Asylum Seekers and Refugees Sexual Health Needs Assessment

NHS Bolton

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ABBREVIATIONS

AIDS Acquired Immune Deficiency Virus
DOH Department of Health
FGM Female Genital Mutilation
HIV Human Immunodeficiency Virus
HPA Health Protection Agency
NASS National Asylum Support Service
PTSD Post Traumatic Stress Disorder
STI Sexually Transmitted Infection
UKBA United Kingdom Borders Agency
UNHCR United Nations Commission for Refugees
WHO World Health Organisation
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Introduction

The aims of this needs assessment is to gain an understanding of the sexual health needs of asylum and refugees living in Bolton in order to establish if the current provision of sexual health services meet the needs of this vulnerable population and identify gaps in services. The findings may be used for monitoring, planning, interventions and can also inform commissioning and service design that will enable asylum seekers and refugees to access services to achieve positive sexual health and wellbeing.

Objectives:

- To explore what is known about asylum seekers and refugees living in Bolton
- To examine the issues that affect the sexual health of asylum seekers and refugees
- To evaluate the local sexual health services that can address the sexual health needs of asylum seekers and refugees.
- To look at how asylum seekers and refugees access these services through consultation with service providers and service users.
- To establish the barriers to asylum seekers and refugees accessing these services
- To identify gaps in the service
- To make recommendations to improve services

In order to understand and address the sexual health needs it is vital that there is an awareness of the external forces that influence health. Whilst the focus of this health needs assessment is on sexual health, there are numerous factors that combine to make asylum seekers and refugees more vulnerable to poor health in general. This combination of factors can ultimately have a significant impact on sexual health both directly and/or indirectly. These include:

- Experience of persecution, oppression and flight
- Inadequate health care in the country of origin
- Insecurity, poverty and powerlessness in the UK
- Loss of community and loneliness
Language barriers, culture (Wilson, Sanders, Dumper, 2007)

Asylum seekers and refugees are not a homogenous group but one that is diverse in its configuration comprising a population differentiated by culture, religion, beliefs and social norms. Consequently, their social, economic and health needs cannot be addressed with a generic approach but should be considered within the context of an individualized, holistic model of care and service provision.

Sexual health covers a broad range of issues including sexually transmitted infections (STIs), HIV/AIDS, contraception, unintended pregnancy, sexual dysfunction, sexuality, psychological concerns related to sexual assault, exploitation, violence, rape, female genital mutilation and abuse. Furthermore, there are medical conditions including mental health problems, acute and chronic illnesses that can impact on sexual health. Socioeconomic and environmental factors along with ethnic and cultural background will influence the sexual health of communities. Therefore providing an holistic approach to those who access sexual healthcare can enable the professional to identify risks and needs. Wider identification of the full range of sexual health needs of asylum seekers and refugees along with the capacity to meet those needs can help not only to reduce the prevalence of STIs and unwanted pregnancies but also ensure sexual health wellbeing.

**National and Local Overview**

The National Strategy for Sexual Health and HIV (Department of Health, 2001) illustrated a strategic approach to the maintenance of sexual health and HIV by setting out its aims to:

- Reduce the transmission of HIV and STIs
- Reduce the prevalence of undiagnosed HIV and STIs
- Reduce unintended pregnancy
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STIs

The new public health white paper ‘Healthy Lives, Healthy People: Our Strategy for public health England (DoH 2010) identifies that sexual health services will be part of the
ring-fenced budget for Public Health England. With regards to marginalized groups, it highlights health inequalities amongst those with poor socio-economic status and reports the intention to develop targeted interventions for particular groups, taking account of their specific needs and motivations.

At a local level, tackling health inequalities is at the centre of the Bolton Local Area Agreement and the Local Strategic Partnership. This sexual health needs assessment aims to:

- Address social inclusion and reduce health inequalities
- Reduce the number of STIs including HIV/AIDS
- Achieve national and local targets
- Improve sexual health services for asylum seekers and refugees.

**Methodology**

This sexual health needs assessment is based on evidence gathered through an in-depth systematic review of existing literature relating to the sexual health of asylum seekers and refugees that includes research into academic journals, government reports, international and non-governmental organizations. A qualitative approach was used including questionnaires, published and unpublished literature, meetings with representatives from voluntary agencies and statutory agencies, informal interviews, existing reports, surveys and demographic data analysis. A mapping exercise was undertaken to confirm the location and provision of sexual health services in Bolton.
**Background**

Global migration is at its highest levels and is increasing worldwide. Asylum seekers and refugees can be distinguished from other migrants because of their lack of choice where most have left their country to pursue a safer and better quality of life. Some may have suffered persecution because of their religious or political beliefs and activities, others because of their ethnicity, their gender or sexual orientation. Many have fled to escape imprisonment, torture and in some cases, death. Some may be victims of sexual violence including sexual torture, rape or female genital mutilation. There are women who are pregnant as a result of rape and some may be infected with HIV, AIDS or other STIs. There are men and women who employ risk taking behaviours or may be susceptible to sexual exploitation. People have been separated not only from their countries of birth that can lead to cultural bereavement, but also from their families leading to loneliness, fear and isolation.

The United Kingdom has seen a rise in the number of asylum seekers and refugees living in the country and for many there are events and factors that have a huge impact on their sexual health. The migration process itself can lead to poverty, unemployment, poor housing and uncertainty of refugee status and often these factors will override sexual health needs. Furthermore, many are entering the country with a complexity of health related problems such as physical trauma, mental trauma, endemic disease and malnutrition. If not adequately addressed, the health implications of asylum seekers and refugees will have serious ramifications on the group itself and also the indigenous population.

**Definition**

According to the United Nations a refugee can be described as:

‘*a person who has a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion, who is outside their country of nationality (or habitual residence if no nationality) and who is unable or unwilling to avail him/herself of the protection of that country*’ (United Nations Convention, 1951).
An asylum seeker has been described as:

‘a person who has claimed protection in a host country that is signatory to the UN Convention and is awaiting a decision by the authorities of that country as to whether his or her case fits with the above definition’ (Le Feuvre, Montgomery, 2001).

Asylum seekers, whilst not having the right to stay in the UK, claim refugee status on arrival and begin a bureaucratic process that can take many months or years to complete.

Data relating to the geographical distribution of asylum seekers and refugees for local areas is in the main, not available. Statistics on the location of asylum seekers in the UK are linked to available information of the support that he/she receives therefore the location of those not receiving support may be unknown. Those asylum seekers who are granted refugee status become ‘free’ as the general population and so cease to exist as a special category and then become invisible to policy makers that can have major implications for health policy.

**Gateway Protection Programme**

In partnership with the UN Commission for Refugees (UNHCR), in April 2003 the Home Office launched the Gateway Protection Programme to create a legal pathway for refugees to enter the UK. These refugees are identified and assessed by UNHCR as being extremely vulnerable, in need of permanent resettlement and protection. The programme focuses on those refugees considered most at risk and are offered indefinite leave to remain. They are assisted to integrate into the UK society through the provision of locally based coordinated support packages.
Issues Affecting the Sexual Health of Asylum Seekers and Refugees

The World Health Organisation (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.’ (http://www.who.int/topics/sexual_health/en/ accessed October 2010).

The main sexual health issues affecting asylum seekers and refugees are:

- Suffering the consequences of sexual violence, torture rape
- Being pregnant as a result of rape
- Suffering the consequences of female genital mutilation (FGM)
- Suffering from HIV/AIDS
- Fleeing persecution because of sexual orientation and fear of prejudice and harassment in the UK
- Being involved with the sex industry
- Being at risk of sexual exploitation
- Risk taking behaviours

(Wilson et al, 2007)

Many asylum seeker and refugee women have experienced assault, sexual abuse and rape as forms of persecution that not only cause physical health problems but often lead to psychological trauma including anxiety, depression, post traumatic distress disorder (PTSD) and sleep problems that will impact on their sexual health. Women from refugee settings can experience higher maternal mortality and morbidity as a result of poor nutrition and repeated frequent pregnancies, increased and often unsafe sexual activity
which can result in an increase in HIV/AIDS and STIs. Rape is sometimes used as a tool for coercion or humiliation.

**Female Genital Mutilation**

There are many women who suffer the consequences of FGM. The World Health Organisation classifies FGM into 4 types:

Types of female genital mutilation

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Excision of the prepuce (covering the clitoris), with or without excision of all or part of the clitoris</td>
</tr>
<tr>
<td>Type 2</td>
<td>Excision of the clitoris and part or full excision of the labia minora (Sunna)</td>
</tr>
<tr>
<td>Type 3</td>
<td>Partial or total excision of the external genitalia with closure or narrowing of the introitus, possibly down to a pinhole, leaving smooth tissue (infibulation or pharonic circumcision)</td>
</tr>
<tr>
<td>Type 4</td>
<td>Includes pricking piercing, scraping cauterizing the genitalia or vagina/vaginal (gishiri) cuts or insertion of caustic substances to narrow and dry the vagina, stretching the labia</td>
</tr>
</tbody>
</table>


In countries where FGM is practiced, it is often performed under non-sterile conditions in the absence of analgesia or anaesthesia. The instruments used may be shards of glass, bamboo slithers, razor blades or knives that have not been sterilized. The consequences of FGM are listed in the following table:
Consequences of Female Genital Mutilation

<table>
<thead>
<tr>
<th>Immediate</th>
<th>Intermediate</th>
<th>Long-term</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Shock from haemorrhage &amp; pain</td>
<td>• Ulceration, abscess</td>
<td>• Epidermal cysts, neuromata</td>
</tr>
<tr>
<td>• Trauma to surrounding tissues e.g. fistula</td>
<td>• Pelvic infection</td>
<td>• Recurrent urinary tract infection &amp; renal damage</td>
</tr>
<tr>
<td>• Urinary retention</td>
<td>• Poor urinary flow</td>
<td>• HIV from traumatic intercourse</td>
</tr>
<tr>
<td>• Wound infection, septicaemia, tetanus (also HIV from infected instruments</td>
<td>• Bacteria or urinary tract infection</td>
<td>• Chronic genital tract infection, pelvic inflammatory disease, infertility</td>
</tr>
<tr>
<td>• Death</td>
<td>• Scarring (may be keloid &amp; tough), dysmenorrhoea &amp; haematomcolpus from obstructed menstrual flow</td>
<td>• Dyspareunia &amp; pelvic pain, lack of sexual sensation, marital conflict</td>
</tr>
<tr>
<td></td>
<td>• Emotional disturbances &amp; behavioural problems in children</td>
<td>• Prolonged &amp; obstructed labour, fetal hypoxia &amp; stillbirth, maternal death, vaginal fistulae</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vaginal &amp; perineal trauma during childbirth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Post Traumatic Stress Disorder, depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Behavioural difficulties in children</td>
</tr>
</tbody>
</table>


Sexual Violence including Torture and Rape

The estimates of asylum seekers and refugees who are victims of torture vary from 5-30% depending on the definition of torture used in their country of origin. It is suggested that the number of people seeking asylum in the UK who are victims of torture is much higher than reported because many do not admit to their experiences owing to shame or unwillingness to disclose the information. Both female and male asylum seekers and refugees may be victims of sexual violence. The techniques used in sexual violation include electric shocks applied to the genital area; forced abduction of hip joints that can sometimes necessitate reconstructive surgery; burning or beating of the genitals; high
power jets directed at the vagina; being forced to watch other including children being abused or raped; forced oral sex or masturbation. Men may have objects forced into their urethral meatus leading to scarring and thickening that can result in dysuria and sexual dysfunction. Rape of both women and men is known to be widespread within some countries where there is political unrest and often takes place within those centres where refugees await transportation to the countries that have granted them refugee status. These acts of violence can lead to physical harm, reproductive trauma, STIs, unwanted pregnancies and psychological trauma including PTSD. There is also the increased risk of HIV. Both men and women experience sexual difficulties and deep shame owing to the social stigma associated with HIV and rape.

**Sexually Transmitted Infections and HIV/AIDS**

Many asylum seekers and refugees originate from the sub-African continent where the prevalence of HIV/AIDS, tuberculosis and Hepatitis B is high. There has also been a rapid rise of syphilis diagnoses in Eastern Europe from where some asylum seekers and refugees migrate. Asylum seekers and refugees as a marginalized group within the UK are considered to be at higher risk of HIV and STIs owing to their past experiences and also risk taking behaviour that includes unprotected sex.

The Health Protection Agency (HPA) lists the five main STIs within the UK in 2010 as genital chlamydia, gonorrhoea, syphilis, genital herpes and genital warts. The rates of STI diagnoses are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Per 1000,000 population, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia (under 25 yrs)</td>
<td>2,883.5</td>
</tr>
<tr>
<td>Chlamydia (Over 25 yrs)</td>
<td>101.9</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>15.2</td>
</tr>
<tr>
<td>Syphilis</td>
<td>4.9</td>
</tr>
<tr>
<td>Herpes</td>
<td>55.2</td>
</tr>
<tr>
<td>Genital warts</td>
<td>159.8</td>
</tr>
<tr>
<td>Acute STIs</td>
<td>797.6</td>
</tr>
</tbody>
</table>
Per 1000,000 population, 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia (under 25 yrs)</td>
<td>3,012.6</td>
<td>(+1.29.1)</td>
</tr>
<tr>
<td>Chlamydia (Over 25 yrs)</td>
<td>89.9</td>
<td>(-12.0)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>28.3</td>
<td>(+13.0)</td>
</tr>
<tr>
<td>Syphilis</td>
<td>3.4</td>
<td>(-1.5)</td>
</tr>
<tr>
<td>Herpes</td>
<td>57.0</td>
<td>(+1.8)</td>
</tr>
<tr>
<td>Genital warts</td>
<td>149.0</td>
<td>(-10.8)</td>
</tr>
<tr>
<td>Acute STIs</td>
<td>782.3</td>
<td>(-15.3)</td>
</tr>
</tbody>
</table>

(Health Protection Agency, 2011)

It is reported that black African and black Caribbean communities in the UK are disproportionately diagnosed with STIs.

According to the Health Protection Agency (March 2011), new diagnoses for people infected with HIV in the UK almost doubled over the past decade. The number of people living with HIV in the UK reached an estimated 86,500. A quarter of these people were unaware of their infection. (HIV in the United Kingdom 2010 Report).
**Estimated number of adults (15-59 years) living with HIV (both diagnosed and undiagnosed) in the UK: 2009**

- **Diagnosed**
- **Undiagnosed**
- **Credible interval**

Total (15-59 yrs) = 80,800 (76,500-85,800)
Total (All ages) = estimated 86,500

**Diagnosed HIV-infected individuals seen for care by ethnicity*, UK: 2000 and 2009, UK**

- **White**
- **Black Caribbean**
- **Black African**
- **Asian/Oriental**
- **Other/mixed**

*Excludes individuals with ethnicity not reported: 1,416 in 2000 and 934 in 2009

Annual survey of HIV-infected persons accessing care

HIV and STI Department - Centre for Infections
Late diagnosis has a detrimental affect on the outcomes of people living with HIV and it is reported that asylum seekers in particular present late for testing. Currently, whilst their application for asylum is being processed, asylum seekers have access to HIV care however, HIV treatment must be paid for by failed asylum seekers which may act as a deterrent for testing. This has major consequences from a public health perspective because not only will there be a proportion of the population who are undiagnosed, there is the risk of onward transmission to the host society, particularly as heterosexual sex is the highest route of infection amongst this group and evidence identifies that many asylum seekers and refugees have unprotected sex. The Centre for Public Health at John Moores University collates data relating to the number of new and all cases of HIVAIDS within each PCT across the north west of England categorized by infection route, age, ethnicity and residency status that includes asylum seekers and refugee.

Whilst Hepatitis C is a global public health issue with approximately 3% of the world’s population infected (Department of Health, 2002) the UK is considered to be a low prevalence country. However, there are groups more at risk of being infected that include asylum seekers and refugees. Even though, within the UK the disease is mainly transmitted through injecting drug users, sexual transmission is a less common route but cannot be ignored. This is also the case for Hepatitis B although sexual transmission is more common than it is with Hepatitis C.
Men
Male asylum seekers and refugees may experience difficulties including:

- Loss of self esteem
- Lack of awareness of social norms within the UK around dating and behaviour towards women
- Lack of knowledge around the law
- Relationship and family difficulties
- Risk taking behaviour including the use of the sex industry
- Involvement in sex trafficking or selling sex to survive
- Reluctance to use condoms
- Reluctance to discuss or seek help for sexual health issues
- Undiagnosed STIs including HIV
- Lack of knowledge around HIV, STIs, testicular or prostate cancer
- Domestic violence
- Consequence of sexual violence and male rape
- Issues around partner being raped
- Issues around sexual orientation and gender identity

Sexual Orientation
Asylum seekers and refugees who are lesbian, gay, bisexual and transsexual often hide their sexuality, particularly as in their country of origin it may be prohibited. Many fear persecution and prejudice. Often they have little knowledge about the UK law and fear their asylum application may be jeopardized. According to the International Lesbian and Gay Foundation, 85 countries criminalize consensual same sex acts amongst adults in 2007. Not all of the countries systematically enforce these laws, however, it still remains that within these countries, it is illegal. There are more countries that outlaw gay male sex rather than lesbian sex. This list was updated on 25/09/09 where eight countries were removed from the list and one, Burundi, was added.
Local Demographics

The estimated population for Bolton is 265,100. It is a geographical area in which deprivation is prevalent and is in the top 50 most deprived districts in England. The borough also has a high ethnic minority rate with the majority living in the most deprived areas. In 2007 there were approximately 750 asylum seekers living in Bolton many of whom were housed in areas with higher concentrations of ethnic minorities. It was also estimated that there were approximately 500 failed asylum seekers living in the town. During the same period there were approximately 200 refugees who arrived in Bolton through the Home Office Gateway Protection Programme. Since then, Bolton has seen the arrival of more asylum seekers and refugees summarised by the tables below although these are approximate estimation only as exact figures for both groups are not known. It is difficult to ascertain the exact number of refugees living in Bolton or where they are registered because when granted refugee status they are free to move where they choose and are difficult to track.
Local Services

This map overlays selected sexual health services, service providers specifically for asylum seekers, refugees and other vulnerable groups and sexual health services within education settings.
Sexual Health Services:

- Bolton Centre for Sexual & Reproductive Health Services, Royal Bolton Hospital
- Lever Chambers Walk In centre
- The Parallel
- Family Planning clinics based at: Lever Chambers
  - Pikes Lane Health Centre
  - Farnworth Health Centre
  - Waters Meeting Health Centre

No official data is collated regarding the number of asylum seekers and refugees who access these services. Although there are no official records, anecdotally it is reported that a large number of asylum seekers and refugees access the Lever Chamber Walk-In centre. The Parallel does record ethnicity but only if the client chooses to complete this on the new patient form.

Organisations that provide services to specifically for asylum seekers and refugees and other vulnerable groups

- Bolton Asylum Team
- SSP Health-Bolton General Practice
- Sexual Exploitation Team
- BRASS
- Starting Point

Nurse Drop-In Clinics and Enhanced Drop-In Clinics within Education Settings:

- Bolton University
- Bolton College (Deane and Horwich Campus)
- Bolton Sixth Form College (Deane and Farnworth)
- Rivington and Blackrod High School
- Smithills School
- Kearsley Academy
Services

Bolton Centre for Sexual & Reproductive Health Services, Royal Bolton Hospital

Offers:

Help and Advice
Contraceptive services
Pregnancy Testing
Screening and treatment for STIs
HIV treatment and Management
Sexual dysfunction
Genital skin conditions
Cytology
Colposcopy
Psycho-sexual counselling
Social Worker for HIV/AIDS

A social worker is assigned to the Bolton Centre for Sexual & Reproductive Health Services. Approximately 50% of her referrals are of sub-Saharan African origin of which approximately 70% have asylum issues. This service provides care to people with HIV, their families and carers. Referrals are made to legal services, immigration, AIDS unit, George House Trust, Gregory’s Place and homeless advice. The social worker facilitates accessing grants for those with financial difficulties.

As part of her remit she facilitates the HIV peer support group held on a monthly basis that is funded jointly by NHS Bolton and the local authority. It is reported that a large proportion of those who attend are asylum seekers and refugees.
Family planning clinics
Held at Lever Chambers, Pikes Lane Health Centre, Farnworth Health Centre and Waters Meeting Health Centre. Hold evening sessions and lunchtime sessions.

Lever Chambers Walk in Centre-town centre
This is a nurse led walk-in service providing health advice and treatment for minor illness. It also offers Chlamydia screening.

The Parallel, Young People’s Health Centre- town centre
The Parallel delivers a generic, holistic service targeted at young people from 11 years – 19 years. Whilst the main centre is located in Bolton town centre, it also delivers outreach ‘clinic in the box’ services in a number of locations across the borough and also delivers school nurse drop-in clinics and enhanced school nurse drop-in sessions at some Bolton schools.
The service includes:
Sexual history taking and risk assessment
Generic information for STI prevention and safer sex advice
Screening and testing for STIs
Treatment for Chlamydia
Contraceptive services
Emergency Hormonal Contraception
Pregnancy testing and appropriate onward referral
Pre and post TOP counselling
Referral for antenatal care

Bolton Asylum Team
A specialist nurse for asylum seekers and refugees employed by NHS Bolton (formerly Bolton Primary Care Trust) is part of the Bolton Council Asylum Team that has been formed to support service users in accessing mainstream health services and to raise
awareness among service providers about issues affecting this group. She works in partnership with the charity Refugee Action and Bolton GPs supporting arrivals of refugees through the Gateway Protection Programme. Initially the specialist nurse was involved with the induction process when asylum seekers and refugees were provided with a comprehensive health assessment. Using the personal health record with a sexual health component enabled the nurse to ask questions relating to FGM, STIs and other sexual health problems. It also facilitated discussion around physical violence, sexual assault and rape, witnessing violence and detention. However, since the induction process has changed, a less comprehensive assessment is undertaken. Following this Nurse Assessment the nurse will signpost her clients to the sexual health clinic and contraceptive services if there is a need although she reports that many will not access these services. She also offers Chlamydia screening and provides condoms. Asylum seekers are not routinely screened for HIV however for people from high risk countries and those who have been sexually assaulted or who put themselves at risk, the specialist nurse will discuss HIV and will offer more support in accessing service as required. Adult Gateway refugees are all screened for HIV and syphilis in the refugee camp prior to their entry into the UK as part of the migration health assessment. The specialist nurse reports that often asylum seekers will not attend appointments therefore often she will go out to them.

**GP Practices**

Many asylum seekers and refugees arriving in Bolton are registered with the SSP Health owned GP practice located in Bolton town centre with a special remit to provide services for refugees, asylum seekers and others at risk of exclusion from mainstream services. For other asylum seekers and refugees who arrive in Bolton, their housing officer faxes their details to LASCA who allocate a GP based on their postcode. The GP allocated is not always the one who is closest to their home. In some cases, people have to approach GPs themselves to register. Most GP practices across the borough offer contraceptive services and referrals for sexual health,
SSP Practice
Specifically set up as an enhanced service for vulnerable groups. When patients register, they are offered a comprehensive health assessment that includes sexual health. The practice nurse holds a stock of health information leaflets in different languages and will access the internet if more information is required. She will use the criteria for retaining asylum seekers and refugees on the enhanced service list and make appropriate referrals or signpost the client. She is also familiar with the locally produced guidance for child protection and FGM.

Condom Promotion Scheme
The Bolton Condom Promotion Scheme has numerous sites across the borough where people can access sexual health information, advice and free condoms. These include most health centres, family planning clinics and GP practices, Bolton Asylum Team, Bolton Sexual Exploitation Team, Bolton Lads and Girls Club, school drop-in clinics and many other statutory and voluntary agencies.

Sexual Exploitation Team
The Sexual Exploitation Team comprises specialists from the local authority including social services and NHS Bolton. Many of the clients are vulnerable young people, mainly from deprived areas. Sexual exploitation is an increasing problem within Bolton. As a vulnerable group, the team manager reports that both male and female asylum seekers and refugees are at risk of involvement with sexual exploitation. She explains that males are vulnerable owing to their lack of knowledge around sex and the law when they may become predators or victims of sexual exploitation. The girls as a vulnerable group are even more at risk. Owing to the increasing number of asylum seekers and refugees living in Bolton, there are increasing numbers who are now clients.

Refugee Action
This service is for Gateway refugees only. It uses the empowerment model that is client centred and offers support for the initial eight months of their arrival. With regards to
sexual health, clients are referred to the specialist nurse based with the asylum team or they may be signposted to Bolton Centre for Sexual and Reproductive Health Services based at the Royal Bolton Hospital. Those who are victims of rape and torture are referred to the Medical Foundation for Care of Victims of Torture or St. Mary’s Hospital in Manchester.

**Starting Point**

In response to the Gateway Project the Starting Point Programme was developed and aims to provide a structured, supportive induction programme for children to facilitate effective integration into local early years settings, schools and colleges. Initially asylum seeker and refugee children would attend Starting Point unit for a 7 week programme. A school nurse visited regularly to carry out health checks and also deliver sessions around sex and relationships. This however, was carried out on an informal basis and eventually her services were withdrawn. Currently, a specialist nurse for Pupil Referral Units is assigned to Starting Point but owing to her increasing workload, health checks are undertaken by a health care assistant who will make referrals for a full health assessment if necessary. Sessions around sex and relationships are no longer delivered by the nurse.

**Young People’s Sexual Health Drop-In Clinic – Further Education (FE)**

This service was set up to provide Tier P and 1 integrated sexual health services to reduce teenage conceptions and new cases of STIs. It aims to address the needs of vulnerable young people and those not accessing services including young people from marginalized groups e.g. migrants, asylum seekers, refugees, sex workers, BME communities and travellers. The clinics are provided in four FE colleges across Bolton: Bolton Community College (including Horwich campus), Bolton North Sixth Form College and Bolton South Sixth Form College. The sessions are staffed by a nurse and a Health Promotion Support Worker.

Within this current academic year the nurse and Health Promotion Support Worker have designated some time prior to the main session held at Bolton College specifically for
ESOL students, many of whom are asylum seekers and refugees. A longer period of time has been allocated for each individual health assessment for ESOL students in order that issues including sexual health can be discussed in detail and relevant referrals made. In addition to this, the Health Promotion Support Worker has delivered sessions directly to the students and staff around sexual health. She has also trained staff to deliver sessions to the students.

Young People’s Sexual Health Drop-In Clinic, Bolton University
This service is provided on a weekly basis to provide a health service to Bolton university students with a focus on providing contraceptive services and sexual health screening. It also provides holistic counselling on a range of health issues including smoking cessation and alcohol/substance misuse.
Barriers to Accessing Sexual Health Services

Owing to the lack of data collected, it is difficult to ascertain the uptake of these services by asylum seekers and refugees living within Bolton. Furthermore, whilst undertaking this health needs assessment, efforts were made to engage with this group through various routes in order to gain an understanding of how they view sexual health and sexual health services within Bolton. Following discussion with key people who work with asylum seekers and refugees it was decided to use a simple questionnaire (see appendix 1). The questionnaire or selected questions from the questionnaire were presented in several workshops, drop-in sessions, focus groups and the HIV Peer Support group. Unfortunately, the number of responses was considerably low. However, the findings from this and informal meetings with key contacts and asylum seekers and refugees themselves are replicated in the findings from current research and related studies.

The results of the questionnaire are as follows:
<table>
<thead>
<tr>
<th>Male: 2</th>
<th>Female: 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages: Male-32yrs</td>
<td>Female- 17yrs, 21yrs, 21yrs, 25yrs, 30yrs</td>
</tr>
<tr>
<td>Country of Origin: All respondents were from Somalia</td>
<td></td>
</tr>
<tr>
<td><strong>What are your biggest health concerns?</strong></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>4 female 1 male</td>
</tr>
<tr>
<td>STIs such as Chlamydia, gonorrhoea, syphilis?</td>
<td>3 female 1 male</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>2 female 1 male</td>
</tr>
<tr>
<td>Contraception</td>
<td>3 female</td>
</tr>
<tr>
<td>Rape</td>
<td>2 female</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>4 female</td>
</tr>
<tr>
<td><strong>Do you know where to get information about contraception?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: 5 female 1 male</td>
<td>No: none</td>
</tr>
<tr>
<td><strong>Do you know what types of contraception are available?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: 4 female</td>
<td>No: 1 female 1 male</td>
</tr>
<tr>
<td><strong>Do you know where to get information about sexually transmitted infections?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: 4 female</td>
<td>No: 1 female 1 male</td>
</tr>
<tr>
<td><strong>Do you know where the nearest sexual health clinic is?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: none</td>
<td>No: 5 female 1 male</td>
</tr>
<tr>
<td><strong>Do you have problems accessing sexual health services?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: 1 female 1 male</td>
<td>No: 4 female</td>
</tr>
<tr>
<td><strong>If so, is it because:</strong></td>
<td></td>
</tr>
<tr>
<td>You don’t know where to go?</td>
<td>2 female 1 male</td>
</tr>
<tr>
<td>Language barrier?</td>
<td>none</td>
</tr>
<tr>
<td>You’re embarrassed?</td>
<td>1 female</td>
</tr>
<tr>
<td>Frightened?</td>
<td>1 female</td>
</tr>
<tr>
<td>Staff may be of the opposite sex?</td>
<td>1 female</td>
</tr>
<tr>
<td>Fear of breach of confidentiality?</td>
<td>none</td>
</tr>
<tr>
<td>Other?</td>
<td>none</td>
</tr>
<tr>
<td><strong>Have you ever had bad experiences with sexual health services?</strong></td>
<td></td>
</tr>
<tr>
<td>Yes: none</td>
<td>No: 5 female 1 male</td>
</tr>
<tr>
<td><strong>Where would you like to get sexual advice or help?</strong></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>5 female 1 male</td>
</tr>
<tr>
<td>Sexual health clinic</td>
<td>1 female</td>
</tr>
<tr>
<td>Family planning clinic</td>
<td>1 male</td>
</tr>
<tr>
<td>Community centre</td>
<td>3 female</td>
</tr>
<tr>
<td><strong>Any other comments?</strong></td>
<td>none</td>
</tr>
</tbody>
</table>
All the respondents were from Somalia therefore the results are not a true representation of all asylum seekers and refugees living in Bolton owing to the diversity of ethnic origins and cultures. Nevertheless, they provide an indication of the views held by some and reflect those of other studies undertaken with asylum seekers and refugees from a wide range of ethnic origins.

Only one black African male who is a member of the HIV Peer Support group responded to the questions around sexual health detailed below:

**Did you have a problem accessing sexual health services? If yes, is it because:**

I did not have a problem accessing sexual health services, but was hesitant, as I felt I would be judged. However that wasn’t the situation.

**Have you had good experiences with sexual health services?**

I had a very good experience with sexual health services. I was treated with great respect.

**If you’ve had bad experiences, in what way were they bad?**

The only bad experience I had was my initial diagnosis of HIV. The lady doctor gave me the diagnosis, was very clinical, cold and heartless. Not arrogant or rude, but just very methodical. She gave me the diagnosis and left the room.

**Where would you like to access sexual health advice or help? GP, sexual health clinic, charitable advice centre or other?**

I think the best place to access sexual health is a dedicated sexual health clinic. They are the experts. Your GP is just the general practitioner. He or she is not a sexual health specialist. The other issue is your privacy. Not everyone would wish their GP to know this side of their health, or indeed the people within that surgery.

Refugee women from WISP (Women’s Integration & Support Project) based at the British Red Cross in Bolton report that they do not know where sexual health services are
located. They have also requested information around contraception choices and STIs. The Sexual Health Training Pool Co-coordinator has delivered ad-hoc sessions around these topics at the centre that were very well received.

In 2010 NHS Bolton, the Bolton Solidarity Association and Refugee Action organised a workshop to enable women from communities where FGM is practiced to share their views, experiences and opinions on FGM (see appendix 2). The majority of women who attended the workshop requested group sessions for different groups such as men/boys and different generations. They also requested an FGM clinic in Bolton.

The main barriers identified in current research and from studies are as follows:

**Language**

Whilst the concern around language was not indicated as a problem for those who responded to the questionnaire, it is the most commonly cited barrier identified in other studies that highlight that many interpreters have different skill levels and vary in their style of working. Often, interpreters are unavailable and when they are, it is difficult for refugees to explain complex health problems. Language difficulties are exacerbated when psychological and emotional problems can only be explored verbally. Furthermore, sexual health issues are challenging for interpreters owing to the sensitive subject matter and also because many languages lack the appropriate vocabulary. For some, the translated words may be insulting or embarrassing to the interpreter and/or client. In addition, the interpreter may have personal values around sexual behaviour which may influence their interpretation. In Bolton, the interpretation and translation service used currently incorporates face to face and telephone interpretation (see appendix 3). The use of family members is discouraged owing to confidentiality issues. However some researchers stress that there are people who prefer to use family and friends because they mistrust the professional interpreters.
Fear and embarrassment.

Fear is described as a major barrier to accessing sexual health services. This can include fear of deportation where asylum seekers may withhold their HIV status because they are afraid it will impact their asylum claim. Fear of stigmatisation, discrimination and being ostracised are also barriers that have been reported particularly in relation to HIV where some report being rejected by their family and communities. Some people who are victims of sexual violence and rape fear scandal, shame and divorce which may prevent them from disclosure. One respondent to the local questionnaire reported embarrassment as a barrier to accessing services particularly as staff may be of the opposite sex.

Knowledge

Lack of knowledge around a range of sexual health issues has been reported as another barrier, particularly HIV, STIs and contraception. This has been substantiated in research with asylum seeker and refugee focus groups where many admit little understanding of STIs including HIV. A recent study by Pasante of the African population living in the UK highlighted the reasons for not using condoms as:

- Religious background
- Being seen as promiscuous
- Underestimation of risk
- Cultural expectations – sex is seen as enjoyment for procreation
- Social status

Out of the six respondents to the local questionnaire used to inform the sexual health needs assessment, two did not know the choices in contraception and two did not know where to access information about STIs. All six of the respondents did not know where the nearest sexual health clinic is located

Health Professionals

As highlighted by the comments made by the member of the HIV Peer Support group, negative attitudes will have a detrimental effect on those who access sexual health
services. A lack of cultural awareness can compound the problem when health professionals are advising and treating asylum seekers and refugees.

**Priority**

For many, sexual health is not a priority when faced with poverty, unemployment, sub-standard housing, isolation and uncertainty around immigration status. This was demonstrated during informal discussion at focus groups and at one to one meetings when individuals explained that for them, sexual health was not considered to be a priority and they did not feel the need to access the services.
**Gap Analysis**

Meetings were held with the specialist nurses, practice nurse, representatives of the Sexual Exploitation Team, Refugee, Befriending Refugees and Asylum seekers, Starting Point, Women’s Integration Support Project, HIV Social Worker, HIV Peer Support Group facilitator and the Bolton Solidarity Community Association. Anecdotal evidence was provided that identified a number of concerns and gaps in service provision.

**Resources**

There are a lack of resources including sexual health information leaflets and posters in relevant languages.

**Cultural and Sexual Health Awareness**

Cultural issues are identified as a concern, particularly amongst young men who enter the country with very little sexual experience and find the UK more overt towards sexual behaviour with greater freedom than within their country of origin. Their lack of cultural awareness leads to risk taking behaviour such as unprotected sex and the risk of STIs including HIV/AIDS. It is reported that many male asylum seekers and refugees are also unaware of the legal implications surrounding underage sex, particularly as the age of consent differs in other countries. Many women who attend sessions delivered by WISP based at the British Red Cross are unaware of issues around contraception, STIs and location of sexual health services. The coordinator for WISP identifies a need for regular sessions around sexual health in order to empower these women who are often isolated by language, education and culture.

**Sexual Orientation**

Men are reluctant to admit to being gay owing to their cultural beliefs and fear of being ostracized. They are unaware of the difference in cultural values, the law and the services available for lesbian, gay, bisexual and transsexual people. As a consequence, many men within this population fail to access these services.
Sex and relationship education (SRE)
SRE is particularly important for children who are asylum seekers and refugees because many have little or no knowledge of puberty, delaying sex, contraception and other sexual health issues. SRE sessions are no longer delivered at Starting Point. The specialist nurse reports a lack of resources, funding and communication as factors that impede adequate service provision. More recently the length of the induction programme has been reduced to five to ten days which further hinder the opportunity to address sexual health issues for young people within this setting.

Sexual Exploitation
Girls in particular are a vulnerable target for sexual exploitation, however, young male asylum seekers and refugees are also at risk of being coerced into becoming predators. Many young people who are asylum seekers or refugees are unaware of the risk and signs that are associated with sexual exploitation.

Staff Training
There is a lack of cultural awareness for people from both the statutory and voluntary sector who deliver elements of sexual health care to asylum seekers and refugees as part of their remit. In addition, some professionals are reluctant to discuss issues around sexual health. The specialist nurse based with the Asylum Team delivers training to GPs and reception staff to raise awareness of the issues surrounding asylum seekers and refugees. However, owing to capacity issues this is only done on an ad hoc basis.

Support groups/clinics
There are no known local support groups for victims of FGM and sexual violence including rape and torture. Victims of sexual violence are referred to the Medical Foundation for Care of Victims of Torture in Manchester which is an organisation that offers medical consultation, examination, psychological treatment and support. However, it is reported that the victims must fulfill rigid criteria, resources are limited and there is a long waiting list at present.
Data

Data relating to the geographical distribution of asylum seekers and refugees for local areas is in the main difficult to access. Whilst asylum seekers have to report to the UKBA, those who have been granted refugee status become ‘free’ as the general population and so cease to exist as a special category and may then become invisible to policy makers that in turn will have major implications for health policy. The health needs of failed asylum seekers are even more difficult to establish because they too become invisible. Whilst undertaking this sexual health needs assessment, accessing local data in relation to numbers and areas in which asylum seekers and refugees live proved to be problematic. Statistics provided tend to be an estimate. In Bolton, data relating to service uptake by asylum seekers and refugees is not recorded apart from the number of HIV diagnosed cases. Consequently these deficiencies in data lead to difficulties in the planning, provision and monitoring of sexual health services.

Partnership Working

Whilst it is evident that in Bolton there are services that include the provision of sexual health for asylum seekers and refugees, some of it is fragmented and some providers are unaware of others with whom they could liaise to avoid duplication. There are a diverse and significant number of asylum seekers and refugees living in the borough and those professionals who have the skills to address their sexual health needs often do not have the capacity. Voluntary sector groups provide the majority of support to asylum seekers and refugees however, the withdrawal of funding will compromise the future running of these projects.
Recommendations

Resources
Publicity materials including leaflets and posters relating to sexual health information and sexual health services should be available in languages appropriate to asylum seekers and refugees. All service providers should hold a stock of these materials.

Cultural and Sexual Health Awareness
A large part of sexual health needs for asylum seekers and refugees is basic advice and education around sexual health. There needs to be a programme that incorporates accessing sexual health services, choices in contraception, STIs including HIV, sexual orientation and legislation that can be delivered in colleges, ESOL classes and community centres. Previous research suggests the use of community champions or peer educators to be actively involved in the design and delivery of a health programme such as this and would ensure that it addresses some of the cultural and religious needs of these communities. This could be linked with other initiatives to address broad health concerns.
A sexual health programme for asylum seekers and refugees cannot be isolated from other initiatives. It must be implemented with other community wide initiatives within Bolton that targets BME communities.

Sex and Relationships Education
Because many asylum seeker and refugee children enter the UK without any sexual health knowledge, an SRE programme designed specifically for them that incorporates self esteem, self awareness, body awareness, puberty and contraception should be delivered in schools including Starting Point. Older children should be made aware of the sexual health services available such as The Parallel. As a vulnerable group at risk of sexual exploitation, they need to be made aware of the associated risks.
Training
Relevant training courses should be made available to all staff from both voluntary and statutory agencies working with asylum seekers and refugees including GPs, practice nurses, health visitors, teaching staff, youth workers, police, hospital staff and community based workers. The courses should include cultural awareness, sexual health issues that affect asylum seekers and refugees including FGM and sexual violence that will then enable them to identify and address the sexual health needs that affect this group. The Sexual Health Training Pool Coordinator can work with the specialist nurse based with the Asylum Team to develop a course that can be delivered by the sexual health training pool.

Getting it Right
An innovative approach to engaging GPS, practice nurses and receptionists is needed as part of an integrated service. ‘Getting it Right’ is a training course designed to improve the quality of delivery of sexual health services by helping professionals to become more accessible to the local communities they support including asylum seekers and refugees. The Sexual Health Training Coordinator will support local services that provide sexual health services at all tiers to interpret and apply the ‘Getting it Right’ quality recommendations for making sexual health services accessible, achievable and consistent across the borough.

Language
There is a need for a robust interpreting service that is sensitive to the sexual health needs of asylum seekers and refugees. Interpreters should be trained in sexual health issues that affect this population. Access to female interpreters is essential for women from this group that will enable them to discuss issues more easily, access services and will also increase uptake of cervical and breast screening. It is reported that greater access to female staff including interpreters will encourage women to report incidents of sexual violence.
Outreach

Whilst the main sexual health services are based in the town centre or at the Royal Bolton Hospital, it is reported that asylum seekers and refugees often will not attend appointments. Outreach work and the use of support workers are effective measures to overcome barriers and empower people. Support workers trained in community approaches are more able to engage vulnerable groups. They can offer advice, signpost, disseminate sexual health information, play an active role in awareness raising campaigns and help to eradicate fear and embarrassment.

Support Groups/Clinics

There is a need for local support groups and clinics including:

- A local support group specifically designed for survivors of sexual violence including rape and torture for victims and their families.
- Drop-in sessions for women that would provide the opportunity to include discussion around sexual health issues such as contraception, cervical screening, STIs and HIV.
- A clinic for women who have undergone FGM
- Continued support for the HIV Peer Support Group
- Support for the Hepatitis C Peer Support group that meets on a weekly basis and has recently been set up to support those infected and could potentially be expanded to include support for people with Hepatitis B for which there is at present no provision.

Data

There is a need for an aligned data reporting system across the providers that needs to be fed back to the Public Health Intelligence team in order that they can support commissioners in the prioritising and planning of services to reduce health inequalities amongst asylum seekers and refugees and improve their sexual health. A regular activity monitoring system needs to be in place that can be used to review and accelerate progress.
Partnership working
A multi-agency approach is essential to address the sexual health needs of asylum seekers and refugees. NHS Bolton, sexual health clinicians, asylum seeker and refugee organisations, representatives from the voluntary sector, local authority and education should work in partnership to develop local strategies that will enable communities to play an active role in decision making around sexual health. Consultation with stakeholders regarding location of services, opening times and appointment systems will influence accessibility and uptake of services. The development of an asylum seeker and refugee sexual health forum can be established to discuss common issues of concern and a local strategy for sexual health. Encouraging collaborative work from existing agencies such as the SSP GP practice, the asylum team, the Bolton Centre for Sexual & Reproductive Health Services and The Parallel will ensure service is consistent and addresses a variety of linguistic, cultural and religious needs.

Care pathways
Providers of sexual health services need to be integrated and coherent, working to an agreed pathway. Whilst there are clear care pathways already in place, service providers need to be aware of these.
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APPENDICES
Appendix 1
Sexual Health Needs Questionnaire

Male                Female

Age…

Country of origin… ........................................................................................................

What are your biggest sexual health concerns? (Tick as many as you wish)

- HIV/AIDS
- Sexually Transmitted Infections such as Chlamydia, Gonorrhea, Syphilis
- Unwanted pregnancy
- Contraception
- Rape
- Female genital mutilation

Do you know where to get information about contraception?  Yes  No

Do you know what types of contraception are available?  Yes  No

Do you know where to get information about sexually transmitted infections?
Yes  No

Do you know where the nearest sexual health clinic is?  Yes  No

Do you have problems accessing sexual health services?  Yes  No
If so, is it because?:

- You don’t know where to go
- Language barrier
- You’re embarrassed
- Frightened
- Staff may be of the opposite sex
- Fear of breach of confidentiality
- Other

Have you ever had bad experiences with sexual health services?  Yes  No

If yes, could you describe your experience?

Where would you like to get sexual health advice or help?

- GP/doctor
- Sexual health clinic
- Family planning centre
- Community centre

Any other comments?
Appendix 2

FGM workshop Notes

Aims and Objectives of the meeting:
The aim of this workshop was to enable women from these practicing communities the opportunities to share their views, experiences, and opinions on FGM. To highlight and identify the different types of FGM practiced by the different practising communities.

Participants:
A group of 15 women attended the workshop all from countries who practise FGM, the countries they were from included, Somalia, Ethiopia and Mauritanian community. Most of the Somali women were surprised to see women of other nationalise at the workshop as most believed it to be a “Somali Culture.”
The session was held at the Asylum Team premise; the reason for the choice in location was the fact that it had a big room enough for 20 people.
On the invitation Nimo and I asked the women to come to BSCA premise first, a place where many of the participants are already familiar with as they access many of the different services offered, in order to take them to the venue ourselves. We also asked women to come at 10:00am, but the actual workshop was starting 11:00 am, the reason we said this was to avoid lateness and absence.

Session:
This event was facilitated by me (Hodan) and Nimo. We opened the workshop by welcoming everyone, and outlining few housekeeping rules. After that, Julia from Refuge Action introduced two icebreaker exercises. The first one known as Names, allowed the participants to get to know each other names. Second one was a team building exercise about what it means to be women. The participants were divided into three groups. Each group was giving the task to cut out of magazines and create their own perception on what it means to be a woman.
On this event there were three Speakers. We had Kathy Burke, a former Midwife and now a Health Promotion Specialist-Teenage Pregnancy and Sexual Health, giving presentation on the human biology and female reproductive system. She showed pictures on the female reproductive system and also on normal (i.e. non-circumcised) female genitalia, both the internal and external organs.
Our next speaker was Catharine Hay, a nurse from the Asylum Team. She did a presentation on the implications of FGM on women/girls heath. She spoke about the prevalence of FGM, the different types of FGM and the health complications. She showed images on different type of FGM in order for the participants to understand what she was talking about. Our last speaker was Kaltuma Ajab, a Somali FGM professional speaker. She talked about the main reasons practicing communities perform FGM and about the UK law, the FGM legislation.
After Kaltuma’s presentation, lunch was served; we had homemade rise, mix vegetables, meat, chicken and salad. After lunch, we had open discussion about the presentations.

Discussion
The women had open discussion about their opinions and there were a lot of myths around FGM which include girls being un-marriageable if they have not undergone FGM, some said it was needed for hygiene reasons, some even had the extreme view that if women do not undergo FGM their clitoris will continue grow at a astonishing rate.

One Mauritanian woman told us a story about her friend back home. She said:

“Some place in Mauritania Female Circumcision is very important custom. If a girl is not circumcised she will not get married, men don’t want her, and I know this because it happened to my friend. She got married and on the wedding night her husband found out she was not circumcised and he divorced her the next morning. This brought shame to her family and the whole neighbourhood were talking about her.”

According to another woman, in Somalia, there were bad names known for families with girls that are not circumcised and they were recognised by everyone in neighbourhood as those who haven’t circumcised their daughters.

The participants were given three questions to discuss about:

1. Thinking about what you heard this morning, was there anything you were surprised by, or still feel unclear about?

   For some the biology aspects and the pictures were new to them, they haven’t seen it before. The majority were surprised to hear about the health complications of FGM, as they never associate with FGM, especially those that occur during childbirth. Some women were surprised to discover the difference between circumcised female genital and a “normal one”.

   A young woman was surprised to hear so many bad stories and experiences of FGM. She said

   “I’m circumcised and it wasn’t that bad for me. I’m not totally against it, I’m neutral. I believe that every woman should decide what to do with her own body”.

   One woman was against the idea that it is always the parents that pressurise their daughter/s to undergo the practice. She said,

   “Sometime it’s the children themselves that pressurise their parents. A family member of mine forced her parents to perform FGM on her because she wanted to be accepted and recognised as a member of her community”.

2. What help and support would you like in the future?

   The majority said they want more information on health complications. They want to have information on where to go for reversal i.e. deinfibulation. Kaltuma told them, there is a clinic in Manchester that do reversal on FGM patience two day a week and they are given certificate to show their husband, as evidence that they have undergone deinfibulation. The majority also requested a clinic specialised in FGM in Bolton, as there aren’t any. Currently GP’s in Bolton refer people who request for deinfibulation to hospital.
3 How do you think that we could engage with more/other groups of people?

The women suggested we should have events for younger and older people. We should organise events for different groups, for different generations. Some women said word-of-mouth is a very good and quick way of spreading news to other people. They also said, the next coming event we need to organise time suitable for everyone. According to them the best time for mothers to come to events like this, is Saturdays or the time when the children are in school. They said we should invite more people from practising countries so they could learn and share experiences from each other. We could invite more women from Sudanese, Eritrean, and Ethiopian

Achievements:
I would say getting the women together and giving them the opportunity to discuss this important topic is in itself, a big achievement as FGM is a taboo subject that is not openly discussed by the practicing communities. I was surprised to see how passionate and willing the women were to discuss about their own feelings and experiences. This workshop gave women a greater understanding of the different forms of FGM there are as well as an introduction to the other practicing communities that they did not previously know about. The workshop helped answer some questions that the women had and helped overcome some of the many myths around FGM.
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<td>Face to Face interpretation in Urdu, Hindi and Gujarati.</td>
<td>NHS BOLTON LINK WORKERS</td>
<td>Yasmin Manjra and Ilyas Adam Tel: 01204 463728 / 01204 463697</td>
<td>N/A</td>
<td>All Provider Services and Contractor Services</td>
<td>Full time staff therefore no associated costs</td>
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<td>Telephone interpretation in all languages</td>
<td>THEBIGWORD</td>
<td>Tel: 0800 321 3053</td>
<td>Access code (Contact your Team leader or the Equality &amp; Diversity manager on 462015)</td>
<td>All Provider Services and Contractor Services</td>
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<td>Tel: 01635 866 888 Email: <a href="mailto:Interpreting@prestigenetwork.com">Interpreting@prestigenetwork.com</a> Online: <a href="http://www.prestigenetwork.com">www.prestigenetwork.com</a></td>
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<td>Translation in all languages and other formats</td>
<td>PRESTIGE NETWORK</td>
<td>Tel: 01635 866 888 Email: <a href="mailto:Interpreting@prestigenetwork.com">Interpreting@prestigenetwork.com</a> Online: <a href="http://www.prestigenetwork.com">www.prestigenetwork.com</a></td>
<td>N/A</td>
<td>All Provider Services and Contractor Services</td>
<td>Central budget. Unless otherwise agreed</td>
</tr>
<tr>
<td>British Sign Language / Other Lip Speaking</td>
<td>MANCHESTER DEAF CENTRE</td>
<td>Tel: 0161 273 6699 Email: <a href="mailto:bookings@manchesterdeafcentre.com">bookings@manchesterdeafcentre.com</a></td>
<td>N/A</td>
<td>All Provider Services and Contractor Services</td>
<td>Central budget. Unless otherwise agreed</td>
</tr>
</tbody>
</table>

Please note that any interpretation services accessed with providers not on this list are payable by the service making the booking.