’s relationships with each other. Often, for economic, political and social reasons, women have less power in relationships than men do, and are not in a position to protect themselves from unwanted sex, sexually transmitted infections or from violence (www.who.int/en, accessed December 2006).

For many women, experience of sexual violence in their country of origin is a factor in seeking asylum. They often face similar dangers during and after flight – in refugee camps, detention and reception centres and other places where they expect to be safe. They may be raped and exploited as they try to travel, or coerced into sex as ‘payment’ to an agent. Travelling with children makes them even more vulnerable and sometimes they are forced to offer sexual services in order to protect or provide for their children.

This has consequences for physical and mental health, including pregnancy, sexually transmitted infections and HIV.

Sexual health issues

For some women, especially those who gain refugee status, living in the UK can provide the opportunity to address health concerns, gain skills and achieve greater independence. They may feel safer, and able to rebuild their lives. The sexual health issues they are concerned about may be similar to those of the host population.



However, asylum seeking and refugee women can face a range of sexual health issues that are linked to their experience of persecution and flight, and the levels of poverty, insecurity and hostility they encounter in the UK.

Difficulties that women can face, which have an impact on sexual health, include:

- lone parenthood
- the consequences of rape and sexual violence
- pregnancy – wanted and unwanted – sometimes as a result of rape
- lack of knowledge about contraception options and contraceptive services
- lack of knowledge of health screening services, including breast screening and cervical screening
- inappropriate accommodation, where women feel unsafe and are at risk of sexual harassment and violence
- fear of being out on the streets
- domestic violence
- the threat or consequences of female genital mutilation (FGM)
- involvement in the sex industry, including exploitation through trafficking
- forced marriage
- concerns about the sexual health and wellbeing of children
- issues around sexual orientation.

Asylum seekers and refugees often come from societies where the sexes are segregated and women are used to being part of an extended and family-based female support network. Single women asylum seekers in this country may feel very insecure and susceptible to abuse. In communal accommodation, they will almost certainly be in a vulnerable minority.

“Women are more in control of their lives in the UK. In my country men have more say in sexual relationships and they control women.”

[Woman, Southern Africa]

Refugee and asylum seeking women may also be seen as the ‘bearers and signifiers of their culture’ (UNESCO, 1996). They may be under pressure to maintain the customs and culture of their community, for example through their behaviour and dress and through that of their daughters. Men may not be expected to conform in this way (Dumper, 2003).

Access to services

For a wide range of reasons, refugee and asylum seeking women can find it particularly difficult to access services and get information about their rights in the UK. These include childcare responsibilities, poverty, lack of education, low status in their country of origin and the disempowerment and stress associated with being an asylum seeker in the UK. Language



is also an important issue – women may not have the opportunity to learn English or may be actively discouraged by husbands or partners.

Women tend to use health services more than men but access can be especially problematic because of the reluctance of some general practices to register asylum seekers, the difficulties of seeing a female doctor and the limited use of interpreting services – difficulties that are even more acute in relation to sexual health.

Good practice: basics

- Enable women to be seen on their own (it can help to make this a rule for all clients, or to insist on it in cases where you have concerns that the woman is unable to speak freely).
- Use professional interpreters to make this possible.
- Allow women to choose the gender of the health worker and interpreter they see and, where possible, other professionals and community representatives.
- Contraception and control of fertility may be difficult issues for women from some cultures – provide culturally sensitive health promotion in places that are safe and accessible.
- Do outreach work and provide flexible access options, including home visits and home tutoring.
- Provide women-only sessions and opportunities for women to meet with other women for mutual support.
- Be aware that homelessness and poverty makes single women vulnerable to sexual exploitation.
- Ensure that communal accommodation is safe for women and children, with locks on bedroom and bathroom doors.
- Work with refugee community organisations and other agencies to empower women and promote their involvement in community and other activities.

Community research

The situation of women

The powerlessness of many women was referred to by interviewees throughout the community research, and a small number of people spoke of the extreme violence, including honour killing, that some women face if they break with social norms. Several interviewees called for better signposting and more centres able to offer help to refugee and asylum seeking women who experience domestic violence. Interviewees also talked about women's powerlessness with regard to contraception – in particular, that some women are unable to insist that their partner uses a condom.

Useful organisations and websites

- Amnesty International



- Asylum Aid
- Foundation for Women's Health Research and Development
- Refugee Action
- Refugee Women's Association
- Royal College of Midwives

Useful publications

Why women flee: persecution against women

(Refugee Women's Resource Project, 2005)

Report of a seminar organised by the Refugee Council, Refugee Women's Resource Project at Asylum Aid, Refugee Women's Association, Refugee Action and Action for Refugee Women.

Available from www.asylumaid.org.uk

Women asylum seekers in the UK: a gender perspective. Some facts and figures

Ceneda S

Statistical data on the numbers of women asylum applicants, and other background information.

See Appendix 2.

Women refugees and asylum seekers in the UK

Dumper H (ICAR, 2003)

A guide to issues relating to women asylum seekers and refugees in the UK. Includes a list of refugee women's projects and organisations working with women refugees.

Available from www.icar.org.uk

7.2

MEN

The British Medical Association (BMA) reports that men can be acutely affected by the drop in status that many experience on becoming an asylum seeker. In addition, men granted refugee status are less likely to find work than women – this can lead to a change in their position within the family that causes some men further distress. The BMA also notes that men are more reluctant than women to access health care (BMA, 2002).

“Men don't talk about things, and they don't go to the doctor, so it's difficult to assess their needs.”

(Policy co-ordinator, regional refugee service)

All these experiences can affect sexual health. Men also have to adapt to or cope with a new society which may have very different values with regard to sexual freedom and the behaviour of men and women. Refugee workers report that some young men can find the UK



environment liberating and exciting on arrival. However, they may not know how to protect themselves, or understand the social mores of dating and city nightlife.

Difficulties asylum seeker and refugee men can face include:

- loss of self-esteem
- lack of awareness of social norms in the UK around dating and behaviour towards women
- lack of knowledge of the law regarding sexual behaviour
- relationship and family difficulties
- risk-taking behaviour, including use of the sex industry
- reluctance to use condoms, and not allowing partners to use contraceptives
- reluctance to talk about or seek help for sexual health issues
- undiagnosed sexually transmitted infections including HIV
- low awareness around HIV, sexually transmitted infections, testicular or prostate cancer
- domestic violence
- issues around sexual orientation or gender identity
- consequences of male rape and sexual violence
- consequences of a partner being raped
- involvement in trafficking, or selling sex to survive.

Good practice: basics

- Target refugee men, and develop ways of encouraging them to take care of their sexual health.
- Provide condoms – men may come for these in the first instance, and then they can be introduced to other issues.
- Offer outreach services, to overcome the stigma attached to seeking help.
- Provide sexual health information in places that refugee men visit.
- Work closely with refugee community organisations and community leaders.
- Set up groups or drop-ins where men can discuss sexual health issues.
- Give men the opportunity to learn about the law in the UK and common cultural practices including behaviour towards women.
- Help signpost men to services that can offer them support if they are concerned about their sexual health, or are affected by sexual violence.

Useful organisations and websites

- Men's Health Forum
- Working With Men



Project examples

The Young Men Initiative

The Young Men Initiative is run by the Refugee Advice and Support Centre, in West London. It works with asylum seekers aged 18–30, aiming to improve their language and communication skills, to provide them with a temporary social network using a 'buddy' system and give them opportunities to develop their confidence and build a stronger identity.

Language classes and volunteer support are an important part of the programme. The project also runs weekly workshops with young men on a range of issues. In response to the interests and needs of young men, several of these have focussed on sexually transmitted infections and on social skills, such as how to approach women and what to say to them.

Visual materials are used to explain sexually transmitted infections, because language barriers mean most leaflets are not accessible to the men. The project has tackled misconceptions – such as the belief that malaria and flu are sexually transmitted – and has talked about prevention, symptoms and treatment. The men are given lists of where to go for help, and free condoms are handed out.

For the workshop on approaching women, two female volunteers came in to role play – one being friendly, the other being 'nasty'. The men tried out different questions on the women, and there was considerable discussion about what comments and behaviour are acceptable in the UK.

For more information, contact the Refugee Advice and Support Centre. Tel: 0208 748 0155.
www.rascentre.org.uk.

Birmingham Asylum Seekers Health Outreach Team (BASHOT)

BASHOT has a full-time male outreach worker. His role is to help male asylum seekers access health care including sexual health services. He promotes health and sexual health in particular. He aims to create awareness among the refugee population of behaviour that puts their health at risk, such as unsafe sex practices or substance misuse.

The post was created because, when it started, BASHOT had an all-female team. It was felt that cultural customs or religious teaching made it difficult for many men to discuss sexual issues openly with women.

The male health outreach worker visits asylum seekers and refugees in their homes, at hostels, colleges and community centres, and in other places where they feel comfortable such as cafes, barber shops and tailors. Many of the men have had little or no sex and relationships education, and a wide range of issues is covered, including contraception and safer sex. There have been incidents at clubs when asylum seeking men have not understood body language, and men often want to know about social and cultural norms so they can avoid this.

For more information, contact BASHOT. Tel: 0121 327 8901.



7.3 YOUNG ASYLUM SEEKERS AND REFUGEES

Young asylum seekers and refugees may be in the UK with members of their family, or may arrive without an adult who can care for them. Those under 18 years old who arrive without an adult are called unaccompanied minors or young separated asylum seekers or refugees.

Many adapt to life in the UK. Their sexual health concerns and needs are likely to be similar to those of other young people growing up in the UK. Some, however, may be more vulnerable, and a number of issues can arise where young people need information, guidance or support. These include:

- living in poverty and having little or no money for social activities
- lack of knowledge of sex and relationships, because they have not had sex and relationships education in their country of origin, or their education has been disrupted
- lack of guidance or support from their family, because their parents are too traumatised or overwhelmed to help them
- differences with their family because they adopt different views and practices
- separation from family and friends
- coping with the consequences of experiencing or witnessing rape and sexual violence
- teenage pregnancy
- forced marriage
- domestic violence
- trafficking
- living in places where they can be vulnerable to sexual exploitation, such as bed and breakfast accommodation and houses of multiple-occupancy
- involvement in the sex industry
- harmful traditional practices, such as FGM.

“Working with refugees is not just about problems, difficulties and challenges. In many ways, young refugees are no different to other people – and this is often the case with regard to sexual health. It is about enabling them to take control of their lives, so they can enjoy health and have access to information.”

**(Policy and practice manager,
children’s organisation)**

Young people may have to move from one support system to another – for example, when they reach the age of 16 or 18. This can cause major disruption and may mean they have to move to another part of the UK, losing the support structures they have built up. Often they do not have people they can confide in and who can give them guidance – they may turn to older asylum seekers who are not in a position to provide stable role models.

In 2003, The Prince’s Trust carried out research that highlighted the vulnerability of young people who have no family, or who have to live in cramped conditions with other family



members. The research found that where young people have no family support structure, many find partners and start families early, perhaps in a bid to create a sense of family. Living in overcrowded conditions with family members often compelled young people to live with partners very early on in their relationships.

The report expressed particular concerns that young refugee women might not be accessing health services, and that early motherhood can act as a barrier to education and employment opportunities. It emphasised the need for access to contraception and sex and relationships education for all young refugees (Prince's Trust, 2003).

Guidelines for service providers

Sexual health work with young people must be conducted sensitively, and in response to the interests and needs of the young people themselves. While some may be keen to learn about sexual health, others may be anxious about losing or betraying their cultural roots. Some may feel that sex is taboo, while others may feel constrained because they carry considerable responsibility. A Somali boy, for example, may be considered the head of his household if he is the oldest male in the family, and this may influence the choices he feels able to make and the relationships he is able to form.

Some, especially young women, may feel fearful of disapproval within their communities if they become more independent and aware. Sometimes, myths circulate among young people that can have a damaging effect – some young women, for example, believe they will be tainted and unlovable if they lose their virginity before marriage. As a result, some refuse to go for cervical screening tests. Myths of this kind can exercise considerable control over young people in a particular community or society.

Good practice: basics

- Take services to young people.
- Create an environment where young people feel safe and able to ask questions.
- Take seriously fears and misconceptions that may strike you as outrageous or bizarre.

“We find that young people don’t know anything about sex or about their bodies. This applies to the girls in particular. Even if they have been raped, they can be very unaware of information and risks.”

(Child and adolescent therapist, organisation working with torture survivors)

“African culture considers talking about sex to young people, especially your own children, taboo. Elders talk to them when they reach initiation stage, but in the UK there are no elders in our community.”

(Woman, African Great Lakes region)



- Consider including sexual health awareness in the remit of mentoring and buddying schemes.
- When appropriate, check that separated or unaccompanied young people are getting the services they are entitled to, including safe housing, social and financial support, health care and education.
- Know about local and national child protection policies.
- Be prepared to take action if you are concerned that a child is being sexually exploited or abused.

Young people and the law

Age of consent

- In England and Wales, the age of consent to any form of sexual activity is 16 for both men and women, whether they are heterosexual, homosexual or bisexual.
- In Scotland, the age of heterosexual consent for women and for sex between men is 16.
- In Northern Ireland, the age of heterosexual consent for women and for sex between men is 17.
- In Scotland and Northern Ireland, there are no specific laws covering sex between women, so provided both women consent and are 16 or over, this is legal.

(fpa, 2007)

See Section 8.1 for information on the law and sexual offences against children under 13.

Contraception and sexual health advice for under 16s

Contraception and sexual health services are confidential. This means that personal information, any information about a visit and tests and treatments that someone has been given will not be shared with anyone outside that service without their permission. Health professionals in England may provide confidential advice, tests and treatment to young people under 16 (including under 13s) if, in their clinical judgement, they believe it is in the young person's best medical interests and they are able to give what is considered to be informed consent.

It is considered good practice for health professionals to follow the criteria commonly known as the Fraser guidelines:

1. The young person can understand the advice.
2. S/he cannot be persuaded to tell a parent or carer about the situation.
3. S/he is going to go ahead with sexual activity whether or not you give the advice.
4. His or her physical or mental health would suffer if you did not give the advice.
5. It is generally in his or her best interests to receive confidential advice



In 2004, the Department of Health issued revised guidance for health professionals in England. This covers confidentiality, duty of care, good practice and the Sexual Offences Act 2003. The recommendations include that services should produce an explicit confidentiality policy and advertise that their services are confidential to under 16s (Department of Health, 2004 and **fpa**, 2004).

Child protection

All professionals and organisations, including health professionals, have a key role to play in safeguarding and promoting the welfare of children. Part of this role is child protection, which involves taking specific action if professionals believe that there is a significant risk to the health, safety or welfare of a young person or others. Professionals may have a duty of confidentiality to all people, including young people. However, there will be occasions when young people disclose information to professionals that makes them believe that there is a risk to the health, safety or welfare of the young person or others that is so serious as to outweigh the young person's right to privacy. If this is the case, the over-riding objective must be to safeguard the young person.

In order to make decisions about when young people might be at risk, professionals should have appropriate training and supervision to recognise and act on risk factors and identify children in need of support. Local education authorities and primary care trusts must have a designated child protection lead and all organisations should have their own child protection policies. Professionals should ensure that they are aware of and understand all of the child protection guidance that affects their work and know who their local child protection lead is. If there are concerns about a young person's welfare which may require information about the young person to be shared, professionals should consider all of their legal obligations, including the duty to confidentiality and concerns should be discussed with a manager or the named child protection professional.

Further information is available in the Government's *Working together to safeguard children* guidance available on www.everychildmatters.gov.uk.

Marriage

The legal age for marriage in England, Wales and Northern Ireland is 16, but only with parental consent. At 18 people may marry without parental consent. In Scotland, the legal age for marriage is 16, with or without parental consent (General Register Office, General Register Office for Scotland, General Register Officer Northern Ireland, January 2007).

Useful organisations and websites

- Africans Unite Against Child Abuse
- Connexions
- ECPAT UK
- **fpa**
- National Children's Bureau
- Refugee Council
- www.ruthinking.org.uk



- Save the Children

Useful publications

A guide to involving young people in teenage pregnancy work

[Teenage Pregnancy Unit, 2001]

Guidance on how, when and where to involve young people.

Available from www.teenagepregnancyunit.gov.uk

Child first, migrant second: ensuring that every child matters

Crawley H [ILPA, 2006]

Examines recent asylum and immigration law and practice, and the broader context of children's law, policy and entitlement.

Available from www.ilpa.org.uk

Children, HIV, asylum and immigration

Conway M [National Children's Bureau, 2006]

An overview of the current situation for children living with HIV and insecure immigration status.

Available from www.ncb.org.uk

Meeting the sexual health needs of unaccompanied asylum seeking minors: an innovative practice guide

Young D [Teenage Pregnancy Unit and Government Office for London, 2006]

Provides information and ideas for people working with unaccompanied asylum seeking minors.

Safeguarding and promoting the welfare of children in the African refugee community in Newcastle

Franks M [The Children's Society, 2006]

Looks at child protection and safeguarding attitudes among African communities in Newcastle.

Available from www.childrenssociety.org.uk

Starting over – young refugees talk about life in Britain

[The Prince's Trust, 2003]

Summarises the experiences of 200 young refugees, including the need for family and experiences of early pregnancy.

See Appendix 2.



Unaccompanied refugees and asylum seekers turning 18: a guide for social workers and other professionals

Free E (Save the Children, 2006)

A guide on providing support during the transition from childhood to adulthood. Includes a comprehensive summary of rights and entitlements.

Available from www.savethechildren.org.uk

Project examples

The Medical Foundation for the Care of Victims of Torture

The Medical Foundation for the Care of Victims of Torture runs several therapeutic groups for young people. Most are mixed sex and mixed nationality groups, though there is one group for girls and young women who have been raped. The groups give young people the chance to make friends and talk about problems and issues that concern them.

Through the groups, the Foundation has found that young people know little about their bodies and sex. It has drawn up a sex and relationships education curriculum which it is running with the young people. The curriculum covers issues to do with anatomy, physiology, parenting, relationships and safety.

For more information, contact the Medical Foundation for the Care of Victims of Torture.

The English for speakers of other languages (ESOL) Threshold Department at West Thames College, Hounslow

The Threshold Department offers an educational programme mainly to recently arrived asylum seekers and refugees aged 15–19. The programme prepares the young people for mainstream education and training. It has its own welfare officer who provides support regarding the welfare needs of the students.

A range of sexual health issues arise, in part because often the young people have had little or no sex and relationships education. The students can talk confidentially to the college counsellor, the welfare officer or their ESOL tutors about matters that worry them. Talks on sexual health are arranged with some of the classes, but the classes are mixed, and some young women feel reluctant to talk about such issues in this setting. The students face many of the same issues as British teenagers, but because many are without family in the UK, they have a greater need for advice and guidance.

Many of the students carry physical and psychological scars of FGM. As a result, many girls suffer from urinary tract infections, and the duration of menstruation is longer and extremely painful. This often affects their studies.



A few of the female students have been sexually abused or exploited in their country of origin, leaving them physically damaged and with mental health problems. Over the past few years the pregnancy rate in the ESOL Threshold Department has risen, and in the cases where the girls have had FGM there have been complications. Cases of forced marriage also occur, for which young people need legal advice and emotional support.

The College has responded by arranging specialist training for staff, and by forging links with a range of referral agencies. These include Save the Children, Richmond and Hounslow Welcare, solicitors, the Foreign Office and the FGM specialist unit at Guy's Hospital. Housing and welfare advisers visit the college once a month.

For more information, contact the ESOL Threshold Department, West Thames College.
Tel: 020 8326 2033.

7.4 PARENTS

Asylum seeking families are often under stress. Poverty, unsuitable and insecure housing, discrimination and communication difficulties can all disrupt a parent's ability to cope. In addition, like many other parents, asylum seekers and refugees can feel anxieties about how their children will cope with sex and relationships in a new country. The situation can feel additionally worrying for parents, grandparents and carers because they may:

- feel confused and threatened by behaviour in this country and by the influence and attitudes of the media and advertising
- feel ill-informed about the risks young people face, and how to deal with these
- have had little access to sex and relationships education in their own country
- feel reluctant to discuss difficult issues with other adults, either within their own community or outside it
- speak little or no English, while their children may become bilingual
- feel their parental authority is undermined by their experience of persecution, asylum and displacement
- not be aware of possible sources of advice and help, for themselves or their children
- think schools provide more comprehensive sex and relationships education than is in fact on offer.

Some parents become more traditional in their outlook as they try to guide their children, and tensions can emerge as young people adapt to British culture and move away from their parents' beliefs.

“You don't want friends or neighbours to know you have problems communicating with your own children.”

[Woman, Southern Africa]



Many families cope with the pressures of rebuilding their lives in the UK. However, some parents and children need additional support. In some instances, whole families have suffered violence and persecution. The children may have been victims of rape and torture, or may have witnessed the sexual abuse of their parents. These experiences will have a significant impact on children's development and on the sexual wellbeing of adults and children alike. Because of their own extreme experiences, parents may not be able to help their children explore their own sexual development.

“Children may witness both their father and mother being raped, or other children being raped. They may be bound to secrecy over this. They have nowhere to talk about their bodies and sexual issues.”

(Family therapist, organisation working with torture survivors)

Sometimes, a child may be conceived through rape and this can also bring long lasting distress. Children and parents may be HIV positive or have AIDS. Some parents have had to leave children behind, and some may not know what has happened to them. Others are bereaved. All these parents need care and understanding to help them cope.

Good practice: basics

- Help build links between refugee community organisations, health promotion services, schools, and voluntary sector agencies that run schemes with refugee parents.
- Provide sexual health promotion and information sessions for parents, including single sex sessions.
- Offer support and information to women's groups, supplementary schools, faith groups and other places where refugee parents may meet and feel comfortable.
- Run courses on parenting in general, and include sexual health.
- Have stalls and give presentations at events where whole families might be present.
- Help parents deal with practical difficulties through direct help or signposting to services that can help them.

“People who've grown up in the UK have a baseline knowledge of sex from what they've been taught at school. Some refugees don't have that knowledge, so you have to go back to basics.”

(Project officer, parenting course)

Useful organisations

- British Red Cross International Tracing and Message Service
- **fpa**
- Multilingual Family in the UK

“It's a shame . . . if our children grow up without knowledge, without awareness of sex and sexuality, because the parents can do so much in educating our children.”

(Bosnian mother, parenting course)



- Parenting UK
- Royal College of Midwives

Project example

Speakeasy

Speakeasy is a project created by **fpa**. It brings parents together in small groups, so they can learn together and acquire the confidence and skills they need to talk to their children about sex and relationships. It is designed to be fun and relaxed, providing an atmosphere where parents can learn together from their own experiences. It is locally organised and can link with educational, community or health services in a particular area.

Courses have been delivered to groups of parents who are refugees and asylum seekers in London, Manchester and Newcastle. Adaptations in course materials and delivery are made to reflect the fact that these parents often lack basic knowledge around anatomy and reproduction. For many it is their first experience of sex and relationships education and an opportunity to gain support in this area of their parenting where they feel particularly challenged in the UK.

For more information, contact **fpa**.

Community research

Education for children and young people about sex and relationships in the UK

The wellbeing of children and young people with regard to sex and relationships in the UK emerged as a priority in the community research. Parents expressed feelings of powerlessness over the cultural and other influences their children encounter. Some wanted to ensure that their children conform to the cultural or religious traditions of their country of origin, while others wanted to enable their children to cope and be safe in a new setting. Like British parents, many said they found it difficult to talk to their children about sex and relationships.

7.5 LESBIAN, GAY, BISEXUAL AND TRANSGENDER REFUGEES

Worldwide, over 70 states criminalise same-sex sexual relations. In at least seven countries, the penalty is death. There is practically nowhere that lesbian, gay, bisexual and transgender (LGBT) people are treated as fully equal before the law.

Some people request asylum in the UK because they are persecuted as a result of their sexual orientation. Numbers are not known – reportedly more men make such applications than women. Like many women refugees, lesbians have often suffered persecution within the family and their cases can be harder to prove. LGBT people challenge society's perceptions of what it means to be male or female, and torture and attacks on them are often of a sexual nature.

Some LGBT refugees may flee other forms of persecution, and not cite their sexuality as part of their asylum application. Some people who arrive in the UK may not have acknowledged to others – or possibly themselves – that they are gay, lesbian or bisexual, but may acknowledge those feelings once they are in a more tolerant society. In addition, there are



those who have sex with people of the same sex as themselves, who may not see themselves as gay, lesbian or bisexual because this is either not acknowledged or is prohibited in their country.

LGBT asylum seekers and refugees in the UK can face a number of difficulties. These include:

- lack of knowledge of rights and services
- lack of clarity and awareness within the legal system
- fear of telling legal advisers about persecution based on sexual identity
- fear of telling community members or agencies their sexual orientation
- lack of awareness and prejudice among service providers
- isolation, loneliness and ostracism
- inappropriate accommodation
- lack of knowledge of sexual health and safety
- homophobia within their community or in the wider population
- lack of language – some languages have no words for gay or lesbian sexuality, and others have only very derogatory terms.

Some people find the openness of the gay and lesbian scene in the UK liberating, and it gives them the opportunity to be themselves and meet people. However, it can also be overwhelming, and asylum seekers and refugees can lack the skills to assert themselves and be safe in an unfamiliar environment. Some asylum seekers and refugees may become involved in the sex industry – see Section 8.6 for more information. Many transgender people do this in order to help fund treatments and operations.

Good practice: basics

- Ensure that your organisation is at ease with sexual diversity.
- Create an environment that acknowledges and welcomes sexual diversity.
- Promote tolerance.
- Let people know their rights.
- Allow the individual to set the agenda.
- Be aware of difficulties of disclosure.
- Be clear about confidentiality.
- Have resources and initiatives to encourage safer sex and sexual wellbeing.
- Provide opportunities for people to socialise.
- Be willing to address practical problems such as housing difficulties, directly or through referral and partnership working.
- Don't allow homophobia to stop you raising the issues.
- Be able to signpost people to LGBT projects and agencies.



Useful organisations and websites

- Amnesty International UK lesbian, gay, bisexual and transgender network
- Beaumont Society
- FFLAG
- London Lesbian and Gay Switchboard
- Naz Project London
- Safra Project
- Sigma Research
- UK Lesbian and Gay Immigration Group

Useful publications

Lesbian, gay, bisexual and transgender (LGBT) refugees and asylum seekers: ICAR navigation guide

See Useful publications, Section 5.9 for more information.

Migrant gay men – redefining community, restoring identity

Keogh P, Dodds C and Henderson L (Sigma Research, 2004)

Published together with a related report on ethnic minority gay men in the UK.

Available from www.sigmaresearch.org.uk

The no-nonsense guide to sexual diversity

Baird V (New Internationalist Publications Ltd and Verso, 2001)

A world-wide overview of sexual diversity.

Available from www.newint.org

Gay and lesbian sexuality and the law

Lesbian and gay sex is legal in the UK (see Young people and the law, Section 7.3 for more information about consent).

The Civil Partnership Act 2004 gives certain rights to same sex couples who enter into a civil partnership.

Attacks, harassment and abuse of people because they are perceived to be gay or lesbian are classed as hate crime. The victim does not have to be gay or lesbian – they can be chosen as a victim because the offender is prejudiced against LGBT people. Importantly, these crimes can be reported by the victim or by a witness.

Hate crime in any form should be reported to the police. There are often special reporting centres which can also be used – refugee agencies, health services and other organisations should be able to signpost people to these.



Project example

Yorkshire MESMAC

Yorkshire MESMAC is helping gay, asylum seeking men who have contacted the service for advice on a range of practical issues, including health and coping with life in the UK. Staff help the men to find out about services in the area where they live and to make appointments. They offer one-to-one advice on HIV and sexual health, and explain the law in the UK with regard to sex and sexuality.

Socialising has emerged as an important issue, especially for men who are from countries where being gay is regarded with hostility. Some of the men are very wary of their own communities and their sexual orientation may be a closely guarded secret. Some want advice on how to act appropriately in the gay scene in the UK, and how to understand cultural codes. Staff at Yorkshire MESMAC help them set up social networks and accompany the men if they want to join a gay support group but feel uncomfortable about attending the first session.

In conjunction with others, the project has published a guide for asylum seekers and other newly arrived communities on how to access health services in the UK. This is available at www.bcathealthinitiative.co.uk.

For more information, contact Yorkshire MESMAC. Tel: 0113 2444209. www.mesmac.co.uk.

7.6 NEW ARRIVALS

Newly arrived asylum seekers are dealt with by the regional asylum teams under the Home Office's new asylum model. See Section 3.3 for more information.

Initially, many new asylum seekers are unlikely to be open about sexual health concerns or experiences of sexual violence. In part, they may have other concerns that are more important to them than sexual health, such as making their asylum claim, and surviving in a strange environment. In addition, talking about some subjects – such as different forms of sexual violence – requires a considerable amount of trust, and a sense that there will be some continuity of contact and care – this environment is unlikely to be achieved in people's first weeks in the UK.

Sexual health issues that may arise early on include:

- suffering the consequences of sexual torture, rape and sexual violence
- being pregnant through rape
- fear of being ill with AIDS defining illnesses such as recurrent pneumonia or TB
- being seriously ill with AIDS
- fleeing persecution because of sexual orientation, and fearing prejudice and harassment in this country
- being in the control of traffickers
- taking risks in the UK with regard to sexual behaviour
- being vulnerable to sexual exploitation on arrival in the UK.



Importantly, new arrivals have little knowledge of services available, how to access them, and their entitlements to treatment and help. They may even fear that being open about sexual health issues may jeopardise their asylum claim.

Initial Accommodation staff and other medical teams can help a new arrival deal with these issues, if they are made aware of the person's situation. With consent, the asylum seeker may be referred on to a specialist service. However, difficulties can arise if an asylum seeker supported by the Border and Immigration Agency is then dispersed to another part of the UK, particularly if they have started medical treatment. Some organisations contest dispersal in the courts if they believe it will be seriously detrimental to a person's health. However, the period between successfully claiming support and dispersal has been significantly reduced, so many may not yet have started medical treatment.

Under the new asylum model, an asylum seeker who seeks help with accommodation is allocated to Initial Accommodation in the region that will determine their claim. They will only remain in this Initial Accommodation for around 21 days before being dispersed to more permanent accommodation (known as dispersal accommodation) within the same region. This limited stay in their primary location, means it is increasingly unlikely newly arrived applicants will forge strong links with health services prior to their dispersal.

Border and Immigration Agency guidelines make it clear that:

- dispersal of HIV positive asylum seekers can only take place when their treating clinician is satisfied that there will be no disruption of HIV treatment
- those providing accommodation for dispersed asylum seekers living with HIV have a responsibility to ensure they register with a general practice.

(National Asylum Support Service (NASS), 2005)

Asylum seeker health services in dispersal areas normally issue welcome packs covering local services. The Department of Health has developed a leaflet about the NHS which has been translated into more than 40 of the main asylum seeker languages, and is available at www.dh.gov.uk/asylum_seekers. Housing providers should give this to asylum seekers when they arrive at their dispersal accommodation.

The Department of Health is also working to improve communication between general practices, so that medical records are transferred between practices in England. In some cases the asylum seeker has hand-held records that travel with them (these are given to asylum seekers who have health checks in Initial Accommodation). Asylum seekers who are being dispersed should be encouraged to be as open as possible with the doctor they see after dispersal.

Good practice: basics

- Bear in mind how fearful and confused new arrivals may be.
- Make clear their rights and entitlements to health care.



- Help asylum seekers access the health services they need.

Useful organisations and websites

- Asylum Seeker Co-ordination Team (Department of Health)
- Home Office Border and Immigration Agency
- Migrant Helpline
- National Aids Trust
- Refugee Action
- Refugee Council

Community research

In the one-to-one interviews, people were asked if there was information that asylum seekers should have when they first arrive in the UK, which would help them to be sexually healthy.

In response, 36 respondents (92 per cent) felt that some aspect of sexual health education or information should be available to new arrivals. This included information on where to go for help/ services available (49 cent) and information on sexually transmitted infections and protection (26 per cent).

7.7 DETAINEES

The Border and Immigration Agency detains some people whose claim for asylum has been refused, people who are found to be in the country illegally and people who go through the 'fast track system' because their asylum claims are judged to be straightforward and probably unsubstantiated. Most are placed in removal centres, though some are held in prisons. The 'fast track system' operates using Oakington, Yarl's Wood and Harmondsworth removal centres.

Currently, removal centres in the UK consist of single sex and mixed sex accommodation. In the mixed centres, men and women are housed in single sex accommodation, but meet during the day. In some centres there are single rooms, in others small dormitories for three or four people. Families have access to separate family quarters.

Those detained in the UK include people who may be emotionally and physically vulnerable, including people who are HIV positive, pregnant women and families with children. Some may have survived traumatic experiences including rape, torture and loss of family members. Most immigration detainees spend less than a month in detention but may, in exceptional circumstances, be held for longer periods.

Removal centres provide detainees with primary care services, although the level of service may vary from centre to centre. While primary health services in public sector prisons are commissioned by the NHS, primary health care in most removal centres is provided through direct contract with private providers. Secondary services for all detainees are the responsibility of the local NHS.



Every removal centre has a multi-disciplinary healthcare team that provides 24-hour cover. Detainees are health screened within two hours of reception and are offered a medical examination within 24 hours of their arrival at the removal centre. Detainees are able to access healthcare throughout their period of detention. Detainees have the right to be examined by a doctor of the same sex. Removal centre healthcare teams are required to have formal arrangements with appropriate secondary healthcare services, including genitourinary care.

Detainees arriving at a removal centre with HIV/AIDS medication continue this medication while in detention, and are referred to the local specialist provider for follow-up care and re-prescribing of medication if they will be in the centre long enough. Their condition is managed in the same way as it would be for any other member of the community. Detainees arriving at a removal centre with no treatment but a prior HIV/AIDS diagnosis are referred for confirmatory testing and follow-up by the local specialist provider if they will be in the centre long enough.

Useful organisations and websites

- Association of Visitors to Immigration Detainees
- Asylum Seeker Co-ordination Team (Department of Health)
- Bail for Immigration Detainees
- British Medical Association
- HM Inspectorate of Prisons

Useful publications

Detention centre rules 2001 Statutory instrument number 238
(HMSO, 2001)

Sets out the purpose of detention centres, and outlines the rights and treatment of detainees.

Available from www.opsi.gov.uk

Removal centre operating standards

Home Office/IND (now renamed the Border and Immigration Agency) (Home Office, 2005)

Sets standards that are designed to build on the *Detention centre rules* and to underpin the management of removal centres.

Available from www.ind.homeoffice.gov.uk

'They took me away' women's experiences of immigration detention in the UK

Cutler S and Ceneda S (Asylum Aid, 2004)

A report investigating women's experiences of immigration detention in the UK, produced with Bail for Immigration Detainees (BID). BID has published other relevant reports.

Available from www.biduk.org



7.8 REFUSED ASYLUM SEEKERS

Once all appeal rights have been exhausted, and if the decision on their case remains negative, refused asylum seekers are required to leave the UK. Some are detained (see Section 7.7). Those not detained are not allowed to work, and most do not have recourse to public funds (see Section 3.3).

Many refused asylum seekers therefore do not have the means to live. They may experience poor and overcrowded housing conditions, sleeping rough, inadequate diet, extreme poverty and particularly severe barriers to getting timely access to health care. Health professionals, community representatives and others across the UK are concerned at the impact this can have on health, including sexual health.

“The thing with destitution is it makes people take risks they don’t really want to take.”

(Team manager, refugee organisation)

A 2004 report by the Greater London Authority found that destitute asylum seekers are more likely to be exposed to crimes such as assault, including domestic violence, rape and other sexual violence. It also states asylum seekers are more exposed to the risks arising from illegal employment in the sex industry and other sectors (Mayor of London, 2004).

A 2006 report by Refugee Action found that the health of destitute asylum seekers deteriorates and they are vulnerable to sexual exploitation in order to survive, either by the sex industry or by individuals to whom they may turn to for support (Refugee Action 2006).

“A patient came to us in great distress. She had had sex with a man the night before because she was destitute. She was desperate and ashamed. This is happening more and more.”

(Health adviser, health service for asylum seekers)

A growing number of organisations are trying to help people who become destitute, including refugee agencies, housing and homelessness organisations and faith groups.

Refused asylum seekers and primary medical services

General practices retain the discretion to accept refused asylum seekers onto their list of registered NHS patients. In refusing an application, a general practice may offer to treat a person on a private fee-paying basis (or to continue an existing registration). Emergencies or treatment which is immediately necessary, in the clinical opinion of a health professional, should be provided free of charge within primary care to anyone.

The Department of Health has committed to review the rules governing access to the NHS by foreign nationals, including NHS primary medical services. The review will be completed by October 2007 and will take into account the 2004 consultation – *Proposals to exclude*



overseas visitors from eligibility to free NHS primary medical services (Department of Health, 2005).

Refused asylum seekers and hospital treatment

Those whose applications are ultimately rejected are no longer entitled to receive free NHS hospital treatment except when the treatment itself is exempt from charge or when it is the continuation of a course of treatment already underway from when they were eligible for free treatment. It will be a matter for clinical judgement as to when a particular course of treatment has been completed.

For secondary care, *The NHS (charges to overseas visitors) regulations 1989, as amended*, list a number of infectious diseases for which treatment is free of charge to everyone on public health grounds, including a number of sexually transmitted infections. For HIV, only the initial diagnostic testing and associated counselling is free of charge. Any subsequent treatment is chargeable unless the patient meets one of the categories of exemption from charges for hospital treatment. The amendments to the Regulations introduced in 2004 did not change that position.

Immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to refused asylum seekers without delay, irrespective of their eligibility for free treatment or ability to pay. However, if they are found to be chargeable, the charge will still apply, and recovery will be pursued as far as the NHS trust considers reasonable.

Any new course of treatment, begun after the asylum claim is finally rejected, will be chargeable, unless the treatment itself is exempt. Trusts should refer to the document *Implementing the overseas visitors hospital charging regulations* for advice on how and when to make charges (Department of Health, 2004).

The *NHS (charges to overseas visitors) regulations 1989, as amended*, do not exempt maternity services from charges in the UK. However, guidance issued to all NHS Trusts makes clear that maternity care should always be considered as being immediately necessary treatment, due to the risks involved to both mother and child. This can include treatment to prevent HIV transmission from the mother to the child, where clinically appropriate.

Further guidance issued in January 2006 stressed that pregnant overseas visitors should not be given the impression that if they do not pay the costs of an antenatal appointment, then future maternity treatment will be withheld (Department of Health, 2006).

At the time of going to press the Department of Health and Home Office are reviewing access to the NHS by foreign nationals. This includes access to both primary and secondary care.

Good practice: basics

- Make links with other organisations offering support to homeless people, including churches and mosques.



- Check all legal avenues have been fully explored.
- Encourage destitute asylum seekers to attend a contraception, GUM or sexual health clinic or an NHS walk-in centre (England only).
- Form links with agencies working with people in the sex industry.
- Offer advice and information on safety issues.
- Provide condoms.
- Make sure pregnant women are accessing antenatal care, and that their rights and entitlements are fully observed.

Useful organisations and websites

- Asylum Seeker Co-ordination Team (Department of Health)
- HARPWEB
- Home Office Border and Immigration Agency
- Medact
- No Recourse to Public Funds Network (NRPF)
- Refugee Council
- Refugee Health Network

Useful publications

Destitute people from abroad with no recourse to public funds

No Recourse to Public Funds Team (Islington Council, 2006)

Highlights the legal framework, eligibility and cost of 'no recourse to public funds' services to local authorities.

Available from www.islington.gov.uk

Destitution among refugees and asylum seekers in the UK

Morrell G and Wainwright S (ICAR, 2006)

Provides an overview, plus listings of related publications and initiatives.

Available from www.icar.org.uk

The destitution trap

(Refugee Action, 2006)

Research into destitution among refused asylum seekers in the UK.

Available from www.refugee-action.org.uk



Down and out in London

[Amnesty International UK, 2006]

Looks at UK Government's policy on rejected asylum seekers and the experience in London.

Available from www.amnesty.org.uk

First do no harm: denying health care to people whose asylum claims have been refused

See Useful publications, Section 3.3.

Mental health, destitution and asylum seekers: a study of destitute asylum seekers in the dispersal areas of the South East of England

Dumper H, Malfait R and Scott-Flynn N [Care Services Improvement Partnership, National Institute of Mental Health in England and South of England Refugee and Asylum Seeker Consortium, 2006]

Findings into research into the effects of destitution on mental health.

Available from www.southeast.csip.org.uk



Chapter 8

SEXUAL HEALTH ISSUES

IN THIS CHAPTER

- 8.1 Rape and sexual torture
- 8.2 HIV
- 8.3 Sexually transmitted infections
- 8.4 Contraception
- 8.5 Unintended and unwanted pregnancy
- 8.6 The sex industry
- 8.7 Trafficking
- 8.8 Domestic violence
- 8.9 Honour killing
- 8.10 Forced marriage
- 8.11 Female genital mutilation
- 8.12 Male circumcision

This section sets out a number of sexual health issues which affect some refugee and asylum seekers. It provides a summary of each issue, and the kinds of action which might be taken to support someone who requires information or help. It also lists organisations and publications that may be useful.

It is important to note that none of these issues are unique to asylum seekers and refugees. Rape, sex work (or prostitution), domestic violence and other forms of abuse all occur within UK society. Contraception and abortion are services in common use. However, particular sensitivity is needed when addressing these issues with asylum seekers and refugees, because of:

- cultural difference
- differing levels of knowledge
- stigma
- fear



- the experience of persecution
- high levels of poverty and vulnerability
- language and communication difficulties
- difficulties accessing services.

Offering choice and allowing the individual to set their own priorities are the values needed to underpin sexual health work with refugees.

Good practice: basics

- Treat people as individuals.
- Be clear about your remit and the level of expertise of your service.
- Know where to refer people on to, and develop strong links with those agencies.
- Adhere to a confidentiality policy.
- Have protocols on how to manage disclosure.
- Allow people to choose whether they have a male or female interpreter.
- Provide support and supervision to staff, volunteers and interpreters who work with survivors of sexual violence.
- Encourage women to be seen on their own, without other family members.
- When appropriate, follow up referrals to check outcomes.
- If the person wants it, put them in touch with others who speak their language and can offer mutual support or friendship.
- Offer sexual health promotion information that is accurate, up-to-date, and in appropriate languages and formats.
- Arrange training on different aspects of sexual health for managers, staff, interpreters and volunteers.

“Lots of the problems we help people with – rape, domestic violence, abortion and other issues – are problems here in the UK. They are not just refugee issues.”

(Counsellor, working with survivors of sexual assault)

See also Section 6.1 on general good practice.

8.1 RAPE AND SEXUAL TORTURE

Rape and sexual torture are a major factor in many people's decision to flee their country.

“With female genital mutilation [FGM], it's a myth that women prefer to see women doctors. They want to see someone who does their job well and who they can trust.”

(Programmes co-ordinator, FGM project)



Rape

The United Nations High Commission for Refugees (UNHCR) adopts the International Criminal Court's definition of rape and marital rape:

'The invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, threat of force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent.'

(UNHCR, 2003)

There are many other forms of sexual harassment and exploitation and it is important to remember that someone who has been raped has probably experienced other forms of sexual violence, and that some people experience sexual violence without rape.

Sexual violence and rape are used routinely in war and armed conflict, mostly against women, though men and boys are sometimes targeted. A recent Human Rights Watch report found that sexual violence continues to be 'systematic and unrelenting' even in times of peace, because of 'state failure to take seriously, prevent and prosecute routine and widespread discrimination and violence against women' (Human Rights Watch, 2004).

Rape can be perpetrated by any person in a position of power, including soldiers, agents of the state, family and community members. Some people are raped in prison. Others are forced into forms of sexual slavery, including children and young people who can be especially vulnerable. In addition, men and women may be forced to have sex in order to escape, or to survive their journey into exile.

Rape can take place within marriage or dating relationships, or the rapist may be a stranger. It can be part of the forced sexual initiation of adolescents. Rape may also be used to punish women for transgressing social or moral codes, such as those prohibiting adultery.

Some asylum seekers and refugees are victims of rape and sexual violence in the UK. The perpetrators may be from within their community, or from the wider population. People who are destitute are particularly vulnerable to abuse (see Section 7.8).

"Rape is often not an immediate complaint. It may come up months later."

(Consultant physician in genitourinary medicine (GUM))

Sexual torture

Torture is the deliberate infliction of physical or psychological pain. In the context of human rights law, for torture to occur the infliction of pain must take place in the custody of, or under the control of, a state agent, or by a non-state agent acting in an organised group.



Sexual torture is often sanctioned, ordered or committed by the military, police, or organised and violent groups (such as a rebel group in control of territory) which the state is either unwilling or unable to control.

UNHCR states that when sexual violence is used as a weapon of war and torture, it is a crime against humanity. It defines such sexual violence as:

'any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession or punishment from the victim or third person, to intimidate her or a third person, or to destroy, in whole or in part, a national, ethnic, racial or religious group'.

(UNHCR, 2003)

Sexual torture can take many forms, including:

- rape
- the insertion of objects into the body openings (sometimes with objects made of a metal to which an electrical current is later connected)
- the forced witnessing of sexual acts
- forced masturbation or to be masturbated by others
- fellatio and oral sex
- a general atmosphere of sexual aggression and threats of the loss of the ability to reproduce and enjoyment of sexual relations in the future
- burning or beating of genitals
- high power water jets directed at the vagina
- being forced to watch others (including children) being abused or raped
- being watched by others, being photographed or filmed
- forced prostitution.

(adapted from Crawley, 2001)

The consequences of rape and sexual torture

Rape and sexual torture have both physical and psychological consequences.

The physical consequences include sexually transmitted infections, including HIV, and conditions associated with untreated sexually transmitted infections – such as pelvic inflammatory disease – and mutilated genitalia, chronic pain, pregnancy, miscarriage, impotence and menstrual disorder. The impact on mental health can also be great, generating strong feelings of shame. The experience of sexual torture can affect the survivor's attitudes to themselves as sexual beings, and to intimate relationships. It can undermine family life.

Rape and sexual torture are intended to have a profound psychological effect. They are used deliberately as a tool to humiliate and destroy and can have a shattering effect on the victim,



their family and wider society. Because of the taboo surrounding sex in many cultures, survivors can find it extremely difficult to talk about what has happened to them. In addition to strong feelings of shame and anxiety, they may fear reprisals if their community finds out what has happened. The mental health impact can last a long time.

Men may find it particularly difficult to talk about sexual violence. The situation can be more complex if they have experienced sexual stimulation during the abuse. It can lead to them questioning their sexuality, and losing interest in sex. Male survivors may doubt their ability to be a father, and feel pessimistic about the future.

“Men who’ve been sexually assaulted often say it is the worst form of trauma they experience – worse, for example, than their experiences of war, conflict and persecution.”

(Adviser to support services for men who have been raped or sexually abused)

Offering help to survivors

If appropriate, a survivor of sexual torture or rape should speak to a doctor or nurse. They need to receive any medical care necessary. Their experience may be important to their asylum application, and if possible a medico-legal report should be written. Not all acts of sexual violence leave physical scars, which can make it difficult for doctors to corroborate accounts of sexual violence – especially if a significant period of time has elapsed. A psychiatric report may also be important in such an asylum claim.

If appropriate, the survivor should also be encouraged to have a test for HIV and other sexually transmitted infections. It is important for them not to delay getting a test and they can have a test done even if they do not have any signs and symptoms. As HIV may not show up on the test straightaway they may be asked to go back for a test three months after they had the sex that put them at risk of HIV. They will also be offered advice and support about the importance of using condoms if sexually active.

Entitlement to treatment varies according to the stage the person is at in the asylum process, and this should also be taken into account.

Many people are nervous of being tested for HIV, for a number of reasons. The pre-test discussion is important to understand the benefits of having the test, what will happen if the test is positive, the availability of post-test counselling and support once the result is available.

In addition, there may be treatment or other forms of support available for people whose mental or physical health has been affected by their experience of sexual torture or rape. Counselling may be helpful to people who feel ready to talk about their experiences of sexual violence, alongside other experiences of loss and trauma. However, others may prefer to concentrate on the practical challenges of living in the UK and rebuilding their lives. Links to community networks and purposeful activity such as community events, volunteering or work can also help people to move forward.



While some asylum seekers and refugees talk to health workers about their experiences, others may confide in someone they have come to trust, such as a voluntary sector worker, volunteer or interpreter.

See also Section 8.2 for more information about HIV.

Good practice: basics

- Ask the survivor separately whether they want their partner to be present during the interview.
- Remember that the survivor may be fearful of their family or community finding out about their experience.
- Make sure medical issues are dealt with.
- When appropriate, encourage the survivor (and their partner(s)) to be tested for sexually transmitted infections, including HIV.
- Be patient: do not press for more information if someone is not ready to speak about their experience.
- Listen calmly and without openly rejecting what is being said.
- Avoid the survivor having to repeat the story in multiple interviews.
- When appropriate, encourage the survivor to talk to their legal adviser about their experience.
- Be aware that some asylum seekers and refugees suffer rape and sexual violence in the UK, and have strategies for responding to this.
- Let the survivor set the agenda – they may want help to rebuild their lives in practical ways.

Rape and sexual assault and the law

Rape

In England and Wales, a man would commit rape if he intentionally penetrates with his penis the vagina, mouth or anus of another person, male or female, without that person's consent or if they are under 13. This is the only sexual offence which can only be committed by a man. Under the Sexual Offences Act 2003, a person consents if s/he agrees by choice and has the freedom and capacity to make that choice.

In Scotland, rape is covered by common law and is defined as vaginal penetration. Anything else, however violent, is the crime of indecent assault. Male rape is not a recognised offence and would be treated as the common law offence of aggravated assault.

In Northern Ireland, a man would commit rape if he has anal or vaginal sexual intercourse with a person, male or female, without their consent (Criminal Justice (Northern Ireland) Order 2003).

Under various case law in each UK country, a man may be charged with raping his wife.

Women cannot be charged with the offence of rape as this is defined as penile penetration, but in England and Wales a woman could be charged with sexual assault by penetration.



Sexual assault by penetration

This offence was introduced in England and Wales by the Sexual Offences Act 2003. It is an offence for someone, male or female, intentionally to penetrate the vagina or anus of another person with a part of their body or anything else, without their consent. The purpose also has to be sexual, which is defined as:

- a) a reasonable person would always consider it to be so, or
- b) if a reasonable person may consider it to be sexual, depending on the circumstances and intention.

Practitioners who legitimately conduct intimate searches or medical examinations are excluded from this offence.

Sexual/Indecent assault

Under the Sexual Offences Act 2003 it is an offence in England and Wales for a person intentionally to touch sexually another person without reasonable belief that they consented. Touching covers all physical contact, whether with a part of the body or anything else, or through clothing.

In Scotland, indecent assault on a man or woman is a common law offence.

In Northern Ireland, indecent assault on a woman is also a common law offence, while indecent assault on a man is provided for in the Criminal Justice (Northern Ireland) Order 2003.

Sexual offences against young people under 16

England and Wales

The Sexual Offences Act 2003 introduced a new series of laws to protect children under 16 from sexual abuse. However, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation.

Specific laws protect children under 13, who cannot legally give their consent to any form of sexual activity. There is a maximum sentence of life imprisonment for rape, assault by penetration, and causing or inciting a child to engage in sexual activity. There is no defence of mistaken belief about the age of the child, as there is in cases involving 13–15 year olds.

In England, children under 13 still have the right to seek, and be provided with, confidential advice on sexual health (see Section 7.3 for more information on provision of sexual health advice).

Scotland

Under section 3 of the Sexual Offences (Scotland) Act 1976, it is an absolute offence for a man to have unlawful sexual intercourse with a girl under 13. The maximum penalty is life imprisonment.

Unlawful intercourse with a girl aged 13–16 is also an offence, punishable by two years' imprisonment. One possible defence is that the man believed himself to be married to the young woman. Also, a man under 23 with no previous similar offences may claim that he believed the young woman to be 16 or over.



Northern Ireland

An offence against a girl aged under 14 carries the maximum penalty of life imprisonment. There is no defence that the man believed her to be 17 or over, whatever her age. Although, in practice, prosecutions are rare, the maximum penalty would be two years' imprisonment, if the girl was 14 years or over.

(fpa, 2004)

Community research

Sexual violence and domestic violence

Sexual and domestic violence were areas of great concern to a significant minority of participants in the community research. However, interviewees talked about rape carried out by family and community members, rather than by soldiers and state agents. Experiences of domestic violence and sexual violence were therefore related, and indicate alarming levels of oppression and abuse of women in some countries of origin – abuse which continues in the UK.

Useful organisations and websites

- Amnesty International
- Directory and Book Services
- Medical Foundation for the Care of Victims of Torture
- Rape and Sexual Abuse Support Centre
- Survivors Trust
- Women Against Rape

Useful publications

National guidelines on the management of adult victims of sexual assault
Clinical effectiveness group (British Psychological Society, 2005)

Available from www.bps.org.uk

Rape as a method of torture

Seltzer A et al (Medical Foundation for the Care of Victims of Torture, 2004)

Shares clinical experiences and provides information to help victims of rape and those working with them.

Available from www.torturecare.org.uk



Sexual and gender-based violence against refugees, returnees and internally displaced persons

[United Nations High Commissioner for Refugees, 2003]

Guidelines offering practical advice on developing strategies and activities to prevent and respond to sexual and gender-based violence. It includes a section on working with refugee children.

Available from www.unhcr.ch

Torture survivors' handbook

[Medical Foundation for the Care of Victims of Torture and Redress Trust, 2003]

Handbook for torture survivors, with information on support, rights and resources. It lists useful organisations across the UK.

Available from www.torturecare.org.uk

8.2 HIV

HIV can carry great stigma. Fear of HIV can combine with anti-asylum hostility, with some sectors of the population wrongly believing that refugees bring disease and infection into the UK. Alongside this are fears that outsiders are overburdening UK health services. All these factors have made HIV an acutely sensitive issue for some asylum seekers and refugees and agencies working with them.

HIV testing

HIV testing is not mandatory for asylum seekers and refugees in the UK and people are not tested at the port of entry. Some asylum seekers request a test soon after arrival and before being dispersed.

Asylum seekers may be reluctant to come forward for testing for a number of reasons including:

- they believe a positive result means they will die
- they fear it will affect their asylum claim
- HIV is highly stigmatised
- they do not know how to access testing
- they think that if other community members see them at a GUM or sexual health clinic or any specialist sexual health centre, it will be assumed that they are HIV positive
- they do not understand drug treatments on offer, and what they can achieve.

If a pregnant woman is HIV positive it is possible for HIV to pass to the baby during pregnancy, during the birth and when breastfeeding. During antenatal care women are recommended to have an HIV antibody test. If a woman is HIV positive she can then discuss with the doctor or midwife:



- the benefits of antiretroviral therapy (drug treatment) for the mother and baby
- whether a caesarean birth is recommended
- if breastfeeding should be avoided.

Eligibility for treatment without charge for asylum seekers whose request for asylum has been turned down may be an issue (see Section 7.8).

Difficulties facing people who are HIV positive

HIV has been epidemic in sub-Saharan Africa for a long time and is therefore an important health consideration for refugees and asylum seekers from some African countries. However, all communities should consider themselves at risk.

Research has shown that Africans in the UK who are HIV positive are likely to face greater hardship than their white, UK-born counterparts. Research showed that disability, discrimination, poverty, anxiety, isolation and loss were all important issues, and they were most acute for people who had only been in the UK for a short while, and which declined with increasing length of stay. Difficulties around housing and immigration status, along with lack of knowledge of HIV treatments, were also pronounced among newer arrivals (Weatherburn et al, 2003 and Chinouya et al, 2003). These difficulties are likely to affect newly arrived asylum seekers of any nationality who are HIV positive.

Other difficulties include:

- incorrect information and beliefs
- resistance to using condoms
- lack of knowledge of services
- lack of capacity among community organisations and support services
- lack of consultation and partnership working between HIV services and community organisations
- stigma from own communities.

“We see women and young girls who’ve been raped and infected deliberately. The rapists say they hope they’ll get HIV and die.”

(Welfare adviser, refugee organisation)



Asylum seekers who receive treatment for HIV can find it hard to manage the treatment regime if they live in shared housing where there is little privacy, or if their lives are chaotic in any way. Stigma, anxiety, loneliness and lack of work can combine to cause depression in some asylum seekers and refugees who are HIV positive.

For many women from more traditional societies, motherhood is an important source of personal identity and validity – failure to have children can have negative economic and social consequences including divorce and abandonment. Some women who are HIV positive try to become pregnant, in the hope it will bring them greater security and a sense of fulfilment (Doyal and Sanderson, 2003). This has particular implications with regard to safeguarding the health of mother and child. Any woman who has been diagnosed as HIV positive should obtain medical advice and care immediately they know or intend to become pregnant.

“When you are HIV positive, diet is key, and asylum seekers don’t have the money for this. Also there is a complex drug regime which it is very hard to maintain in shared accommodation. Confidentiality is almost impossible in these situations.”

(Team leader, AIDS support service)

Good practice: basics

- Target communities that are particularly at risk.
- Use community development principles to enable communities to influence services and be involved in awareness-raising.
- Find out about fears, misconceptions and barriers and address these wherever possible.
- Provide condoms and information on how they should be used, even if your organisation is not a health service.
- Make it clear that being HIV positive will not affect the individual’s asylum claim or lead to them being deported.
- Encourage asylum seekers and refugees who may be at risk to have a test as soon as possible as this will help to ensure they receive treatment, even if their asylum claim is later refused. But do not push or coerce people into having a test.
- Check their entitlement to treatment – this varies according to immigration status.
- Make sure they are offered pre-test discussion and post-test counselling, as appropriate.
- Check that people are getting enough to eat – especially children, pregnant women and new mothers.
- Support work to decrease stigma about HIV in communities, and challenge prejudice surrounding HIV.

“I persuaded eight people to get HIV tests. Seven were negative, one was positive. The seven all say they are more careful about sex now. And the one who is positive is glad he knows, because he is healthy, and he could have done something bad like pass the infection on without knowing.”

(Health co-ordinator, refugee community organisation)



Community research

HIV emerged as an issue of primary concern among interviewees and focus group participants. This included attitudes, awareness and behaviour among the host population, as well as within refugee communities. A number of participants reported that many asylum seekers and refugees do not understand how the HIV virus is passed on, and that many don't know that effective treatment is available.

Useful organisations and websites

- African Health for Empowerment and Development
- African HIV Policy Network
- Electronic Quality Information for Patients
- Health Protection Agency
- Medical Foundation for Aids and Sexual Health
- National Aids Trust
- Naz Project London
- Positively Women
- Terrence Higgins Trust

For national helplines, see Section 2.4.

Useful publications

Children, HIV, asylum and immigration

See Useful publications, Section 7.3.

The handbook of sexual health in primary care

Toni B et al (**fpa**, 2006)

Has a useful chapter on diagnosing HIV in a primary care setting.

Available from www.fpa.org.uk

HIV

(**fpa**, 2007)

fpa's leaflet for the public that can be used by sexual health practitioners with service users.

Small quantities of all fpa's leaflets on contraception and sexually transmitted infections may be available free from health promotion units in England. Contact your local unit directly. They are also available to purchase from fpa (see Appendix 3).

Migration and HIV; improving lives in Britain

See Useful publications, Section 7.6.



Recommended standards for NHS HIV services

[Medical Foundation for AIDS and Sexual Health, 2002]

Covers 12 aspects of service provision for people with HIV and offers guidance on managed service networks.

Available from www.dh.gov.uk

Talking about HIV and AIDS

[Centre for HIV and Sexual Health, 2003]

An audio resource for African people living in the UK, available in several languages.

Available from www.sexualhealthsheffield.nhs.uk

8.3 SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted infections can be passed on by vaginal, anal or oral sex and through sharing sex toys and drug equipment. Some sexually transmitted infections can be transmitted to a baby during pregnancy and/or birth.

Most sexually transmitted infections are easily treated but it is usually best if treatment is started as soon as possible. Some infections, such as HIV and herpes, never leave the body but there are drugs available that can reduce the symptoms and help prevent or delay the development of complications. HIV is not always treated but will be monitored until treatment is necessary. If left untreated many sexually transmitted infections can be painful or uncomfortable. They can permanently damage health and fertility, and can be passed on to someone else.

Signs and symptoms of a sexually transmitted infection can include unusual discharge from the vagina or discharge from the penis, pain or burning when passing urine, itches, rashes, lumps or blisters around the genitals or anus, pain and/or bleeding during sex or bleeding after sex or between periods and pain in the testicle or lower abdomen.

Not everyone who has a sexually transmitted infection has signs or symptoms – sometimes they don't appear for weeks or months and sometimes they go away, so people do not always know they have a sexually transmitted infection and can pass them on without realising.

All tests and treatments are available at a GUM or sexual health clinic. General practices, contraception clinics, young people's services and some pharmacies may also provide testing for some infections.

All advice, information and tests are free, but people may have to pay a prescription charge for any treatment if they go to a general practice.

Tests for both men and women may include:

- an examination of the genitals, mouth, anus, rectum and skin to look for obvious signs of infection



- testing a sample of urine
- having a blood test
- taking swabs from the urethra and any sores or blisters
- taking swabs from the throat and the rectum. This is less common and depends on which sexually transmitted infection is being tested for.

In women the tests might also include:

- taking swabs from the vagina and cervix (entrance to the womb)
- having an internal examination.

Asylum seekers and refugees may arrive in the country with a sexually transmitted infection, or may be exposed to sexually transmitted infections in the UK. Sexually transmitted infections may be caught as a result of rape or serious sexual assault, and the survivor may have a number of fears surrounding their condition. They may not want to disclose all that has happened, and they may not want their partner to know that they have been raped.

Health workers report that the profile of sexually transmitted infections among asylum seekers and refugees is broadly similar to that of the UK population and that most asylum seekers and refugees do not have a sexually transmitted infection.

Good practice: basics

- Provide education and information to enable asylum seekers and refugees to act safely and minimise risk, and to encourage them to seek medical help if needed.
- Asylum seekers and refugees who are concerned they may have contracted a sexually transmitted infection should be encouraged to see their doctor, or to visit a GUM or sexual health clinic.
- Make it clear that all services are confidential and that tests are optional and will only be done with their permission.
- If appropriate, let people know in advance what kind of checks they may have.

See Sections 2.3–2.6 for information on sexual health services.



Project example

The Huddersfield GUM clinic

The Huddersfield GUM clinic has asylum seekers and refugees among its clients. Like everyone, they can phone and make an appointment directly or they may be referred by a health worker. To be more accessible to asylum seekers, the clinic has built links with the Whitehouse Centre in Huddersfield which offers a general practice service to asylum seekers and other transient or vulnerable groups. Whitehouse Centre health workers can book people into the GUM clinic at particular times of the week – this makes it easier for interpreters to be arranged.

For a number of reasons, a relatively high number of asylum seekers miss their first appointment. The clinic has worked to understand the pressures asylum seekers are under, and accepts that a number will not attend. People are phoned wherever possible to remind them of appointments.

Asylum seekers and refugees are offered the same service as anyone else. They can remain anonymous if they choose – no proof of identity is needed. They are offered testing for HIV and a wide range of sexually transmitted infections, regardless of their reason for visiting the clinic and regardless of age. If appropriate, they are offered other tests. In the case of sexually transmitted infections, they can phone for the results of tests if they want. They are given a prescription on the day of their appointment if they show definite symptoms. Otherwise the prescription can be posted out or picked up from the clinic.

Staff are sensitive to the emotional issues that asylum seekers and refugees may face as a result of their experiences. Sometimes there are psychosexual issues that need to be addressed. The clinic has linked up with the Whitehouse Centre and Huddersfield Health Promotion to run a half-day training course for health professionals, refugee workers and general practice receptionists. It aims to help them understand the services on offer and the issues involved when working with asylum seekers and refugees.

For more information, contact Huddersfield GUM clinic. Tel: 01484 344311.

Useful organisations and websites

- **fpa**
- Medical Foundation for Aids and Sexual Health
- The Society of Sexual Health Advisers

“Sexually transmitted infections are a real concern to us. We know that in large hostels, where people stay sometimes for many weeks, relationships start up between asylum seekers, and also with people outside the hostel. People do not always know about protection.”

(Project worker, organisation working with new-arrivals)



Useful publications

fpa produces a range of leaflets on sexually transmitted infections.

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

The handbook of sexual health in primary care

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

The British Association for Sexual Health and HIV (BASHH) publishes guidelines on all sexually transmitted infections.

Available from www.bashh.org

8.4 CONTRACEPTION

People's knowledge of contraception will vary according to their experience prior to arriving in the UK. Some refugees may have little knowledge of the range of contraceptives available.

Free contraception, including emergency contraception, is available from:

- a general practice, unless they say they don't provide contraception services
- a contraception (family planning) clinic
- a sexual health clinic
- a young people's service (these will have an upper age limit)
- some GUM clinics.

Free hormonal emergency contraception is also available from:

- most NHS walk-in centres (England only) and minor injuries units
- some hospital accident and emergency departments (phone first to check)
- some pharmacies (there may be an age limit).

Contraception is free even if the service gives a prescription to take to the pharmacy.

Some pharmacists are able to provide a range of sexual health services including contraception. People aged 16 or over can buy hormonal emergency contraception from most pharmacies for around £23. They also sell condoms, diaphragms, caps and spermicide.

"We held a women-only session with a community group, and the women talked about who decides which contraceptive to use. They said they thought that health workers decide – they didn't feel able to ask questions. They shared a lot of fears that contraception could make you infertile. They were really interested when we showed them all the different choices."

(Health promotion officer, health promotion service)



Some methods of contraception (including emergency contraception) can also be bought at clinics run by Marie Stopes. Emergency contraception can also be bought at clinics run by bpas.

(See also Section 2.3 for information on NHS sexual health services.)

As in the wider UK population, there can be resistance to using contraceptives among refugees. Some men are reluctant to use condoms. Some want to control women's fertility, either by preventing women from using contraceptives, or by determining which contraceptive should be used. In addition, some women are unable or unwilling to say no to unprotected sex.

Some asylum seekers and refugees may not be aware of the importance of condoms in ensuring safer sex, though some health workers report that female condoms are popular among women from some African communities. Female condoms may be available free from some contraception clinics and young people's services, and GUM or sexual health clinics. Some pharmacies may sell them but they are expensive. Male condoms are more widely available free of charge from contraception and sexual health clinics, and young people's services and most GUM clinics.

There are many different contraceptive methods available and different methods suit people at different times of their lives. Contraceptives can be divided into two types:

No user failure (contraceptive injections, contraceptive implant, IUS, IUD and female and male sterilisation): these do not depend on remembering to take or use contraception. These are long-acting methods.

User failure (contraceptive patch, combined pill, progestogen-only pill, male and female condom, diaphragms and caps and natural family planning): These are methods people have to use and think about regularly or each time they have sex. For these methods to be effective they must be used according to the instructions given.

People attending contraceptive services will be asked questions about their medical and sexual history. If they choose certain methods of contraception, such as the IUD or IUS, they will need to have an internal examination, have their blood pressure taken (if wanting to use hormonal methods of contraception) or may be offered a test for sexually transmitted infections. Medical staff will discuss all the methods available and discuss any concerns people have, for example, some hormonal methods of contraception, such as the contraceptive injection, can

“We find that for some women, if their lives are a bit chaotic, contraception can go down the list of priorities. In some countries it is normal for women to become pregnant early in life, so we explain why it helps to delay the first pregnancy if you can, and to have time between pregnancies.”

(GP, Initial Accommodation)



affect a woman's periods, causing them to become irregular, longer or stop completely. These methods may not be suitable for women who see menstruation as culturally important.

It is important to raise awareness of emergency contraception with asylum seekers and refugees. Emergency contraception can be used if someone has had unprotected sex, that is, sex without using contraception, or they think their contraception might have failed. There are two methods:

- **Emergency hormonal pill.** This must be taken up to three days (72 hours) after sex. It is more effective the earlier it is taken after sex.
- **An IUD.** This is a small plastic and copper device that is put into the womb by a specially trained doctor or nurse. It can be fitted up to five days after unprotected sex at any time in the menstrual cycle, provided this is the *only* unprotected sex that has occurred since the last period. If someone has had unprotected sex more than once since their last period then an IUD can be fitted up to five days after the earliest time they could have released an egg (ovulation).

By acting quickly, emergency contraception will usually prevent pregnancy.

Good practice: basics

- Provide information and choice.
- Share information in one-to-one and group sessions.
- Be sensitive to difference, including different cultural and religious views.
- Explain the safer sex value of condoms.
- Enable women to feel confident about using contraceptives.
- Advertise contraceptive and sexual health services in places asylum seekers and refugees visit.
- Make free condoms widely available.
- Provide information in community languages and other formats.
- Make leaflets and cards widely available.
- Provide training and resources for refugee workers, housing workers, local authority staff and others who work with refugees.
- Use staff and volunteers who understand, and possibly come from, refugee communities.

Contraception and the law

See Section 7.3 for information on the law concerning confidentiality around giving contraception and sexual health advice to under 16s.



Project examples

The Arrival Practice

The Arrival Practice in Stockton-on-Tees works only with refugees and people seeking or refused asylum. All new arrivals are encouraged to attend an initial health assessment with an interpreter present if needed. There is a 90 per cent take up rate, and a health assistant visits non-attenders to encourage them to visit the practice. Contraceptive needs are explored during the initial assessment. As part of this, health workers explain:

- the age of consent
- safer sex
- contact with people in prostitution
- use of condoms.

Those at risk of HIV are also counselled and encouraged to access the testing service available through the practice.

Whenever appropriate, the benefits of condoms are explained, along with how to use them. If culturally acceptable, this is demonstrated on a condom demonstrator. The patient is then given a small card with a large, red C on one side and with the practice contact details on the other. Asylum seekers are then able to visit the practice and a local community centre, where they can show the card and so get free condoms. This helps people who are not confident speaking English or are embarrassed about asking for condoms.

For more information, contact the Arrival Practice. Tel: 01642 615415. www.arrivalpractice.com.

Leeds Primary Care Trusts

Leeds Primary Care Trusts (PCTs) run a condom scheme to promote the use of condoms for safer sex, and contraception. The project became aware that asylum seekers' access to condoms is limited by a number of factors, including cost, language and lack of knowledge, and the scheme has been extended to include them.

Free condoms are made available at a popular drop-in for asylum seekers, which opens three times a week. Health workers are present. The condoms can be picked up from a free dispenser in the toilets, or are given out by the health workers. People who want condoms are given the opportunity to talk about other sexual health issues if they wish, and a number of the young, male asylum seekers do this. A community project and two specialist black and minority ethnic health projects are also part of the scheme. Free training on condom use and demonstration are on offer to the staff. A leaflet on condoms has been translated into the most commonly spoken languages in Leeds.

For more information, contact Leeds PCTs. Tel: 0113 305 9830.

Useful organisations and websites

- Brook
- [fpa](http://www.familyplanningassociation.org.uk)



- Marie Stopes International
- Sexual Health Line

Useful publications

fpa produces a range of leaflets on different methods of contraception.

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

The handbook of sexual health in primary care

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

8.5 UNINTENDED OR UNWANTED PREGNANCY

Unwanted pregnancies can occur for a variety of reasons. Women may:

- feel their situation is too financially insecure to support a baby
- fear deportation, and the added difficulties of being deported when pregnant or with a small child
- be separated from the child's father – through death or exile, or for other reasons – and not want to bring the child up on their own
- come from a culture that sees abortion as a normal form of contraception
- be pregnant as a result of rape.

It is important not to make assumptions about what a woman will want. For example, while some women who are pregnant as a result of rape request an abortion, not all will make this choice. Likewise, some women become pregnant through short-term and unstable relationships, but not all will want an abortion. For some, bringing new life into the world can give a sense of purpose and fulfilment. Some may have lost their children, and want to recreate a family. Others believe that abortion is morally wrong.

In some cases women are too advanced in pregnancy to have an abortion and their options are then limited. They may prefer to consider adoption. Some women may feel a mixture of emotions and find it difficult to make a decision.

Good practice: basics

- Provide clear and unbiased information about the choices available, including abortion, adoption and keeping the baby.
- Avoid making assumptions based on a woman's culture, religion, or economic and personal circumstances.
- Make it clear that abortion is legal and safe.



- Explain the choices regarding contraception.
- Provide information about and access to emergency contraception.

Useful organisations and websites

- bpas
- British Association for Adoption and Fostering
- Brook
- **fpa**
- Marie Stopes International

Useful publications

Abortion: your questions answered

{**fpa**, 2007}

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

Pregnant and don't know what to do? A guide to your options

{**fpa**, 2007}

See Useful publications, Section 8.2.

Available from www.fpa.org.uk

The handbook of sexual health in primary care

See Useful publications, Section 8.2.

Available from www.fpa.org.uk



Abortion and the law

In Great Britain (England, Scotland and Wales) the law (Abortion Act 1967, as amended by the Human Fertilisation and Embryology Act 1990) allows a woman to have an abortion up to 24 weeks of pregnancy, if two doctors agree that it would cause less damage to her physical or mental health than continuing with the pregnancy. An abortion can be done after 24 weeks if there are exceptional circumstances, for example if there is a serious risk to the woman's health or there is a substantial risk of physical or mental disability if the baby was born. Most abortions (90 out of 100) are carried out before 13 weeks of pregnancy, and 98 out of 100 are carried out before 20 weeks.

The Abortion Act does not extend to Northern Ireland. Abortion is legal in Northern Ireland in very exceptional circumstances. It is only lawful where there is a real and serious risk to the woman's mental or physical health and the risk is permanent or long-term. Consequently most women from Northern Ireland have to travel to England to obtain a private abortion. They are not entitled to an abortion on the NHS.

The decision to have an abortion is a matter between the woman seeking the abortion and her healthcare team. All information and treatment is confidential whatever age the woman is. This means that information about her cannot be shared with anyone else without her agreement. The hospital or clinic where she has her abortion is not required to tell her GP. Many abortion services like to let her GP know out of courtesy, to provide information in case she has any health problems after the abortion, and to allow her medical records to be updated. They can only do this with her permission.

A young woman under 16 years of age can have an abortion without telling her parents. The doctors will encourage her to involve her parents or carers, or another supportive adult. If she chooses not to do this, she can still have an abortion if the doctors believe it is in her best interests, and that she fully understands what is involved. This is called giving consent.

All information, advice and services are confidential. However, health professionals will involve social services if they suspect a service user, or another person, are at significant risk of sexual abuse or emotional or physical harm. They will not do this without talking to the service user about this first.

(fpa, 2007)

8.6 THE SEX INDUSTRY

There is growing concern that asylum seekers and refugees – both adults and children – are vulnerable to exploitation in the sex industry. There are also concerns that some male asylum seekers and refugees who pay for sex do not know the 'rules of behaviour' that ensure safety for the person selling sex, and the client, and that they do not realise the potential risks.

In many cities, newly arrived asylum seekers are housed in areas of deprivation which may also be red light areas. Male asylum seekers may be approached by people in prostitution and they may also approach female sex workers on the street themselves. These men may or may not have had contact with sex workers (or people in prostitution) in their countries of origin.



Some have little understanding of how the industry works, and there is a range of cultural attitudes and expectations which can lead to misunderstandings and, in some cases, abuse of people in prostitution.

Impoverished asylum seekers and refugees, and asylum seekers who become destitute may sell sex in order to survive. A report published by the Mayor of London in 2004 highlighted the vulnerability of destitute asylum seekers to recruitment by the sex industry, where they face intense exploitation, intimidation and abuse (Mayor of London, 2004). There have been reports of pimps visiting hostels where asylum seekers are housed, to recruit them into prostitution.

An asylum seeker may resort to selling sex only occasionally, as a desperate measure. Others may become dependent on selling sex in order to survive, or because they are in the control of a pimp or 'boss'. Some may be in situations that are more informal – a woman may be in a relationship with a man she hardly knows, in order to have a roof over her head. Some women are vulnerable to exploitation by members of their own community, while others may hide what they are doing from their community. Health professionals and refugee workers report that not only women are at risk – some male asylum seekers sell sex, and may be in the control of pimps.

“Your awareness of risk changes if you’re an asylum seeker and your self-esteem is very low. You may be willing to sell sex and not use a condom if you are desperate.”

(Outreach worker, organisation for people in prostitution)

There are concerns that women, young men and children who are in the control of pimps are moved from one city to another, and that they could be trafficked on to other countries.

Asylum seekers, and people whose request for asylum has been turned down, are especially vulnerable in the sex industry:

- Most have not come to this country expecting to sell sex, and may feel acute shame and a need for secrecy.
- Many will see selling sex as a short-term solution to acute problems, so may not identify themselves as sex workers.
- They may be reluctant to approach mainstream health services because they fear it will adversely affect their asylum claim.
- If their immigration status is insecure, women are additionally vulnerable to dependency on men who exploit and abuse them.
- They may be exploited through underpayment, long working hours, unprotected and unsafe working conditions.
- They may be isolated because of cultural differences, language problems and lack of information on their social and legal rights.



- Insecurity and fear can cause physical and psychological problems (such as alcohol dependence or depression).
- If their request for asylum has been turned down, they will have lost free entitlement to most health services, and may fear removal to another country.

Fear of authority and deportation means that asylum seekers who sell sex are unlikely to be working out on the streets. This means that outreach workers are less likely to meet them. Asylum seekers who sell sex may be more likely to approach a service they know and trust to ask for help, such as a refugee project or dedicated refugee health service, rather than a specialist service for people in prostitution.

“It’s very important to raise awareness of sexual health services, and that they are free at the point of need. It’s not the exchange of money that affects sexual health – it’s what you are doing and how safe it is.”

(Co-ordinator, support network for people in sex work)

Good practice: basics

The following apply to working with asylum seekers and refugees who are buying *or* selling sex.

- Provide general sexual health information.
- Make condoms freely available, and explain their importance.
- Make sure people are receiving all the support and benefits they are entitled to.
- Make people aware of the law regarding the sex industry, and the risks of being involved.
- Explain entitlement to sexual health services, and the level of anonymity these offer.
- Develop links with projects and services that can provide specialist health and social care, and help people in need to access them.
- Make links with the police to help protect asylum seekers and refugees from being targeted and recruited by pimps and others who may sexually exploit or abuse them.
- If appropriate, target particular groups to raise awareness.
- Make sure interpreters are able to handle this topic professionally.

Prostitution and the law

Prostitution (the exchange of sex for money) is not a criminal activity in the UK, but many activities surrounding the practice of sex work are criminalised, such as soliciting and kerb-crawling. It is also illegal to rent property for sex work, manage brothels, run escort agencies or to control and make a financial profit from someone in prostitution.



The Sexual Offences Act 2003 protects children under 18 years old against commercial sexual exploitation. It is an offence to pay (or have another financial arrangement) in order to be sexual with someone under 13 or who you do not reasonably believe to be over 18. The maximum penalty is life imprisonment.

It is an offence to cause or incite, or control, or arrange or facilitate child prostitution or child pornography of someone under 13 or someone you know to be under 18. The maximum penalty is 14 years imprisonment.

See also Section 8.7, Trafficking and the law.

This is a complex area of law and more information is available from www.sw5.info.

Useful organisations and websites

- European Network for HIV-STD Prevention in Prostitution
- Network of Sex Work Projects
- SW5
- TAMPEP
- United Kingdom Human Trafficking Centre

Useful publications

Hustling for health: developing services for sex workers in Europe

(European Network for HIV/STD Prevention in Prostitution (EUROPAP), 1998)

Practical guidance on setting up and running services for sex workers. It includes a chapter on working with migrant sex workers, and is available in all European languages.

Available from www.europap.net

Multilanguage information and education materials for sex workers

(TAMPEP, 2002)

A CD-Rom with leaflets and publications for sex workers and outreach workers, in a range of languages.

Available from www.tampep.com

Practical guidelines for delivering health services to sex workers

(EUROPAP, July 2003)

Guidelines for health and social workers who deliver health care and health promotion services to sex workers.

Available from www.nswp.org



8.7 TRAFFICKING

Human trafficking has been defined as ‘the movement of people through violence, deception or coercion for the purpose of forced labour, servitude or slavery-like practices’ (www.antislavery.org, accessed February 2007). It is a global problem and has been ranked as the third most lucrative form of international crime after arms and drugs trafficking (Shearer Demir, 2003).

Most commonly, the victims are women and children who are trafficked for the purposes of sexual exploitation through selling sex or for pornography. Men and women are also trafficked for the purposes of labour exploitation. Many women who are trafficked into domestic labour end up being raped and sexually abused by their ‘employers’. Their working conditions are unregulated and tantamount to slavery. Some women and children are also trafficked so they can be exploited as benefits claimants.

Often, victims of trafficking are lured into migration by the promise of a better life. Common ‘push’ factors include poverty, lone parenthood, a history of abusive relationships and a dysfunctional or disrupted family life. In some cases, young women and children are abducted, or they are given (and sometimes sold) by their parents to someone who promises a job abroad or the possibility of schooling.

The main areas of origin for trafficked women and children are West Africa, Eastern Europe and South East Asia. Their journeys are often circuitous and they may travel through several countries. Many end up being trafficked to, and working in, more than one country.

Traffickers often move women and children from one city to another, to keep them isolated and unable to build up networks of support, and to avoid detection. There have been several cases of unaccompanied minors who claim asylum at the port of entry and then disappear shortly after being taken into care. This is because they are under strict instructions from the trafficker to contact an agent once they have gained entry and are afraid to disobey.

In some cases, victims of trafficking are warned against trying to escape by threats of violence, voodoo curses or even death as well as threats to their families at home. They may be kept in isolation, without travel documents or money and deceived into believing that they owe an inflated debt for travel and living expenses.

There are also women who choose to come to this country to sell sex. Some of these may be considered ‘trafficked’ if their travel is facilitated by someone else, and the conditions they work under in the UK are exploitative and not what they expected – for example, if their earnings are taken from them, documents removed, movements controlled or they experience other forms of abuse.

The health impact of trafficking

The physical, psychological, sexual and emotional effects of trafficking have a profound and sometimes irreversible impact on a person’s wellbeing and reproductive health.



Victims of trafficking may suffer from:

- anxiety, depression, panic attacks, flashbacks, memory loss, insomnia and nightmares
- loss of trust as a result of being so profoundly deceived by someone they trusted, who may have offered 'love and protection'
- guilt, low self-esteem and a feeling of complicity for their gullibility and failure to escape the trap of trafficking
- the consequences of forced vaginal, anal and oral sex, violence and psychological abuse
- physical difficulties with menstruation and vaginal bleeding associated with rape
- sexually transmitted infections from unprotected sex (sex without a condom sells at a higher price)
- alcohol and drug use, sometimes forced
- fatigue and injury from intense exploitation, often working seven days a week seeing up to 40 clients a day
- poor general health as a result of inadequate nutrition and hygiene.

Trafficked women and children who are kept incarcerated in poor accommodation under close surveillance and relocated frequently (sometimes as often as twice a month) have few opportunities to learn English or visit health or any other services. They may be forced by a pimp to use a false name when they contact services.

Issues for agencies

Hospitals and clinics, especially those concerned with obstetrics, gynaecology or sexual health, and Accident and Emergency Departments, may encounter victims of sexual exploitation. If child protection issues are involved, social services must be alerted (see Section 7.3).

There is little specialist provision for people who have been trafficked. Social services have a statutory responsibility to provide support for cases involving children, but there are few facilities offering specialist support for adult women on their own. The women will need accommodation, counselling, health services, education, training and legal advice, including advice on their immigration status, entitlement to services and the options if they choose to return to their country of origin.

Services that work with people who have been trafficked should form links with other agencies that may be able to help. There are some specialist agencies in London. Outside London, organisations should form links with the local authority, the Community Safety Partnership, Women's Aid, services working with women and

"I know what it means, it had just happened to me. I was being sold as though I was cattle. I was being captured and stripped of all my dignity and self-control."

(A trafficked woman)



children, and specialist sexual health projects. Some of these may be able to provide different forms of advocacy and support.

It is vital that confidentiality is observed, unless there is a legal requirement to report to the police, for example, in cases of suspected child abuse (see Section 7.3). Women and children who come from small communities fear exposure and lack of acceptance. There have been cases where interpreters have betrayed the women or children to pimps, or have acted as a trafficker themselves. There are also many examples of women and children escaping and being re trafficked.

Good practice: basics

- Ensure the woman or young person has good legal representation.
- Help to secure safe and appropriate accommodation.
- Ensure that immediate health needs are addressed.
- Find ways of ensuring emotional and psychological support is on offer.
- Make sure they have contact details of people and organisations that can help (though be aware that they may have nowhere safe to hide such numbers).
- Assess risk when making referrals to other agencies, particularly to refugee organisations.
- Whenever possible, make sure that trafficked women are able to speak to female professionals.

Trafficking and the law

The Nationality, Immigration and Asylum Act 2002 introduced the offence of trafficking for the purpose of prostitution. This carries a maximum penalty of 14 years.

The Sexual Offences Act 2003 sets out wide-ranging offences covering trafficking into, out of or within the UK for sexual exploitation.

An offence of trafficking for non-sexual exploitation was introduced in the Asylum and Immigration (Treatment of Claimants etc) Act 2004. This is aimed at people who arrange the travel of people into, out of or within the UK in order to obtain forced or coerced labour, or the removal of organs, or to force, threaten or deceive them to provide services or benefits, or to enable another person to acquire benefits. It is also an offence to arrange travel for a person into, out of or within the UK if you believe it is likely another person will exploit them.



Project example

The Poppy Project

The Poppy Project is funded by the Home Office, and provides housing and support for up to 35 adult female victims of trafficking for sexual exploitation who meet Home Office criteria. It takes referrals from the police, sexual health agencies, refugee organisations and other agencies across the UK. It also accepts self-referrals. It helps women to escape prostitution and situations into which they have been trafficked and is run by Eaves Housing for Women, a housing scheme for vulnerable women in London.

In the first instance, the project provides short-term accommodation and other support including a living allowance, interpreting and translation, access to legal services, health assessment and liaison with police and immigration. During the first four weeks on the Project, women are provided with support and information and have time to make an informed decision about whether they wish to assist the authorities. While they are encouraged to speak to the police during this period, they are not obliged to do so.

Women who are prepared to actively assist the authorities, whether by assisting the police with general intelligence gathering about trafficking networks or to secure a prosecution, are entitled to longer term support (6–12 weeks). Support during this second stage includes safe accommodation, specialist counselling, legal advice and assistance in determining eligibility for statutory funding. They are also given help in addressing their immigration status in the UK or assisted in returning to their country of origin should they wish to do so. The Poppy Project offers follow-on support to women moving into the community, and liaises with agencies in the country of origin to support women who return. In 2006 it set up an outreach team to provide support to victims of trafficking throughout the UK and work with other agencies to promote best practice.

The Poppy Project has a 24-hour hotline for victims of trafficking and a safe website with the facility to translate material into other languages. Poppy Research and Development aims to develop services to assist women who want to leave prostitution, including trafficked women. Poppy has researched the experiences of trafficked women in the UK, mapped the scope of London's commercial sex industry and has highlighted gaps in services for women in prostitution in London.

For more information, contact Eaves Housing for Women. Tel: 020 7735 2062.
www.eaves4women.co.uk. Poppy Project 24-hour phone line: 020 7840 7129.

Useful organisations and websites

- Africans Unite Against Child Abuse
- Anti-Slavery International
- Asylum Aid
- ECPAT UK
- International Organisation for Migration
- United Kingdom Human Trafficking Centre



Useful publications

Forced migration review

[Refugee Studies Centre and Norwegian Refugee Council]

A regular review.

Available from www.fmreview.org

The health risks and consequences of trafficking in women and adolescents: findings from a European study

Zimmerman C

Covers different stages of trafficking, from pre-departure to integration and reintegration, with recommendations. See Appendix 2.

Hope betrayed. An analysis of women victims of trafficking and their claims for asylum

Richards S, Steel M and Singer D (Poppy Project and Asylum Aid, 2006)

Considers all the asylum claims made by women who were trafficked into the UK and subsequently supported by the POPPY Project from March 2003 until August 2005.

Available from www.eaves4women.co.uk

The migration-trafficking nexus: combating trafficking through the protection of migrants' human rights

Kaye M (Anti-Slavery International, 2003)

Gives an overview of global trafficking (both for forced labour and for sexual exploitation) and looks at ways of protecting the rights of migrants.

Available from www.antislavery.org

Stolen smiles: a summary report on the physical and psychological health consequences of women and adolescents trafficked in Europe

Zimmerman C et al (London School of Hygiene and Tropical Medicine, 2006)

Provides fact-based information on the range of health consequences for women who have been trafficked.

Available from www.lshtm.ac.uk

Trafficking of people crime reduction toolkit

(Home Office, 2003)

A practical toolkit, covering legislation, definitions, and practical strategies for a range of services, including multi-agency co-operation at local level.

Available from www.crimereduction.co.uk



What the professionals know: the trafficking of children into, and through, the UK for sexual purposes

Somerset C (ECPAT UK, 2001)

A research report based on interviews with officials, such as police and immigration officers, non-governmental organisations, journalists and academics.

Available from www.ecpat.org.uk

When women are trafficked: the gendered experience of trafficking in the United Kingdom

Dickson S (Poppy Project, 2004)

Explores the situation of women in the UK who have been trafficked.

Available from www.eaves4women.co.uk

WHO ethical and safety recommendations for interviewing trafficked women

Zimmerman C and Watts C (World Health Organization, 2003)

Recommendations for use by researchers, members of the media and service providers unfamiliar with the situation of trafficked women.

Available from www.lshtm.ac.uk

8.8 DOMESTIC VIOLENCE

Domestic violence is 'physical, psychological, sexual or financial violence that takes place within an intimate or family-type relationship and forms a pattern of coercive and controlling behaviour' (www.womensaid.org.uk, accessed December 2006).

Rights of Women have defined it as 'any violence or threat of violence that takes place in or outside the home between family, household members or partners in existing or previous relationships. It can include mental, emotional, physical and sexual violence. This includes harassment, for example persistent letters, telephone calls, text messages or emails, and psychological or mental abuse' (www.rightsofwomen.org.uk, accessed February 2007).

While in most cases of domestic violence the abuse is carried out by a man against a woman, it can occur in same sex relationships and in a minority of cases, the abuse may be carried out by a woman against a man. According to the Council of Europe, one in four women experience domestic violence (www.womensaid.org.uk, accessed February 2007). Women's Aid reports that two women are killed every week in the UK by a current or former partner and that domestic violence accounts for 22 per cent of all recorded violent crime. Domestic violence occurs across all classes, ethnic groups and cultures. However, asylum seekers and refugees are particularly vulnerable:

'Refugee women have a particularly hard time of it due to the uncertainty of their immigration status, their lack of knowledge of the language, of systems, of services, and their experience of racism – all of which is made worse by their invisibility stemming from subjugation in their own communities' (Johal in Gupta, 2003).



Male asylum seekers and refugees may feel threatened by Western values and gender roles. Many women enjoy much more freedom in this country than the one they have fled. This can undermine men's traditional dominant role in the household. At the same time, many asylum seeking and refugee men are unemployed or have to take on work that does not reflect their skills and experience. Women and girls may find more opportunities to work, or to live independently. Frustration, fear, anxiety, poverty and traditional beliefs can, for some men, be factors leading to domestic violence. They are, however, no excuse.

Barriers to getting help

Women who experience domestic violence are frequently silenced by shame. Domestic problems are considered private, and women who seek help may be condemned and ostracised by their communities. A woman may not dare to tell her whole story for fear of punishment from her abuser and pressure from the family and community.

Family law in some countries states that wives should obey their husbands and that physical punishment for not doing so is considered legitimate. Asylum seekers are unlikely to be aware of the law on domestic violence and child protection in this country, so may not know that they can seek help or that the person committing the domestic violence is breaking the law.

The Home Office Border and Immigration Agency has issued a policy bulletin giving guidance to their staff working with asylum seekers and refugees, and other services. It lists the following common difficulties that may prevent someone reporting violence or abuse:

- fear that they will not be believed
- fear that they will be blamed
- belief that their partner's behaviour is normal and all relationships are like theirs
- belief that the abuse is their fault
- fear that their partner will find out that they have reported abuse
- fear of homelessness or destitution
- fear that they will be removed from the UK
- uncertainty about the availability of services and their legal rights
- uncertainty about their rights in relation to any children and that the children may be taken away by social services or their partner.

[Immigration and Nationality Directorate (IND) (now the Border and Immigration Agency), 2004]

Organisations working with refugees report that women who press for divorce often face huge pressures from the community, and can become very isolated: this can deter them from escaping domestic violence. Some women fear the

“They won't speak up. If they're not scared of their husbands, they're scared of their parents. If not of their parents, then of their society.”

(Woman, focus group)



authorities because of experiences in their country of origin. Some speak little English. In addition, asylum seekers' uncertainty about immigration status or an unresolved asylum claim may contribute to a misguided belief that involving the authorities in a report of domestic violence may somehow count against them. For some women, entry into this country is on condition that their husbands will support them. When they leave an abusive relationship, many find themselves ineligible for public funds.

Taking action

Because of the importance placed upon marriage, the way that some community members respond to domestic violence is to attempt reconciliation through community or religious leaders or family members. This is not always appropriate and may place women and children at greater risk and perpetuate a desperate situation.

Moreover, many service providers are wary of intervening in situations of domestic violence among minority ethnic communities for fear of being called racist or culturally insensitive. This means that some women and children are especially vulnerable and isolated, particularly if they do not speak English and have no means of accessing services independently. In the case of young people who are subject to violence from parents, statutory services are often reluctant to intervene in what they see as a 'culture clash' and young asylum seekers may fear repercussions in terms of their parents' immigration status if they complain to teachers or social services.

Good practice: basics

- Translate information about rights and sources of help and make it widely available.
- Be clear about the kind of service and support you can offer, and if necessary build links with specialist agencies.
- Provide a safe, private space where women can talk about their experiences.
- Access to refuges is limited for women who are seeking asylum – build networks and explore local links to find ways of ensuring a safe haven.
- Women being housed by the Border and Immigration Agency may be rehoused, but will benefit from having an advocate who can help them express their needs.
- Find out if your local authority has a special fund for women who want to escape domestic violence.
- Use same sex independent interpreters, preferably ones who are trained in domestic violence issues.
- If child protection issues are involved, you must inform social services.
- Be aware that sometimes men are victims of domestic violence.
- Address these issues with the whole community including education with boys and young men.



Project example

The Al-Aman Family Safety Project

The Al-Aman Family Safety Project is an Arabic speaking outreach project and part of the Domestic Violence Intervention Project based in Hammersmith and Fulham in West London. Its aims are to increase awareness of all issues related to domestic violence among Arabic-speaking communities, to improve professional responses to domestic violence, and to provide services to women and children experiencing domestic violence, and to male perpetrators within Arabic-speaking communities.

The project works with victims of domestic violence on a one-to-one basis looking at their belief system and issues such as self-blame. It offers advocacy and emotional and practical support. Because domestic disputes are traditionally 'settled' within the family or by religious leaders, Al-Aman does outreach work with mosques and runs training for imams. Its work with perpetrators makes Al-Aman a pioneering project. The project gets referrals from courts, social services departments and the probation service as well as self-referrals from both men and women.

Al-Aman ran the first ever family safety conference in Arabic at the Muslim Cultural Heritage Centre, which was addressed by its imam – a major breakthrough as the organisation is sometimes accused by the local community of being 'family breakers'. In 2004 it held the first ever training day on domestic violence for imams, at London Central Mosque.

Since the organisation started, the volume of casework has increased considerably, particularly with those women who are not eligible for public funds, should they leave their husbands. Al Aman increasingly runs training and speaks at conferences as a result of its growing specialism in this area.

For more information, contact Al-Aman. Women's Support. Tel: 020 8563 2250. Violence Prevention Programme. Tel: 020 8748 2577.

Useful organisations and websites

- Asylum Aid
- Imkaan
- Rights of Women
- Southall Black Sisters
- Women's Aid

Useful publications

Refugee women and domestic violence: country studies

[Asylum Aid, ongoing]

Country reports on domestic violence for legal practitioners and others working with asylum seekers fleeing domestic violence.

Available from www.asylumaid.org.uk



Young people and vulnerable adults facing forced marriage. Practice guidance for social workers

(Foreign and Commonwealth Office, 2004)

Useful appendix on domestic violence provisions in the immigration rules.

Available from www.adss.org.uk

Domestic violence and the law

There is no definition of domestic violence in the law of England and Wales. However, a range of legislation in the UK relates to domestic violence. The Family Law Act 1996 sets out two ways of dealing with acts of domestic violence: occupation orders, which regulate the occupation of the family home, and non-molestation orders, for protection from all forms of violence and harassment.

The Protection from Harassment Act of 1997 enables the criminal court to make a restraining order against the abuser. Under the Domestic Violence, Crime and Victims Act 2004 the powers of the criminal court were strengthened to enable them to impose a restraining order on an abuser even if he is found not guilty of committing an offence. Common assault, which includes a range of behaviours including physical assault as well as behaviour causing you to fear violence, such as threats, is an arrestable offence (www.rightsofwomen.org.uk, accessed February 2007).

Refugee women and asylum seekers who experience domestic violence often fear asking for help in case it jeopardises their asylum claim or status in the UK. They should get advice from an immigration lawyer who specialises in domestic violence cases.

8.9 HONOUR KILLING

Honour killing and honour-related violence involve the maiming or murdering of a woman or girl as punishment for behaviour considered inappropriate to her sex. The woman's behaviour is seen as bringing shame on the family or community. Honour killing and violence can also include the maiming or murdering of the man she is believed to be involved with.

The victim is often a woman who dates or marries a man who has not been chosen by her family.

However, actions as minor as chatting to a male neighbour or shopkeeper can be considered shameful enough to warrant severe physical punishment or even death in some countries.

In reality, women are much more likely to be killed than men, who can usually pay compensation to the family to escape death. Rape is often seen as an assault on the honour of the family or community – however, in some countries, prison sentences for rapists may be reduced or waived if they agree to marry their victim. In other cases, it is the woman who is punished for the 'crime' of being raped.

'The issue of preserving family honour remains central to the community attitude to domestic violence. If a woman brings dishonour to her family, then any violence committed against her can be justified on this basis.'

(Johal in Gupta, 2003)



In many countries, particularly in the Middle East and South Asia, murder in the name of family honour is exonerated or receives a lenient sentence. There is often great pressure on male family members to defend their honour in this way. In some countries honour killing is endorsed by community leaders and even the state and the judiciary. In others a blind eye is turned.

The act can be perpetrated by a parent, husband, other family members or members of the community. In some cases it is common practice to assign the task of killing the woman who has brought shame on the family to a young boy, to ensure a reduced sentence. There have also been many cases of suspicious 'suicides', where women who are considered in breach of accepted moral codes are given a rope and told how to hang themselves.

Honour killings take place in the UK among the host population and, occasionally, in refugee communities.

'In practice the concept of honour has been degraded to such a degree that it is used as a justification for a wide spectrum of violent crimes against women. Women can be locked in their homes, ostracized and murdered for being victims of rape.'

(www.kwahk.org, accessed December 2006)

Good practice: basics

See Section 8.8.

Useful organisations and websites

- Amnesty International
- Honour Crimes Project
- Kurdish Women Action Against Honour Killing
- Southall Black Sisters

Useful publications

From homebreakers to jailbreakers

Gupta R (ed) [See Appendix 2]

A selection of articles concerning violence against black women. Follows the Southall Black Sisters struggle to challenge legislation and community attitudes to domestic violence, honour killing and other issues.

Available from www.southallblacksisters.org.uk

Turkey: women confronting family violence

[Amnesty International, 2004] [See Appendix 2]

A report on the prevalence of violence against women in Turkey, including widespread honour killings.

Available from www.kwahk.org.uk



8.10 FORCED MARRIAGE

There is often confusion between forced marriage and arranged marriage. An arranged marriage is where families seek out potential spouses for their children (to ensure compatibility in areas such as religious beliefs, education, status) and either party can accept or reject the match. A forced marriage is when one or both of the parties do not give their consent, or where consent is exacted under emotional and/or physical pressure. Although it is mainly women who are forced into marriage, male victims form 15 per cent of the Foreign and Commonwealth Office Forced Marriage Unit's cases.

The Home Office provides the following definition, 'A forced marriage is a marriage conducted without the valid consent of both parties, where duress is a factor' (Home Office Communications Directorate, 2000).

Forced marriage occurs in many different contexts. These may include:

- Controlling unwanted behaviour and sexuality (including perceived promiscuity, or being gay, lesbian, bisexual or transgender) – particularly the behaviour and sexuality of women.
- Preventing 'unsuitable' relationships, such as those outside the ethnic, cultural, religious or caste group.
- Family honour or long standing family commitments. In some instances, agreements may have been made about a marriage when the children were very young.
- Peer group or family pressure. Some parents come under significant pressure from their extended families to get their children married.
- Attempting to strengthen family links.
- Ensuring land, property and wealth remain within the family.
- Assisting claims for residence and citizenship.
- Providing a carer for a disabled family member, or trying to reduce the 'stigma' of disability.
- Women who have been raped are sometimes forced to marry the perpetrator as a way of reducing shame to the family.
- In war situations there are many instances of young girls and child soldiers being captured and forced to 'marry' combatants.
- Women may be forced into marriage by traffickers as a way of maintaining control and to help with immigration.

Forced marriage can involve a number of different forms of abuse, including emotional pressure and threats, psychological abuse, financial abuse, physical pressure, imprisonment, abduction and rape, restrictions on freedom of movement and association, forced abortion and forced pregnancy and murder (so-called 'honour killing'). These lead to high rates of self-harm and mental health problems, including suicide.



The right to enter into marriage with free and full consent is a fundamental human right (Article 16 in the Universal Declaration of Human Rights, 1948), as is the entitlement to equal rights to marriage, during marriage and at its dissolution. Forced marriage is sometimes mistakenly justified on religious grounds. However, every major faith condemns forced marriage. Freely given consent is a requirement in Christian, Jewish, Hindu, Muslim and Sikh marriages.

Many asylum seekers and refugees come from countries where forced marriage is practised in some parts of the country. Forced marriage has formed the basis of some asylum claims by women, often in combination with domestic violence. There is at least one case where refugee status was granted to a woman fleeing forced marriage. In other cases, although asylum was refused in the first instance, some women have been granted leave to remain on appeal.

In the UK, most cases of forced marriage are from the Indian sub-continent but cases have been reported from the Middle East, Europe, East Asia and Africa.

The emotional and psychological pressure put on young people to marry someone chosen by parents can be acute. They may be told that a parent's health or the family honour and the future prospects of siblings are at stake. They may also be threatened with violence and there have even been cases of reluctant spouses being murdered. Young people who are pressurised into marriage are frequently taken out of school and miss out on education and careers. Sometimes, their only recourse is to flee the family home and go into hiding or a refuge. If they are from a sheltered background this could be the first time they are isolated from the family, a situation they find so disturbing that they may return home.

When working with young people the following may be signs that they are threatened with forced marriage:

- withdrawal from school or truancy and poor performance
- not being allowed to work, poor attendance at work or lack of control over their own finances
- self-harm, depression or eating disorders
- family history of domestic violence, of siblings forced to marry or restrictions on their movement outside the home.

The Foreign Office in partnership with the Association of Directors of Social Services has produced guidance for working with young people or vulnerable adults faced with forced marriage (see below). Guidance is also available for the police, education professionals, and most recently, health professionals (see below).

Good practice: basics

If you suspect that someone is the victim of a forced marriage or that one is being planned you should:

- talk to them alone even if they come accompanied by someone else



- be aware of their personal safety and be vigilant about heightening risk through contact, whether by phone, post or text messages – their safety is paramount
- be sure that any interpreter you use is independent and professional and not part of the same community
- take into account their own wishes but activate local protection procedures and use existing national and local protocols for multi-agency liaison including contacting the local Child Protection Unit of Social Care Services if the person is under 18 or if there are children involved and you consider their safety to be at risk
- give them accurate information on their rights and choices.
- refer to the Foreign and Commonwealth Office Forced Marriage Unit if you are unsure about anything, especially if the person is, or is about to be, taken abroad
- contact the police if a crime has been committed or if there are concerns about the safety of the victim, their siblings or the victim's children – follow statutory guidance on child protection and sharing information.

Do not:

- try to mediate with the family or husband
- breach confidentiality by speaking to the family or members of the community without the consent of the victim, even if they make contact and request information.

Refer the individual to an appropriate organisation for further support and emergency accommodation if necessary (bearing in mind restrictions on people with no recourse to public funds accessing public services, and therefore refuges).

Useful organisations and websites

- Foreign and Commonwealth Office Forced Marriage Unit
- The International Centre for the Legal Protection of Human Rights
- The Law Society
- Southall Black Sisters

Useful publications

Dealing with cases of forced marriage: Practice guidance for health professionals
(Foreign and Commonwealth Office, 2007)

Provides general guidance on forced marriage and guidance for health professionals on how they can make a difference.

Available from www.fco.gov.uk/forcedmarriage



'It was written in her kismet': forced marriage

In Gupta, R (ed), *From homebreakers to jailbreakers*

Siddiqui H (Zed Books, 2003)

Chapter 4 gives an analysis of the Government's working group on forced marriage and the complex gender issues involved, along with case studies showing the difficulties faced by people who oppose forced marriages.

Available from www.zedbooks.co.uk

Love snatched: forced marriage and multiculturalism

(Faction Films, 2004)

One of three videos produced by Faction Films on issues relating to forced marriage.

Available from www.factionfilms.co.uk

Young people and vulnerable adults facing forced marriage. Practice guidance for social workers

(Foreign and Commonwealth Office, 2004)

Provides general background on forced marriage, guidance to social workers on best practice and an appendix on domestic violence provisions in the immigration rules.

Available from www.fco.gov.uk/forcedmarriage

Forced marriage and the law

There is no specific criminal legislation dealing with forced marriage in the UK. People guilty of enforcing a marriage can be prosecuted for other offences, such as abduction, assault, threats to kill, rape, kidnapping, child abduction or false imprisonment. Forced marriage can also be seen as an infringement of the European Convention on Human Rights.

The Forced Marriage (Civil Protection) Bill is, at time of press, going through Parliament. This will give courts wide discretion to make appropriate injunctions in order to respond effectively to the individual circumstances of a case and prevent or pre-empt forced marriages from occurring.

Where a forced marriage has taken place, they would also be able to make orders to protect the victim and help remove them from that situation. Where there was significant risk of harm, the court could add a power of arrest. The Bill will also enable people to apply for an injunction at the county courts, rather than just the high courts, and enable third parties to apply for an injunction on behalf of somebody else.

Under the Matrimonial Causes Act 1973 a marriage can be annulled if either party to the marriage did not validly consent to it (nullity must be sought within three years of the marriage taking place).

Forced marriage is a form of domestic violence or child abuse if the person is under 18. Sexual intercourse without consent is rape, including between husband and wife.

(Home Office Communications Directorate, June 2000)



8.11 FEMALE GENITAL MUTILATION

Female genital mutilation (FGM), often referred to as ‘female circumcision’, comprises ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons’ (World Health Organization, 2000).

There are many different forms of FGM, ranging from removing part or all of the clitoris through to removing the labia and stitching the vaginal opening (infibulation), leaving only a tiny hole for urination and the passing of blood during menstruation.

FGM is usually performed on girls between the ages of four and ten but this varies from country to country and it may also happen at birth, in adolescence or before marriage or childbirth. Traditional practitioners, such as birth attendants or relatives are most likely to perform FGM, often using unsterilised and crude implements, but it is also undertaken by health professionals in some countries.

The origins of FGM are not fully known – it has been practised for many centuries and takes place predominantly in parts of East, West and Central Africa but is also found in some Middle Eastern and Asian countries. FGM also occurs in this country, although it is illegal.

A number of reasons are given for FGM, including:

- religious belief (although FGM is not recommended anywhere in either the Koran or the Bible)
- cultural belief and initiation rite
- hygiene
- aesthetics
- chastity and curbing female sexuality
- enhancing male pleasure
- increasing fertility.

There is often an assumption that FGM serves men’s interests most and they are responsible for its continued practice. However, it is often women who encourage, perform and manage FGM.



The health impact of FGM

The consequences of FGM for women's physical, reproductive and mental health may include:

- severe pain and trauma
- infection, sometimes chronic, of the pelvic or genitourinary system
- haemorrhaging, sometimes fatal
- damage to reproductive organs sometimes leading to infertility
- increased susceptibility to sexually transmitted infections
- incontinence and urinary retention
- painful intercourse
- sexual dysfunction
- depression
- difficulties during menstruation
- complications in childbirth.

There are now clinics that offer surgery to reverse FGM, but women do not always welcome reversal and this is a service that should be offered sensitively. Where women have been infibulated it is sometimes mistakenly believed by midwives and doctors in this country that the only way to deliver a baby is through a caesarean section. However, it is normal practice in countries where FGM is common to cut (or de-infibulate) women before birth and sometimes at marriage.

The Royal College of Midwives (RCM) recommends that de-infibulation always takes place before childbirth, to facilitate a normal vaginal birth and reduce risks to the fetus. Members of the RCM and the Royal College of Obstetricians and Gynaecologists cannot re-infibulate a woman after childbirth, even if this is her preference. It is illegal to do so.

Good practice: basics

- Use a professional female interpreter who is sensitive to the issues of FGM.
- Be clear about the need for confidentiality, but inform other involved practitioners in case complications arise.
- Remember that for women from some countries FGM is part of a deeply held belief system and they may assume it is the norm.
- Be sensitive about using the term 'female genital mutilation' – it can be considered insulting.
- Try not to register shock or distaste – it can be humiliating and hurtful.
- Women who have undergone FGM may be unused to internal examinations, which can be difficult and painful if women have been stitched up.



- Be aware that penetrative vaginal sex may be impossible for some women where infibulation is extreme – in these cases, anal sex may be practised. This may have health implications.
- Explain the law – FGM is illegal (see FGM and the law below).
- Enable people to challenge FGM, through educating communities and making young women aware of their rights.
- Young girls may still be at risk of being taken out of the UK to have FGM performed on them – this is illegal. Contact Foundation for Women's Health Research and Development if you need advice about this, and work closely with social services and the community to prevent such action.

FGM and the law

Under the Female Genital Mutilation Act 2003, a person is guilty of an offence if s/he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.

It is not illegal for a medical practitioner to perform genital surgery on a girl or woman if it is for the purpose of labour or childbirth, or if it is for her physical or mental health. In determining whether the operation is necessary for the mental health of a person, it is immaterial whether the girl or woman or any other person believes the operation is required as a matter of custom.

It is illegal to assist a female to mutilate her own genitalia, or to have female genital mutilation performed outside the UK. Parents who allow female genital mutilation to be performed on their daughter can be sentenced to a maximum of 14 years imprisonment.

Useful organisations and websites

- Amnesty International
- British Medical Association
- Foundation for Women's Health Research and Development
- Royal College of Midwives
- World Health Organization



Useful publications

Female genital mutilation

Momoh C (ed) (Radcliffe Publishing, 2005)

Focuses on caring for the needs of those who have experienced or are risk of having FGM.

Available from www.radcliffe-oxford.com

Female genital mutilation: caring for patients and child protection

(British Medical Association, 2006)

Guidance and information for UK doctors.

Available from www.bma.org.uk

8.12 MALE CIRCUMCISION

Male circumcision is the surgical removal of the sleeve of skin and mucosal tissue that normally covers the glans (head) of the penis. This double layer, sometimes called the prepuce, is more commonly known as the foreskin.

Male circumcision may be carried out by a medical practitioner for therapeutic reasons. Some people ask for non-therapeutic circumcision, either for religious or cultural reasons. Non-therapeutic circumcision may be carried out by a non-medical practitioner.

Non-therapeutic circumcision is a controversial issue. Some faiths – including Islam and the Jewish faith – see circumcision as essential. Other people, including those who campaign against the practice of male circumcision, strongly believe that it is wrong to perform the procedure on children who are not old enough to give informed consent.

Good practice: basics

- Parents considering circumcision should be encouraged to read about the procedure, and to discuss the risks and benefits with a doctor.
- Children who are capable of expressing a view should be involved in decisions about whether they should be circumcised, and their wishes taken into account. Competent children can decide for themselves.
- Be aware that some people believe that circumcision offers complete protection against HIV and penile cancer, and may be requesting circumcision for this reason.



Male circumcision and the law

Male circumcision (therapeutic and non-therapeutic – that is, whether or not there is a physical need for circumcision) is generally assumed to be lawful in the UK, provided that:

- it is performed competently
- it is believed to be in the child's best interests
- there is valid consent from both parents.

If a young person is considered competent and refuses non-therapeutic circumcision, proceeding with the circumcision is likely to be unethical. Where people with parental responsibility for a child disagree about whether he should be circumcised, doctors should not circumcise the child without the leave of a court. The legality of circumcision is controversial and has been challenged by some. If doctors and other practitioners are in any doubt about the legality of their actions, they should seek legal advice.

[British Medical Association, 2006]

Useful organisations and websites

- British Medical Association
- General Medical Council
- NORM-UK

Useful publications

The law and ethics of male circumcision – guidance for doctors

[British Medical Association, 2006]

Good practice guidelines on male circumcision.

Available from www.bma.org.uk





Chapter 9

INTO ACTION

IN THIS CHAPTER

- 9.1 Sexual health promotion
- 9.2 Peer education
- 9.3 The role of refugee community organisations
- 9.4 Community research

This section provides an introduction to some of the practical work that organisations, services and community groups can get involved in to promote sexual health among asylum seekers and refugees.

9.1 SEXUAL HEALTH PROMOTION

Sexual health promotion aims to improve the positive sexual health of the general population and to reduce inequalities in sexual health.

The National strategy for sexual health and HIV emphasises the importance of developing strategies to respond to the specific information and prevention needs of particular communities, including black and minority ethnic groups and other vulnerable groups. The *Strategy* explains that this includes overcoming the common barriers to accessing information and prevention services, including:

- stigma
- discrimination
- poverty and social exclusion
- language
- access problems
- low awareness
- concerns about confidentiality.

[Department of Health, 2001]

At its broadest, for asylum seekers and refugees, sexual health promotion involves challenging and changing inequalities which lead to them being disadvantaged with regard to health and wellbeing.



There are many ways of promoting sexual health. Health promotion activities may be carried out with community members and refugee community organisations (RCOs), and with professionals and services working with refugees. Teachers delivering sex and relationships education can take into account the issues and concerns of asylum seekers and refugees attending their school. Sexual health promotion can also include community development, lobbying for change in national policy and ensuring asylum seekers and refugees are included in local health strategies.

It needs to cover many different aspects of sexual health, including safer sex, sexually transmitted infections and general awareness of sexual health. It can include helping asylum seekers and refugees to understand and cope with the environment they find in the UK, which may be more liberal than in their country of origin. It can also include promoting the emotional health and wellbeing of individuals, groups and communities – the inclusion of emotional health acknowledges the link between people’s emotional wellbeing and their ability to take control over the decisions and choices which affect their sexual health (Adams, 2001).

“We encourage questions, because in some cultures you’re not meant to ask about things.”

(Training and development worker, refugee community organisation)

Good practice: basics

(In addition to the guidelines set out in Section 6.1)

- Address language and communication issues.
- If possible, provide translated material and material in alternative formats.
- Work with existing networks and groups, including colleges, drop-in services and refugee organisations.
- Make sexual health promotion part of other activities, such as sewing classes, fitness activities and community events.
- Give people the opportunity to hear information more than once.
- Be aware that people have differing levels of knowledge.
- Be aware that people have different priorities – sexual health may not be high on their list.
- Make it clear you are not part of the immigration service.
- Make it clear that it’s okay to ask questions.

“The main thing is to try and help asylum seekers and refugees by educating the general public and staff who work with asylum seekers and refugees. Staff also do not know much about HIV and are not aware.”

(Woman, African Great Lakes region)



Project example

Centre for HIV and Sexual Health

In Sheffield, the Centre for HIV and Sexual Health has been involved in a number of sexual health promotion initiatives with asylum seekers and refugees by building links with a number of communities and with city based organisations. These include developing support networks for African women who are HIV positive, running information stalls and workshops at community events and festivals and the production of resources (including audio tapes on HIV/AIDS in a number of languages that are free to groups in Sheffield).

tandem formed a partnership with **fpa** and the Centre for HIV and Sexual Health to run the Asylum Seekers and Refugees Sexual Health Project. With tandem, the Centre for HIV and Sexual Health recruited and trained community researchers, who carried out research in South and West Yorkshire. Since then, the Centre for HIV and Sexual Health has developed this model of training and inclusion to recruit a number of volunteers from African communities. These volunteers now deliver a range of workshops, discussion groups and information days on sexual health within African community settings.

These different strands of work have enabled the Centre for HIV and Sexual Health to build links, gain insight and develop a strategy for working with asylum seekers and refugees.

For more information, contact the Centre for HIV and Sexual Health.

Community research

Information needs

In one-to-one interviews, people were asked if there was information that asylum seekers should have when they first arrive in the UK that would help them to be sexually healthy.

A total of 36 respondents (92 per cent) felt that some aspect of sexual health education or information should be available to new arrivals. This includes:

Information on where to go for help/services available	19	49 per cent
Information on sexually transmitted infections and protection	10	26 per cent
Sex and relationships education	6	15 per cent
Family planning	6	15 per cent
HIV awareness	5	13 per cent
Free condoms	4	10 per cent
Sexually transmitted infections in the UK	3	8 per cent
Advice about safer sex	3	8 per cent

People also requested information on the way of life in the UK, with information on the law including the age of consent and the law regarding rape.



Ways of learning

One-to-one interviewees were asked to look at a list and say which they thought would be a useful way to learn about sexual health.

Their responses (set out below) indicate that:

- talking one-to-one with a health adviser is widely acceptable
- many people would welcome leaflets, videos and DVDs in their own languages
- many would talk to a trained member of their community, but a significant minority would prefer not to
- many welcomed group discussions with a health adviser at a health or community centre, but a significant minority would not want to take part
- there are uncertainties around using the internet, partly because of lack of knowledge, language skills and access.

Project example

The Ethiopian Community Centre in the UK

The Ethiopian Community Centre in the UK regularly broadcasts information about sexual health on its Amharic radio programme on Spectrum Radio. The programme initially ran on Saturday afternoons, but now has two two-hour slots, on Saturdays and Sundays. It is digital, and broadcasts nationwide, in response to the needs of the growing numbers of Ethiopians who have been dispersed to different parts of the country. Up to 20,000 radios and televisions are tuned in to the programme at any one time, and the Ethiopian Community Centre estimates that many more than 20,000 people are listening. The Ethiopian Community Centre felt that sexual health was taboo in the community, and that a radio programme would provide an effective way to break down barriers. The health slot includes interviews with Ethiopian doctors and other health professionals working in the UK, and people are able to phone in with queries. They can also write to the team's nurse for information or local contact details.

The Ethiopian Community Centre also gives out information about general health, immigration, housing and welfare benefits, and provides IT, English to Speakers of Other Languages (ESOL), parenting, interpreting, supplementary and mother-tongue classes, and conducts research. It also organises yearly cultural events.

The Ethiopian Community Centre currently runs HIV prevention and caring services for Pan African and Caribbean Communities and in 2006 served over 40 nationalities.

For more information, contact the Ethiopian Community Centre in the UK, or tune in to Channel 0185 on Sky digital TV or digital radio, or visit www.spectrumradio.net. An archive of programmes is also available at www.eccuk.org. Tel: 020 8801 9224.

Useful organisations and websites

Contact your local Primary Care Trust or Health Promotion Unit (see Section 2.3).



The following national agencies are helpful starting points:

- African HIV Policy Network
- Centre for HIV and Sexual Health
- **fpa**
- Medical Foundation for Aids and Sexual Health
- Society of Sexual Health Advisers

The following are useful for culturally-diverse posters and resources:

- African Aids Helpline
- Festival Shop
- Headon Productions
- Naz Project London
- Terrence Higgins Trust
- UNHCR

Useful publications

Database of HIV resources relevant to African people living in England

[African HIV Policy Network, 2004]

A CD-Rom with extensive listing of leaflets, posters and other useful materials. There is an accompanying handbook.

Available from www.nahip.org.uk

Effective sexual health promotion. A toolkit for primary care trusts and others working in the field of promoting good sexual health and HIV prevention

[Department of Health, 2003]

Provides a range of practical, usable tools for those working in the field of sexual health promotion and HIV prevention.

Available from www.dh.gov.uk

Making women visible: strategies for a more woman-centred asylum and refugee support system

[Refugee Council 2005]

A report that identifies some key issues facing refugee and asylum seeking women with practical strategies for addressing them.

Available from www.refugeecouncil.org.uk

Meeting the sexual health needs of unaccompanied asylum seeking minors: an innovative practice guide

Young D [Teenage Pregnancy Unit and Government Office for London, 2006]



See Useful publications, Section 7.3.

Recommended standards for sexual health services
(Medical Foundation for Aids and Sexual Health, 2005)

Covers ten aspects of service provision.

Available from www.medfash.org.uk

The sexual health and sexual educational needs of refugees in Stockton-on-Tees

See Useful publications, Section 3.2.

9.2 PEER EDUCATION

Peer education can be defined in a number of ways. It usually involves ‘interaction between people who are similar in some way which can be a positive force for spreading ideas and altering attitudes and behaviour’ (Teenage Pregnancy Unit, 2002).

As well as imparting knowledge, peer education approaches usually aim to raise the self-esteem and social competence of the people involved. They develop skills, so that participants can make informed choices. Peer education approaches are often used with young people, and are seen as a valuable way of sharing information and skills with marginalised groups.

Good practice: basics

- If possible, carry out a needs assessment to identify interests and concerns.
- Consult with the community to find appropriate ways and times to offer training and peer education.
- Consider incentives, such as accreditation of training, payment of expenses and the possibility of paid, sessional work for peer educators.
- Link sexual health peer education to other activities, such as other group activities and community events.

Project example

Barnardo's African Communities' Service

Barnardo's African Communities' Service in Leeds is running a peer education programme which offers training to members of African communities in the city who then go out to talk to a range of groups. They work with people of all ages, and have sessions targeting children and young people. The aim is to promote sexual health and wellbeing and raise awareness of HIV among members of African communities.



Refugees are among the peer health educators. They take part in group discussions in the community, and train community leaders so they can disseminate information. They play an active part in Refugee Week, arranging exhibitions and events. In addition to providing information about sexual health issues, the educators aim to empower people to reflect on their traditional beliefs about sex, reproduction and gender roles, and enable them to make informed decisions about changing their sexual attitudes and behaviour.

For more information, contact Barnardo's African Communities' Service. Tel: 0113 258 9290.

Useful organisations and websites

- Joint United Nations Programme on HIV/AIDS (UNAIDS)

Useful publications

Involving young people in peer education: a guide to establishing sex and relationships peer education projects

Teenage Pregnancy Unit (Department of Health, 2002)

Provides an introduction to peer education and explains how to set up and run a peer education project using a range of techniques.

Available from www.teenagepregnancyunit.gov.uk

Meeting the sexual health needs of unaccompanied minors: an innovative practice guide

See Useful publications, Section 9.1

Peer education handbook on sexual and reproductive health and rights: teaching vulnerable, marginalized and socially-excluded young people

Zielony R and International Planned Parenthood Federation (IPPF) European Network (IPPF European Network, 2004)

Information and toolkit on peer education, with short sections on ethnic and cultural minorities and refugees.

Available from www.ippfen.org

Training manual for community health educators – the involvement of African communities in the promotion of sexual health in the north of England

See Useful publications, Section 6.3.

9.3 THE ROLE OF REFUGEE COMMUNITY ORGANISATIONS

Refugee community organisations (RCOs) have a key role to play in promoting sexual health, because of their knowledge of the community, its culture and needs. It is therefore important that RCOs and health agencies build partnerships to develop ways of ensuring community activists and members have access to sexual health information and advice.



This approach is endorsed by *The national strategy for sexual health and HIV*, which stresses the need for sexual health and HIV services to ‘understand and respond to local communities and their cultures by learning from, and supporting, community organisations and individuals’ (Department of Health, 2001).

Some RCOs have initiated sexual health projects in response to the needs of their communities. Other community-based initiatives have started when a local health agency has contacted an RCO. Some RCOs may be reluctant to address sexual health issues. Barriers can include:

- concerns about the possible impact within the community of raising controversial issues
- lack of confidence among community leaders and activists because they lack information about sexual health
- community leaders who have a particular religious or moral stance that they wish to impose
- concerns about wider public perceptions of refugees – RCOs may feel that raising the profile of sexual health issues could expose their community to labelling and hostility
- lack of resources
- lack of knowledge of agencies and services that can help with sexual health promotion.

Good practice: basics

Health promotion workers, health workers and others who want to work with RCOs should:

- consult and work with the community and community representatives
- find community activists who want to address sexual health issues
- help to set up and run one-off and ongoing activities
- help RCOs prepare funding proposals for sexual health projects
- offer sexual health promotion activities within the community, at community venues, in people’s homes, or at community events
- work with interpreters
- run men-only and women-only sessions
- find ways of reaching the most vulnerable members of the community.



Project example

African Community Advice North East (ACANE)

The health project at ACANE developed from conversations between ACANE members and African asylum seekers and refugees. When asked about their health concerns, community members frequently mentioned HIV. Some refugees were arriving with HIV, sometimes as the result of rape. Some did not know if they were HIV positive, or not. Others were concerned that they could contract HIV in the UK. ACANE offered to set up a series of health meetings, with the aim of raising awareness around HIV.

ACANE ran monthly meetings where community members could find out about sexual health and other health issues. They made contact with the Newcastle Health Promotion Service and the local Asylum Seekers' Health Team, and these organisations have worked in partnership with ACANE, providing speakers and materials, and helping with administration. Funding was provided by Newcastle Asylum Seekers' Unit and, for an initial period, Sure Start provided a crèche.

The groups began with a session about health services in the UK and some general health issues. Then participants were asked what they would like to find out about. HIV and contraception were proposed.

Groups alternate, so that one month the meeting is targeted more at women, and the next at men. ACANE volunteers back up the group sessions with one-to-one contact with people who may be vulnerable. All the work is done by volunteers and obtaining funding for the work to continue is a constant challenge.

For more information, contact ACANE. Tel: 0191 265 8110.

Useful organisations and websites

- ICAR
- Refugee Action
- Refugee Council

Useful publications

Database of HIV resources relevant to African people living in England

See Useful publications, Section 9.1.

Making women visible: strategies for a more woman-centred asylum and refugee support system

See Useful publications, Section 9.1.

Strategic approaches to consulting local communities

BME Health Forum Kensington, Chelsea and Westminster (Westminster Primary Care Trust, 2004)

Available from: www.westminster-pct.nhs.uk



9.4 COMMUNITY RESEARCH

Community research has an important role to play in enabling local organisations to help create and sustain appropriate sexual health initiatives. It can:

- make organisations and services aware of the needs, concerns and priorities of refugee and asylum seeker communities
- highlight the services and initiatives already in place, and how they need to be developed
- identify gaps in service provision
- provide evidence to support funding proposals to develop sexual health services and community projects
- provide information for sexual health campaigns
- inform policy makers of the key sexual health issues identified by asylum seekers and refugees
- help develop partnerships and networks which include refugee community organisations.

The involvement of asylum seekers and refugees in designing and carrying out research brings a number of benefits. It helps ensure that the research is relevant to those who are interviewed, and that the findings are useful to refugee communities as well as other audiences. This is particularly important when the focus of the research is such a sensitive and sometimes taboo subject. The involvement of asylum seekers and refugees can also play a part in developing research skills and experience.

Because of the sensitivity of the subject matter, and the level of social exclusion and vulnerability among asylum seeker and refugee communities, it is particularly important that ethical guidelines are agreed, covering issues such as confidentiality, anonymity and data protection.

It is also important that the research is made widely available, and that the findings are fed back to the communities involved. Research can be made available through appropriate websites, such as those run by ICAR and HARPWEB.

Useful organisations and websites

- African HIV Research Forum
- HARPWEB
- ICAR
- International Centre for Reproductive Health
- International Community of Women Living with HIV
- INVOLVE
- North East London Consortium for Research and Development
- Sigma Research
- tandem



Useful publications

Doing case studies for the refugee sector

Esterhuizen L (ICAR, 2004)

A DIY handbook for agencies and practitioners.

Available from www.icar.org.uk

Doing research with refugees

Temple B and Moran R (eds) (The Policy Press, 2006)

Explores methodological issues relating to the involvement of refugees in both service evaluation and development, and research more generally.

Available from www.policypress.org.uk

Ethical guidelines

(Social Research Association, 2003)

Ethical guidelines for individuals and organisations carrying out social research.

Available from www.the-sra.org.uk

Make better use of data and information

(ICAR, 2004)

An online pack that provides ideas and guidance for effective collection and use of data and information by refugee and other relevant agencies.

Available from www.icar.org.uk

Sexual health in exile: the sexual health concerns, issues and needs of refugees and asylum seekers in South and West Yorkshire: a community research report

Wilson R et al (Centre for HIV and Sexual Health, 2007)

A community research report looking at the sexual health concerns, issues and needs of asylum seekers and refugees in South and West Yorkshire.

Available from www.sexualhealthsheffield.co.uk, www.tandem-uk.com and www.fpa.org.uk



Project example

Asylum Seekers and Refugees Sexual Health Project

In 2004, the Asylum Seekers and Refugees Sexual Health Project carried out research into the sexual health priorities, needs and concerns of asylum seekers and refugees living in South and West Yorkshire. The community research component of the project was led by the Centre for HIV and Sexual Health and tandem communications and research, with funding from the Department of Health.

The community research was carried out to:

- find out what are the needs and concerns of asylum seekers and refugees with regards to sexual health in the UK
- hear their views on a range of issues
- find out if there are issues that require further action and make recommendations
- provide training and research experience for up to 16 refugees
- include the views of asylum seekers and refugees in this handbook.

The project placed great emphasis on involving and training community researchers. They received ten days training in sexual health and community research skills, and helped design the questionnaire for interviews and focus groups. Expenses were covered and the community researchers were paid for the work carried out after the training period.

Ten researchers, from eight countries of origin, carried out the research. They conducted one-to-one interviews – often in languages other than English – and led focus group discussions. They also played an active role in commenting on the draft research report and in drawing up the recommendations.

A total of 73 people, from 29 different countries of origin, took part in one-to-one interviews or focus groups. The final report, *Sexual health in exile*, is available from the Centre for HIV and Sexual Health, **fpa** and tandem.



Chapter 10

INTERNATIONAL INFORMATION

Many of the organisations already named in this handbook have useful international information on sexual and reproductive health and sexual violence. The following provide a starting point if you want to find out more about international perspectives and the countries that asylum seekers and refugees come from:

Amnesty International	www.amnesty.org
Asylum Aid	www.asylumaid.org.uk
Avert	www.avert.org
European Country of Origin Information Network	www.ecoi.net
Global Migration and Gender Network	www.gender.gcim.org
Home Office Country of Origin Information Service	www.homeoffice.gov.uk
Human Rights Watch	www.hrw.org
International Lesbian and Gay Association	www.ilga.org
International Planned Parenthood Federation	www.ippf.org
Joint United Nations Programme on HIV/AIDS (UNAIDS)	www.unaids.org
Ontario Consultants on Religious Tolerance	www.religioustolerance.org
Reproductive Health Response in Conflict Consortium	www.rhrc.org
UNHCR	www.unhcr.ch
World Health Organization	www.who.int

Useful publications

The atlas of women: an economic, social and political survey

Seager J (The Women's Press, 2003)

Explores the status of women in relation to a number of issues.

The Penguin atlas of human sexual behaviour, sexuality and sexual practice around the world

Mackay J (Penguin, 2000)

Gives an overview of human sexual behaviour worldwide.





Appendix 1

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Appendix 2

REFERENCES

The following are publications referenced within the text of this handbook. In addition to these, each section of the handbook has a summary list of publications relating to particular issues, under the subtitle Useful publications. These lists usually include additional resources that are not referenced in the body of the text and anyone interested in a particular subject should therefore also look at the earlier sections of this handbook for summaries of key publications.

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Appendix 3

USEFUL ORGANISATIONS AND WEBSITES

How fpa can help you

Sexual health direct is a nationwide service run by **fpa**. It provides:

- confidential information and advice and a wide range of leaflets on individual methods of contraception, common sexually transmitted infections, pregnancy choices, abortion and planning a pregnancy
- details of contraception clinics, sexual health clinics and genitourinary medicine (GUM) clinics.

fpa helpline

Tel: 0845 122 8690

9am to 6pm Monday to Friday

www.fpa.org.uk

African AIDS Helpline

Tel: 0800 0967 500

www.blackhealthagency.org.uk

A service for people of African origin, and their families.

African Health for Empowerment and Development (AHEAD)

Tel: 020 8317 0865

www.africanhealth.org.uk

Provides awareness education and information for African communities on HIV/AIDS and other sexual health issues.

African HIV Policy Network

Tel: 020 7017 8910

Email: info@AHPN.org

www.ahpn.org

Umbrella organisation representing African community groups addressing HIV and sexual health in the UK. Also runs the National African HIV Prevention Programme (see later in this section).

African HIV Research Forum

Tel: 020 7380 9650

Email: info@ahrf.org.uk

www.ahrf.org.uk



Aims to bring together individuals and organisations to focus on all aspects of HIV research relating to the various African communities within the UK.

Africans Unite Against Child Abuse (AFRUCA)

Tel: 020 7704 2261

Email: info@afruca.org

www.afruca.org

Works to promote the welfare of African children in the UK and overseas.

Amnesty International (International Secretariat)

Tel: 020 7413 5500

Email: amnestyis@amnesty.org

www.amnesty.org

Defends the human rights of those persecuted or imprisoned for their sexuality. Amnesty also defends women's rights, and is campaigning against domestic violence.

Amnesty International UK lesbian, gay, bisexual and transgender (LGBT) Network

www.ailgbt.co.uk

Raises awareness of human rights' violations based on sexual orientation.

Anti-Slavery International

Tel: 020 7501 8920

Email: info@antislavery.org

www.antislavery.org

Campaigns for the eradication of all forms of slavery.

Association of Visitors to Immigration Detainees (AVID)

Tel: 01883 717 275

Email: coordinator@aviddetention.org.uk

www.aviddetention.org.uk

Supports groups and individuals visiting detainees. Provides information and training and works to influence policy and raise awareness of detention issues.

Association for Women's Rights in Development

www.whrnet.org

Information and analysis on women's human rights and global issues.

Asylum Aid

Tel: 0207 354 9264

www.asylumaid.org.uk

Assists asylum seekers including running the Refugee Women's Project.

Asylum Seeker Co-ordination Team (Department of Health)

Tel: 0113 254 6605

Co-ordinates Government policy relating to the health care of asylum seekers and refugees.

**Bail for Immigration Detainees (BID)**

Tel: 020 7247 3590

Email: info@biduk.org

www.biduk.org

Provides a free dedicated bail service for asylum seekers and migrants detained in removal centres under immigration legislation plus useful publications.

BBC

www.bbc.co.uk

Information on asylum, different religions and beliefs, and links to BBC news stories and to other refugee organisations.

Beaumont Society

Tel: 01582 412 220

Email: enquiries@beaumontsociety.org.uk

www.beaumontsociety.org.uk

Transgendered support group.

Black Health Initiative

Tel: 0113 307 0300

Email: bhi.sexualhealth@virgin.net

www.bcathealthinitiative.co.uk

Detailed online guides to NHS services in the UK, in different media and languages.

bpas

Tel: 0845 730 40 30

www.bpas.org.uk

Supports reproductive choice by advocating and providing high-quality, affordable services to prevent or end unwanted pregnancy with contraception or by abortion.

British Association for Adoption and Fostering

Tel: 020 7421 2600

Email: mail@baaf.org.uk

www.baaf.org.uk

Promotes high standards in child-centred policies and services for children separated from their families of origin.

British Association for Sexual Health and HIV (BASHH)

Tel: 020 7290 2968

www.bashh.org

Professional body for those practising in sexual health, including the management of STIs and HIV in the UK. Offers training and education.



British Humanist Association

Tel: 020 7079 3580

Email: info@humanism.org.uk

www.humanism.org.uk

Represents the interests of ethically concerned but non-religious people in the UK.

British Medical Association (BMA)

Tel: 020 7387 4499

www.bma.org.uk

A professional association for doctors. Provides information and guidance on asylum and health, female genital mutilation, male circumcision and child protection issues.

British Red Cross International Tracing and Message Service

Tel: 0870 170 7000

Email: iwd@redcross.org.uk

www.redcross.org.uk

Works to deliver messages and re-establish contact within families separated by war or disaster.

Brook

Tel: 0800 0185 023

www.brook.org.uk

Free and confidential sexual health advice and services specifically for young people under 25.

The Center for Reproductive Rights

Tel: 001 917 637 3600

Email: info@reprorights.org

www.reproductiverights.org

A not-for-profit legal advocacy organisation dedicated to promoting and defending women's reproductive rights worldwide. Based in New York.

Centre for HIV and Sexual Health

Tel: 0114 226 1900

Email: admin@chiv.nhs.uk

www.sexualhealthsheffield.nhs.uk

Works to promote sexual health. It runs training and has resources and guidelines relating to sexual health promotion.

Commission for Racial Equality

Tel: 020 7939 0000

Email: info@cre.gov.uk

www.cre.gov.uk

Tackles racial discrimination and promotes racial equality.

**Community Legal Service Direct**

Tel: 0845 345 4345

www.clsdirect.org.uk

Aims to ensure that people in England and Wales can get impartial information and advice about their legal rights, and help with enforcing them. Website gives information in different languages.

Connexions

Tel: 080 800 13219

www.connexions-direct.com

The Government support service for 13–19 year olds, providing one-to-one careers counselling, support and advice on any matter of concern a young person may have.

Directory and Book Services (DABS)

Tel: 01709 860023

www.dabsbooks.co.uk

Provides a telephone information service and a mail-order service for books on sexual abuse and related issues.

Department of Health

Tel: 020 7210 4850

Email: dhmail@dh.gsi.gov.uk

www.dh.gov.uk

Information on the entitlement of asylum seekers, refugees and refused asylum seekers to health care.

ECPAT UK

Tel: 020 7233 9887

Email: info@ecpat.org.uk

www.ecpat.org.uk

Campaigns to end child prostitution, child pornography and the trafficking of children for sexual purposes.

Electronic Immigration Network (EIN)

Tel: 0845 458 4151

Email: info@ein.org.uk

www.ein.org.uk

Specialises in immigration and refugee law including case law, legislation and links to the Home Office Country of Origin Information Service.

Electronic Quality Information for Patients (EQUIP)

www.equip.nhs.uk

Links to sites offering translated health and social care information for UK patients, their families and carers, and to providers of interpreting and translation services.



Ethnologue

www.ethnologue.com

Language maps and extensive information about over 6,000 main languages.

European Network for HIV-STD Prevention in Prostitution (EUROPAP)

Email: info@europap.net

www.europap.net

A network linking specialist health projects, sex workers' projects and social support programmes across Europe.

Exile

Tel: 0870 285 6094

www.exile.org.uk

An email newsletter service providing information on asylum, immigration and rights.

Festival Shop

www.festivalshop.co.uk

Tel: 0121 444 0444

Provides multi-faith, multicultural and citizenship resources.

FFLAG (Families and Friends of Lesbians and Gays)

Tel: 0845 652 0311

Email: info@fflag.org.uk

www.fflag.org.uk

Supports parents and their gay, lesbian and bisexual sons and daughters.

Foreign and Commonwealth Office Forced Marriage Unit

Email: fmu@fco.gov.uk

www.fco.gov.uk/forced-marriage

Provides advice and information for people who are worried about being taken abroad to be married against their will.

Foundation for Women's Health Research and Development (FORWARD)

Tel: 020 8960 4000

Email: forward@forwarduk.org.uk

www.forwarduk.org.uk

Promotes action to stop practices such as female genital mutilation and early and forced marriages, which violate the human rights of girls and women.

fpa

[see start of this Appendix].

General Medical Council

Tel: 0845 357 8001

Email: gmc@gmc-uk.org

www.gmc-uk.org



Registers doctors to practise medicine in the UK and provides guidance on a range of issues including male circumcision.

Headon Productions

Tel: 0161 998 8877

Email: sales@headonltd.co.uk

www.headonltd.co.uk

Produces educational resources, including packs on sex and relationships education.

Health for Asylum Seekers and Refugees Portal (HARPWEB)

Tel: 0778 900 67 24

www.harpweb.org

Information on a wide range of issues relating to refugee health, along with practical tools. Includes a multilingual appointment card.

HM Inspectorate of Prisons

Tel: 020 7035 2136

www.inspectorates.homeoffice.gov.uk

Aims to provide independent scrutiny of the conditions for and treatment of prisoners and other detainees. Publishes reports on visits to detention centres.

Home Office Border and Immigration Agency

www.bia.homeoffice.gov.uk

Provides information on asylum in the UK, including statistics and procedures.

Honour Crimes Project

Tel: 020 7898 4683

Email: cimel@soas.ac.uk

www.soas.ac.uk

A collaborative research project on strategies to address 'crimes of honour'.

Human Rights Watch

Tel: 020 7713 1995

Email: hrwuk@hrw.org

www.hrw.org

Independent organisation dedicated to protecting the human rights of people around the world.

ICAR

Tel: 020 7040 4596

Email: icar@city.ac.uk

www.icar.org.uk

Promotes understanding of asylum seekers and refugees in the UK and encourages information-based debate and policy-making.



Imkaan

Tel: 020 7434 9945

Email: enquiries@imkaan.org.uk

www.imkaan.org.uk

Particularly supports refugees supporting Asian women and children experiencing domestic violence.

Immigration Law Practitioners' Association (ILPA)

Tel: 020 7251 8383

Email: info@ilpa.org.uk

www.ilpa.org.uk

Promotes and improves the advising and representation of immigrants.

The InterFaith Network UK

Tel: 020 7931 7766

Email: ifnet@interfaith.org.uk

www.interfaith.org.uk

Works to build good relations between the communities of all the major faiths in Britain.

International Centre for Reproductive Health (ICRH)

Tel: 00 32 9 240 35 64

Email: info@icrh.org

www.icrh.org

Focuses on research, training and interventions within sexual and reproductive health. Researching the prevention of gender-related violence against refugee women. Based in Belgium.

The International Centre for the Legal Protection of Human Rights (Interights)

Tel: 020 7278 3230

Email: ir@interights.org

www.interights.org

An international human rights law database.

International Community of Women Living with HIV

Tel: 020 7704 0606

Email: info@icw.org

www.icw.org

Promotes ethical participatory research with HIV positive women.

International Gay and Lesbian Human Rights Commission (IGLHRC)

Tel: 00 212 268 8040

Email: iglhrc@iglhrc.org

www.iglhrc.org

Promotes human rights of people discriminated against or abused on the basis of sexual orientation or expression, gender identity or expression, and/or HIV status. Based in New York.

**International Lesbian and Gay Association (ILGA)**

Tel: 00 32 2 5022471

www.ilga.org

A worldwide federation of LGBT organisations. Provides country by country information and links to groups. Based in Belgium.

International Organization for Migration (IOM)

Tel: 020 7233 0001

Email: ops@iomlondon.org

www.iomlondon.org

Projects include the Voluntary Return Programme. Also has a large counter-trafficking campaign and publishes information.

International Planned Parenthood Federation (IPPF)

Tel: 020 7939 8200

Email: info@ippf.org

www.ippf.org

Promotes the right of women and men to decide freely the number and spacing of their children and the right to sexual and reproductive health.

INVOLVE

Tel: 02380 651 088

Email: admin@invo.org.uk

www.invo.org.uk

Promotes and supports active public involvement in NHS, public health and social care research.

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Tel: 0041 22 791 3666

Email: unaids@unaids.org

www.unaids.org

The main advocate for global action aimed at preventing transmission of HIV, providing care and support, and alleviating the impact of the epidemic. Based in Switzerland.

Kurdish Women Action Against Honour Killing (KWAHK)

www.kwahk.org

A network of Kurdish and non-Kurdish activists, lawyers and academic researchers.

The Law Society of England and Wales

Tel: 020 7242 1222

Email: info.services@lawsociety.org.uk

www.lawsociety.org.uk

The regulatory and representative body for solicitors in England and Wales.



Legal Day

Tel: 020 7226 4888

www.legalday.co.uk

Daily news updates on UK law and pages on domestic violence, family law, gay rights, immigration, sex offences, trafficking and other related issues.

www.likeitis.org.uk

Information for young people about all aspects of sex and relationships education and teenage life.

London Lesbian and Gay Switchboard

Tel: 020 7837 7324

Email: admin@llgs.org.uk

www.llgs.org.uk

Information, support and referral service for lesbians, gay men and bisexual people from all backgrounds throughout the UK.

Marie Stopes International

Tel: 0845 300 8090

Email: info@mariestopes.org.uk

www.mariestopes.org.uk

Offers abortion, contraception, emergency contraception, male and female sterilisation and health screening.

Medical Foundation for Aids and Sexual Health

Tel: 020 7383 6345

Email: enquiries.medfash@medfash.bma.org.uk

www.medfash.org.uk

Promotes the prevention and management of HIV and other sexually transmitted infections.

Medical Foundation for the Care of Victims of Torture

Tel: 020 7697 7777

www.torturecare.org.uk

Provides survivors of torture in the UK with medical treatment, practical assistance and psychotherapeutic support. Runs training for health professionals, including training on writing medico-legal reports.

Men's Health Forum

Tel: 020 7388 4449

www.menshealthforum.org.uk (for health professionals)

www.malehealth.co.uk (for the general public)

Information about the key health problems that affect boys and men in England and Wales.

**Migrant Helpline**

Tel: 01304 203977

Email: info@migranthehelpline.org

www.migranthehelpline.org.uk

Provides a comprehensive and wide-ranging reception and advice service to asylum seekers and refugees.

Multi-faith Group for Healthcare Chaplaincy

Tel: 020 7898 1892

Email: chief.officer@mfghc.com

www.mfghc.com

Seeks to advance multi-faith healthcare chaplaincy in England and Wales. The website has links to faith websites and other resources.

Multikulti

www.multikulti.org.uk

Information, advice, guidance and learning materials in English and community languages, plus a database of over 13,000 agencies in the UK.

Multilingual Family in the UK

www.multilingualfamily.co.uk

Website that links up families who speak the same language.

National African HIV Prevention Programme (NAHIP)

Tel: 020 7017 8910

Email: info@nahip.org.uk

www.nahip.org.uk

The national programme of HIV prevention initiatives targeting Africans in England.

National Aids Trust

Tel: 020 7814 6767

Email: info@nat.org.uk

www.nat.org.uk

Has published reports and policies relating to refugees and asylum seekers.

National Children's Bureau (NCB)

Tel: 020 7843 6000

www.ncb.org.uk

An umbrella body for organisations working with children and young people in England and Northern Ireland. Has developed The Asylum Seeking and Refugee Children: Developing Good Practice Project website.

Naz Project London

Tel: 020 8741 1879

Email: npl@naz.org.uk



www.naz.org.uk

Provides sexual health and HIV prevention and support services to targeted black and minority ethnic communities in London.

Network of Sex Work Projects

Tel: 00 55 21 2522 5944

Email: secretariat@nswp.org

www.nswp.org

An international organisation set up to promote sex workers' health and human rights. Based in Brazil.

Newcastle Interpreting Service

Tel: 0191 256 3210

www.newcastlepct.nhs.uk

Has developed a sexual health training course for interpreters, accredited by the Open College Network, plus materials.

NHS Direct

Tel: 0845 46 47 (England and Wales)

Tel: 08454 24 24 24 (Scotland NHS 24)

www.nhsdirect.nhs.uk.

Provides general health information and details of all sexual health services including general practices and pharmacies.

No Recourse to Public Funds (NRPF) Network

www.islington.gov.uk

Concerned with the statutory response to those destitute people from abroad who have to no recourse to public funds.

NORM-UK

Tel: 01785 814044

Email: info@norm-uk.org

www.norm-uk.org

Promotes education around circumcision and other forms of surgical alteration of the genitals.

North East London Consortium for Research and Development

Tel: 020 8223 8741/8086

www.nelcrad.nhs.uk

The Support Unit for Minority Ethnic Health Research provides a practical, facilitative role for researchers and ethnic minority populations involved in health research.

Northern Ireland Council for Ethnic Minorities (NICEM)

Tel: 028 9023 8645

Email: info@nicem.org.uk



www.nicem.org.uk

Provides services and support to ethnic minorities living and working in Northern Ireland.

Parenting UK

Tel: 020 7284 8370

www.parentinguk.org

The national umbrella organisation for those who work in parenting.

Positively Women

Tel: 020 7713 0222

Email: info@positivelywomen.org.uk

www.positivelywomen.org.uk

Provides support for women living with HIV by women living with HIV.

Rape and Sexual Abuse Support Centre

Tel: 0845 122 1331 helpline

Tel: 020 8683 3311 counselling

www.rasasc.org.uk

Support for anyone who has been raped or sexually abused.

Refugee Action

Tel: 020 7654 7700

www.refugee-action.org.uk

Works with refugees to build new lives in the UK. Particularly experienced in reception, resettlement, development and integration.

Refugee Council

Tel: 020 7346 6700

Email: info@refugeecouncil.org.uk

www.refugeecouncil.org.uk

Works with asylum seekers and refugees giving direct help and support and ensures their needs and concerns are addressed.

Refugee Health Network

Tel: 020 7324 4739

Email: info@medact.org

www.medact.org

UK-based charity taking action on key global health issues.

Refugee Women's Association

Tel: 020 7923 2412

Email: rwa@refugeewomen.org.uk

www.refugeewomen.org.uk

Provides a range of services for refugee women in London, and offers capacity building support and training to refugee women's groups around the UK.



Refugee Women's Legal Group

Email: info@rwlg.org

www.rwlg.org

Provides practitioners and others working with refugee women access to appropriate sources of information and support to assist in the presentation of individual cases.

Rights of Women

Tel: 020 7241 6575/6

www.rightsofwomen.org.uk

A women's voluntary organisation committed to informing, education and empowering women concerning their legal rights.

Royal College of Midwives

Tel: 020 7312 3535

Email: info@rcm.org.uk

www.rcm.org.uk

The professional organisation for midwives. Can give information and guidance relating to female genital mutilation and on providing maternity services to refugees and asylum seekers.

www.ruthinking.co.uk

Sex and relationships website aimed at young people.

Safra Project

Email: info@safraproject.org

www.safraproject.org

A resource project on issues relating to lesbian, bisexual and/or transgender women who identify as Muslim.

Save the Children

Tel: 020 7012 6400

www.savethechildren.org.uk

Campaigns for children who experience poverty, disease, injustice and violence, including working with young asylum seekers and refugees in the UK.

Scottish Refugee Council

Tel: 0141 248 9799

www.scottishrefugeecouncil.org.uk

Offers advice, information and assistance to asylum seekers and refugees in Scotland.

Sexual Health Line

Tel: 0800 567 123

Textphone: 0800 521 361

www.condomessentialwear.co.uk



A free, confidential 24-hour helpline for information on sexual health. The service also has access to Language Line for callers who do not speak English.

Sexwise

Tel: 0800 28 29 30

Sex and relationships helpline for young people under 18.

Sigma Research

Tel: 020 7820 8022

Email: admin@sigmaresearch.org.uk

www.sigmaresearch.org.uk

A social research group specialising in the behavioural and policy aspects of HIV and sexual health.

The Society of Sexual Health Advisers

Email: info@ssha.info

www.ssha.info

A professional organisation for sexual health workers.

Southall Black Sisters

Tel: 020 8571 9595

Email: southallblacksisters@btconnect.com

www.southallblacksisters.org.uk

Aims to meet the needs of black (Asian and African-Caribbean) women by highlighting and challenging violence against women.

Survivors Trust

Tel: 01788 551154

www.thesurvivorstrust.org

A national umbrella agency for specialist voluntary sector services working with survivors of rape, sexual violence and childhood sexual abuse.

Sussex Interpreting Services

Tel: 01273 702005

Email: info@sussexinterpreting.org.uk

www.sussexinterpreting.org.uk

A community interpreting and translation service with guidelines and a checklist on working with interpreters.

SW5

Tel: 020 7370 0406

Email: web@sw5.info

www.sw5.info

Offers information and support for male and transgender sex workers.



TAMPEP (European Network for HIV/STI Prevention and Health Promotion Among Migrant Sex Workers)

www.tampep.com

Tel: 0031 20 692 69 12

Email: info@tampep.eu

An international networking and intervention project operating in Europe. Based in Amsterdam.

tandem

Tel: 0113 266 9123

Email: ruth.wilson@tandem-uk.com

www.tandem-uk.com

Carries out social research and other consultancy work. Partner organisation in the Refugees and Asylum Seekers' Sexual Health Project.

Terrence Higgins Trust

Tel: 0845 122 1200

Email: info@tht.org.uk

www.tht.org.uk

Aims to reduce the spread of HIV and STIs and promote good sexual health.

UK Lesbian and Gay Immigration Group

Tel: 020 7620 6010

Email: admin@uklgig.org.uk

www.uklgig.org.uk

Information and advice on immigration rights for same sex couples and asylum seekers.

UK Network of Sex Work Projects (UKNSWP)

Tel: 0161 953 4051

Email: info@uknswp.org.uk

www.uknswp.org

Promotes the health, safety, civil and human rights of sex workers in the UK.

UNHCR

Tel: 00 41 22 739 8111

www.unhcr.ch

The UN refugee agency. Based in Switzerland.

UNICEF

www.unicef.org

Information on the Convention on the Rights of the Child.

**United Kingdom Human Trafficking Centre**

Tel: 0114 252 3891

Email: info@ukhtc.org

www.ukhtc.org

Works to ensure the police and partner agencies maintain a joined up and strategic approach to tackling human trafficking in all its forms.

United Nations Development Fund for Women (UNIFEM)

Tel: 00 1 212 906 6400

www.unifem.org

The women's fund at the United Nations. It provides financial and technical assistance to foster women's empowerment and gender equality. Based in New York.

Welsh Refugee Council

Tel: 029 2048 9800

Email: info@welshrefugeecouncil.org

www.welshrefugeecouncil.org

Provides advice, support, casework and advocacy for asylum seekers and refugees.

www.whrnet.org/fundamentalisms

A resource for women's human rights, focusing on identifying the international dynamics of fundamentalism.

Women Against Rape

Tel: 020 7482 2496

Email: war@womenagainstrape.net

www.womenagainstrape.net

Campaigns with the Black Women's Rape Action Project against rape, domestic violence, racist sexual assault, and provides information on seeking asylum after rape.

Women's Aid

Helpline: 0808 2000 247

Email: info@womensaid.org.uk

www.womensaid.org.uk

Working to end domestic violence against women and children.

Workers Education Association

Tel: 020 7426 3450

www.wea.org.uk

Runs a variety of courses throughout the UK, including a Community Interpreting Project.

Working With Men

Tel: 020 7237 5333

Email: info@workingwithmen.org

www.workingwithmen.org



Supports work that benefits the development of men and boys and raises awareness of issues impacting upon them.

World Health Organization (WHO)

www.who.int

Tel: 0041 22 791 21 11

Email: inf@who.int

The United Nations specialised agency for health. Provides information about sexual health worldwide.

www.yourrights.org.uk

The Liberty guide to the Human Rights Act 1998.



ABOUT THE AUTHORS

Ruth Wilson has more than 15 year's experience of working in the voluntary and public sectors, and has worked on refugee issues throughout that period. She is director of tandem communications and research, providing project management, social research, events, writing and editorial services to a range of public and voluntary sector organisations. She runs the Volunteering and Asylum Project, which promotes UK-wide good practice in volunteer management. In addition to working with refugees, Ruth has worked with clients on issues such as health promotion, drug use, community safety, domestic violence and teenage pregnancy.

Marsha Sanders has worked for many years in the field of language support services and advocacy, carrying out research, development and project management. She works in the voluntary sector and in health and local government in the UK, and as far afield as South Africa.

Marsha's publications include *As good as your word . . . a guide to community interpreting and translation in public services* (Maternity Alliance, 2000).

Hildegard Dumper began her career in youth and community development. She has worked in the refugee sector for the past 17 years, developing policy and helping projects that enable refugees to take part in the public life of the UK, such as Action for Refugee Women. In 1986 she helped establish the Refugee Women's Legal Group. She currently works freelance in the UK, European Union and Eastern Europe, offering expertise on capacity building, project management and evaluation, and social research.



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Sexual health, asylum seekers and refugees

A handbook for people working with refugees and asylum seekers in England

Ruth Wilson with Marsha Sanders and Hildegard Dumper

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