

## Research paper

# 'I had to cry': exploring sexual health with young separated asylum seekers in East London

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### What is known on this subject

- Asylum seekers are at the forefront of political and media discourse and have been associated with issues including criminality, religious extremism, terrorism, the spread of tuberculosis and HIV/AIDS, as well as overfertility and overpopulation, which is understood to carry negative implications for already scarce health, housing and welfare resources.
- Certain reports and non-governmental organisations suggest that young separated asylum seekers may experience inequalities and risks in sexual exploitation and sexual health, although there is a paucity of research regarding this.
- These issues are compounded by other research suggesting difficulties in access to healthcare for them, which may be further added to by the stigma they face in wider society.

### What this paper adds

- Qualitative data on the under-researched area of sexual health with young separated asylum seekers concerning sex and relationships, sex education and knowledge, sexual exploitation and accessing sexual healthcare.
- Insight into: culture, gender, religion and their impacts on sex and relationships; gaps in sex education and knowledge; links between material resources, the possibility of removal and sexual exploitation; barriers in access to healthcare.
- We add practice and policy implications on widening access, sexual exploitation and cohesive service delivery, as well as sex education and sexual healthcare in educational establishments for this client group.

## ABSTRACT

In the UK, asylum seekers are at the forefront of political and media discourse, with research describing how they are perceived as imminent threats to the nation and its citizens. Research also questions whether this discourse, the asylum and immigration framework, and discriminatory practice result in young asylum seekers being exposed to health risks and inequalities in standards of service delivery and outcome. Particular concerns have been raised about

sexual health and sexual exploitation for those young asylum seekers separated from parents, who, if under social services care, are categorised as 'unaccompanied'. There is a paucity of studies exploring these issues and suggesting ways in which the situation might be improved. Our research seeks to help redress this. We carried out in-depth interviews and small focus groups with 17 young unaccompanied asylum seekers, and in-depth interviews

with 10 professionals in the London borough of Hackney. Culture, gender and religion appeared to combine with relationships and sexual activities in complex ways. Young people described more opportunities to meet potential partners in the UK than before migration. Young people experienced varying pre-migration access to sex education, but almost none in the UK, which may contribute to increased risks. Insecurities over material needs, and uncertainty over immigration status appeared to push some towards sexual exploitation. Multiple barriers to accessing healthcare were also reported by professionals and young people.

Based on these results we argue that professionals are challenged with reforming institutional practices

to achieve positive sexual health in the face of existing inequalities. This may require measures such as facilitating registration with general practitioners; working practices supporting widening access; interprofessional working to share information on sexual exploitation; and the integration of both an understanding of culture and religion as contextual into practice and sex education into English language courses in colleges.

**Keywords:** asylum seekers, culture, ethnicity, practice, religion, sexual health

## Introduction

The UK General Election of 2005 and the local elections of 2006 saw asylum seekers placed at the forefront of political and media discourse as imminent threats, and linking them to a variety of phenomena both in East London and nationally (Marfleet, 2006). These phenomena included criminality, religious extremism, terrorism and the spread of tuberculosis and HIV/AIDS, as well as overfertility and overpopulation, which carried implications for already scarce health, housing and welfare resources (Browne, 2005; Doughty, 2005; Tempest, 2005; African HIV Policy Network, 2006; Lowles, 2005, 2006).

Legislation such as the 2004 Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989 (Department of Health, 2004) is argued to further embed a negative image of this group. Against the wider context of hostility, critics argued that this image underlined the social construction of asylum seekers as infectious, fertile over-consumers of resources (Pollard and Savulescu, 2004; Hargreaves *et al*, 2005). This image also played a part in the removal of entitlements to free healthcare, other than from accident and emergency departments, for persons with insecure immigration status, including both failed asylum seekers whose appeal process has come to an end, and those whose presence is not known to state authorities (see Box 1). Moreover, it aims to discourage asylum seekers from entering the country and makes the (non-)provision of health services a tool of immigration control (Coker, 2005). Studies report that the legislation has contributed to confusion over entitlements, and has thereby adversely affected access to healthcare for asylum seekers who *do* have full rights to NHS care, as well as those who do not (Kelly and Stevenson, 2006).

There are tensions between the proclaimed universalism of policy initiatives such as Every Child

### Box 1

Compulsory psychiatric care and care for certain communicable diseases *except* HIV are exempted from the removal of entitlement to free healthcare. It is only the first diagnosis of HIV and connected counselling sessions that are charge free. Further information can be found at: [www.dh.gov.uk/en/Policyandguidance/International/OverseasVisitors/index.htm](http://www.dh.gov.uk/en/Policyandguidance/International/OverseasVisitors/index.htm)

Matters (Department for Education and Skills, 2004) with the inequalities that young people seeking asylum are understood to face (Crawley, 2006; Dunkerly *et al*, 2006). Sexual health, sexual exploitation and healthcare access are among the particular areas of concern about young separated asylum seekers (Stanley, 2001; United Nations High Commissioner for Refugees, 2004; Patel *et al*, 2004; Box 2). In terms of sexual health, the separation from family, material inequalities and the risks of sexual exploitation, sexual ill health and unintended conceptions experienced by this group are similar to those difficulties faced by young people who are homeless, or looked after, and by some who are lesbian, gay, bisexual or transgendered (Social Exclusion Unit, 1999; O'Connor and Molloy, 2001; Cant, 2002; Burtney and Duffey, 2004). However, the situation of young separated asylum seekers is made worse by tensions between the state, which must be seen to defend the nation and its citizens from those cast as a threat, and individual responses to the need to protect vulnerable youth. Thus, racial discrimination, institutional confusion over their legal rights to service access, and many other factors have the potential to impact on sexual health. Although concerns about the vulnerability of young separated asylum seekers to sexual ill health and exploitation have been raised, there is a paucity of both research exploring this, and

information to help professional practice. Nonetheless, this is beginning to change (Sinha *et al*, 2006; Young, 2006). Our research is part of this process of change. In this paper, we provide an overview of the project, its methodology and specific contextual issues. The data yielded important themes about sexual behaviour, sex education, sexual exploitation and access to services. We discuss these with reference to their implications for those health and social care professionals who want to support the achievement of positive sexual health for this group within a hostile social and political environment.

### Box 2

We use the term ‘separated’ rather than ‘unaccompanied’ when describing asylum seekers under 18 years not cared for by parents or their usual carer as the United Nations High Commission on Refugees (UNHCR, 2004:2) suggests. This is to include both those classified as ‘unaccompanied’, and therefore receiving social services care, and those who are also separated from parents but do not receive such support because they are deemed to be living with extended family.

## Methods

We interviewed 14 young separated asylum seekers aged between 15 and 18 years who were being cared for by social services and two who were not. We also interviewed a young person aged 23 years, separated from parents, awaiting the outcome of her asylum application and not in touch with social services. Although outside our target age range, we allowed her to take part as her peers wanted to participate with her as a whole group. Young people were asked to choose a pseudonym to maintain anonymity while allowing them to recognise their comments in our outputs. Table 1 shows the countries of origin and gender of the young people to whom we spoke.

With the young people, we conducted eight one-to-one interviews and four small focus groups with 2–3 participants, giving interviewees the choice of taking part in a one-to-one or group situation. We offered all young people the opportunity to use an interpreter during interview, which was taken up by six participants. There was no co-facilitator present in the groups. In not having a co-facilitator we were mindful of potential power imbalances occurring when adults interview young people, and not wanting to exacerbate these by having too many adults in what were small focus groups (Christensen and James, 2000).

**Table 1** Country of origin and gender of young people

Country of origin	Male	Female	Total
Burundi		1	1
Congo	4	3	7
Ethiopia		1	1
Guinea		1	1
Jamaica	1		1
Kosovo		1	1
Nigeria	1		1
Sierra Leone	1		1
Somalia	1		1
Vietnam		2	2
Total	8	9	17

We also interviewed 10 professionals from education, health, social and youth sector settings, with job responsibilities relating to policy development and/or frontline work with this client group. This was through one-to-one in-depth interviews. They are described by the sector they work in and a number from 1–10 to distinguish them from each other and protect anonymity.

Consent was obtained verbally and through a written consent form from both young people and professionals. We wrote up a project information sheet and informed consent form specifically for young people, and had this translated into five languages: Dari, French, Mandarin, Vietnamese and Farsi. Professionals used separate forms. Our information sheet for young people stipulated that their comments would be kept strictly confidential apart from where we had an obligation to share any information they told us if it related to either themselves or somebody else at risk of harm. Researchers underwent Criminal Records Bureau disclosure, and a protocol involving child protection experts was in place in the event that any young person divulged information that met child protection criteria. For both young people and professionals, the sheets also included information about consent, and specified that participants did not have to answer any particular question during the interview if they so wished and were also free to leave the interview at any point, neither of which they needed to provide a reason for. All of this was explained verbally at the outset of the interview.

Interviewers were matched for sex with young people. Interviews were conducted by a British Indian female

aged 25 and an Indian male aged 32. Young people were recruited by researchers through personal pre-arranged visits to local education, health and social care agencies from the statutory and voluntary sector. Our sample of young people was self-selected. During the course of the interview, researchers discussed the following themes with young people: being in the UK; education; friends and activities; previous or current access to sex and relationships; education; experiences of using services in the UK; accommodation; knowledge and experience of health systems, GPs and sexual health services; meeting partners and engaging in sexual behaviour; employment and trafficking. With professionals we discussed what they and their organisation did and their involvement with young separated asylum seekers, sexual health, sexual exploitation, healthcare and possible problems/improvements to service delivery. Data collection took place between July and November 2005, with the study reaching completion in June 2006.

All data were recorded and transcribed by ourselves. We listened to the recordings and then examined transcriptions to increase the reliability and validity of our data. We used the framework approach for data analysis (Ritchie and Spencer, 1994). This involved doing preliminary readings of the data to familiarise and immerse ourselves in it. We then identified a framework of key patterns and themes that related to our research questions and aims for both young people and professionals. This allowed us to identify similarities and differences in responses between them (Ritchie and Spencer, 1994). We used these themes and subcategories to code the data and then analysed them by looking at each code and the responses grouped under it. Part of this process involved researchers independently coding some of the same transcripts. This was to increase both validity and reliability in standards of data coding. At points we updated the framework and added subcategories where necessary, and then recoded the data. The use of the framework allowed us to rework our data groupings because the previous analysis process had been well documented with specific data under specific codes (Ritchie and Spencer, 1994). Our study was approved by an NHS research ethics committee – East London and the City Local Research Ethics Committee 3. The data we discuss in this paper cover sex and relationships, sex education and knowledge, sexual exploitation, and accessing sexual healthcare.

## Limitations

A potential bias may have been introduced by interviewing some young people through small focus groups, resulting in the under- or over-reporting of particular issues because co-participants were present.

However, a counterweight to this were the potential advantages not available in one-to-one interviews, including the facilitation of the discussion of sensitive issues and a possible increase of disclosure as talk amongst some participants may have encouraged it amongst others (Frith, 2000; Frosh *et al*, 2002; Connell *et al*, 2004). We also offered one-to-one in-depth interviews because some young people might have felt more open about talking without co-participants being present.

All qualitative data are shaped to some degree by the networks and methods of access used. A possible response bias was introduced as our potential sample of young people was limited to the local education, health and social care agencies we accessed. This meant the views of other young separated asylum seekers, whose interests were or were not catered for by these agencies, were possibly unheard. Similarly, there was a potential bias in our data from professionals. Those agreeing to take part in the study might have been more sympathetic towards this client group than some of those who did not. Our sample size of 17 young people and 10 professionals also limits the generalisability of our findings. However, our work extends knowledge in the context of a paucity of research in this area and of services finding this group hard to reach. While not providing a complete picture, it does identify pertinent issues for practice and research on young separated asylum seekers.

## Findings

### Sex and relationships

Five young people talked of differences in relationships and sex between their pre-migration countries and the UK. For example, Yan, a 17 year old from Congo, mentioned being in the UK for one month and two weeks. He said he met girls at church or at basketball tournaments in Congo but, like others, felt there were many more places where he could meet partners in the UK: 'Many places, park, school, street, bus, church, college, many, many'. Lily, also aged 17 years and from Vietnam, mentioned that boyfriends and girlfriends were not approved of by older people in Vietnam, although she reported her friend had sex while there. Like other young women in our sample, Lily told us that she did not have sex because she did not want to get pregnant. She did think it was ok to have a boyfriend though for the company and support:

'Yeah, when I upset something, they can stay to me, 'it's, that good. It's very good to have boyfriend'. But, about sexually ... about like I don't want it.'

However, other activities outside of what she described as sexual might occur. She added, 'If you want a boyfriend, but just like friend, but a bit more than friend, a little bit, not much, so it's ok'.

Religion was particularly identified by our groups as having a significant influence on attitudes to sexual practices. For example, Tony, an 18 year old from Somalia, described how having a 'girlfriend' did not fit his situation or complement his interpretation of Islam. Instead, he had what he termed a 'wife-future' with whom he did not have sex. Tony explained the difference between 'girlfriend' and 'wife-future':

'A girlfriend is a girl, someone who stay with you, sleep together, that means girlfriend. And what you call, er, wife-future, situation is talk together, sit together, but you're not doing nothing. That's why, if you want, 'future'. It's a talk, see how you talk well, sitting, eating with her, but you're not doing nothing, that's why. And the girlfriend you're doing something [sexual]. That's difference.'

Like Tony, Skolo, 17 years old and from Sierra Leone, was a Muslim, but his religious beliefs did not stop him from having had sex in Sierra Leone. Although he had not yet experienced sex in the UK, Skolo expressed a desire to do so and wondered what it was like to have a girlfriend here:

'Because I think I am a young boy, you understand? Because I think it's necessary you understand? To have a girlfriend because without having a girlfriend you gonna sit in lonely. But I really want a girlfriend, you understand because I want to know much about this style of loving in England really.'

At the same time he mentioned sometimes feeling guilty about having sex and related this to his faith. Skolo commented: 'but just after sex with them I feel so bad, because I have sin, you understand to Allah, so I have to repent to him'.

There appeared to be a gendered norm amongst some young women in expressing the need to get to know a partner before having sex:

'... before you have a boyfriend, you have to see what he does, you can't just hurry up to get into a relationship, ok?' (Ygrette 18 year old from Congo)

Religion added nuance to this as some young women, like young men, were against having sex before marriage because of religion. Nora, aged 17 years and a Muslim from Ethiopia, said, 'Only if you marry me, only like that, I go with man'.

Professionals indicated that sexual attitudes and experiences could not be read into someone's culture or assumed by knowing someone's religion:

'... we don't assume that 'cos you're from a certain group you are going to be sexually active, but acknowledging that within that there are beliefs, or religious beliefs that the young person, may adhere to or they might not.' (Health Professional 2)

## Sex education and knowledge

Cultural and religious diversity characterised this sample in terms of reported sexual behaviour. Divergences also appeared in access to pre-migration sex and relationships education. However, once in the UK, participants shared similar experiences of non-access to sex education. Only one young person received sex education in the UK, and this was in the form of a one-off visit to her college by a sexual health promotion agency.

Young people from Congo, Guinea and Sierra Leone reported regular access to sex education in those countries. Jean-Claude, aged 18 years and from Congo, reported that he got more sex education in Congo than the UK: 'I've not done that at school [sex education in the UK], but in Congo right from primary school up to university they are teaching everyone'. Aicha, a 17 year old from Guinea, described how she felt such knowledge meant she avoided an unintended conception: 'In Guinea we've got a lecturer for that. That's why I don't have a kid before now'. Young people from Ethiopia, Somalia, Kosovo and Vietnam all reported that they had no formal sex education in their pre-migration countries. Two young Vietnamese women linked older people's disapproval of boyfriends and girlfriends in Vietnam to a disinclination to pass on knowledge about sex: 'Because they think it ... if they talk about that too early, it gets children naughty' (Lily aged 17 years, from Vietnam). Nora, aged 18 years, from Ethiopia, added that she only heard about contraception in the UK and that was from a friend of hers:

'In my house, my friend she, she told me this danger, this like that, she ... she's a good girl, but she speak me this not good, you have to use [contraception or protection], your friend, boyfriend, anyone like that she told me everything.'

Comments from five other young people reiterated the need for them to have a degree of accurate sexual health information. Skolo, aged 17 years from Sierra Leone, reportedly did not use a condom with the partner he mentions because *she* believed it could damage her biological capacity to give birth:

'... she refused to use the condom, that's why, it might be the condom gonna remain in the vagina, and that will destroy her cells so she not gonna have pregnancy, so she don't like condom.'

Two education professionals in colleges mentioned they had a lot of contact with young separated asylum seekers in English for Speakers of Other Languages (ESOL) courses, and that this provided a rare opportunity to reach groups of these young people for sex education. They highlighted a need to develop sex education materials and a sexual vocabulary in English and wanting to link sexual health promotion initiatives

into this. However, they mentioned problems working interprofessionally to do this:

'I mean we do, occasionally have experiences of working with other organisations, but it's not like I know people in certain offices, you know some jobs you just know people in certain offices that you call. It's not like that here at all. I was kinda surprised about that, I thought it would be more, given the sort of students that we're working with and some of them have to deal with all kinds of different services.' (Education Professional 4)

## Sexual exploitation

Professionals raised concerns about the vulnerability to sexual exploitation of both young men and young women from this group. They saw a combination of emotional vulnerability, the possibility of forced removal, and limited welfare support as making young people increasingly dependent on others. This lack of independence reportedly made sexual exploitation more likely:

'The only thing that they can do is sell their bodies, if they have none of that financial independence, and they are very dependent on other people, they have to, they have to survive in some way. And I think these policies are just pushing them into it [sexual exploitation] ... How much control do you have over them [sexual partners]? What kind of sex you're having, whether it's safe sex or it's not safe sex, whether anybody else is [goes quiet].' (Health Professional 1)

Accounts from young people suggest that while culture and religion may be important in choices about sexual behaviour, social positioning and circumstances may combine to push these young people towards sexual exploitation. Lise, a 23-year-old Burundian, was interviewed in a voluntary sector setting attended by often destitute and sexually exploited young people. Her comments reflected professionals' concerns relevant for care leavers, about both increased vulnerability to sexual exploitation as the safety net of social services protection is removed, and their encountering bureaucratic difficulties in getting benefits paid. They also reflected professionals' concerns about separated young people, whether in care or not, who find that the possibility of removal is a disincentive to try and achieve educationally, meaning that there is less to lose by engaging in sexual exploitation to meet material needs (see Box 3).

Additionally, professionals raised concerns about both informal exploitation and the normalisation of exploitative relationships by, at that time, particularly Vietnamese young women. This reportedly resulted in them not seeing their behaviour as prostitution but as having multiple, older boyfriends. For instance, Lan, aged 17 years, from Vietnam, highlighted the mix of forces physically exploiting her economic and social

### Box 3 Lise's story

*Lise:* 'Sometimes I don't want to go to school because, there's no, there's not point to go to school.'

*Interviewer:* 'Why not?'

*Lise:* 'Because you don't know, you don't know what, what tomorrow, er ...'

*Interviewer:* 'Yeah'

*Lise:* '... brings for you, you don't know, you not gonna stay, they're gonna send you back. Yeah.'

Lise's comments below also reflect what professionals said about sexual exploitation often being strongly hinted at by young people if not spelt out:

*Lise:* 'Like me ... it's, it's been two years ... I haven't heard anything about it [an immigration decision].'

*Interviewer:* 'Nothing at all?'

*Lise:* 'Nothing, and ... I don't receive any money from them, I don't have any, any help ... so ...'

*Interviewer:* 'So, how do you ... survive? How do you live, where do you get money from?'

*Lise:* That is ... [sighs] so difficult.'

*Interviewer:* 'It's really difficult.'

*Lise:* 'I cannot say ... No [hinting at possible sexual exploitation].'

vulnerability. Lan was not related to her 'aunt', but was reliant on her for accommodation. Under UK procedure, and in opposition to United Nations High Commissioner for Refugees' (UNHCR, 2004) recommendations, she was not living under social services care and officially recognised as 'unaccompanied' at this point because, although separated from parents, she was living with what was presumed to be her extended family. Lan described meeting what she described as her first 'boyfriend' for the first time through her 'aunt', becoming pregnant by him, and subsequently being told by her 'aunt' to leave her accommodation. The 'boyfriend' no longer saw her or her baby and proceeded to make other Vietnamese young women Lan knew pregnant.

A sense of exploitation being normal seemed to be reinforced not only by the description of the father of her baby as 'boyfriend', but also when she mentioned another Vietnamese friend who had become pregnant three times by different men:

*Lan:* 'No, I, I, I, I er ... I have a friend, yeah?'

*Interviewer:* 'Yeah.'

*Lan:* 'Er ... one, one, two, three – she's pregnant.'

*Interviewer:* 'She's been pregnant three times?'

*Lan:* 'Yeah, er three person.'

*Interviewer:* 'With three different people?'

*Lan:* 'Yeah.'

## Accessing sexual healthcare

Professionals reported barriers to healthcare access (see Box 4). Young people reported the same barriers to access that professionals did, with a frequent disclosure of difficulties in finding a general practitioner (GP). They mentioned barriers such as the non-acceptance of official identification documentation issued by social services:

‘When I went to the health service, the GP, to the surgery, I presented the letter from social services but they told me that without a passport, they’re not going to register me.’ (Aicha, aged 17 years, Guinean)

### Box 4 Barriers to accessing health services

- Non-acceptance by GP surgeries of official social services letters guaranteeing the identity and access rights of young people
- Non-provision of interpretation services
- Young people being repeatedly directed from surgery to surgery to register even though professionals reportedly knew that particular surgeries were not full
- GP surgeries’ excuses for not registering young people: ‘Oh we haven’t got room’, ‘they don’t this, they don’t speak English, we don’t have interpreters ... that’s not just a one-off – it’s ongoing’ (Social Services Professional 7)

Some mentioned being repeatedly told that surgeries were full even though they had been informed by social services that spaces were available:

‘I been to eight GP – nobody take me. They say to me, “we’re not registering anymore”.’ (Emma, aged 18 years, Kosovan)

Lily’s account suggested that difficulties accessing GPs can be one reason for the exacerbation of health, and in this case, possibly sexual health problems. She told us how she had an infection and tried to access a health centre but was reportedly told how she had to register with a GP first. She described repeatedly being directed around health centres, GPs’ surgeries, hospital and back again and how she felt about this:

‘I had to cry because it’s too difficult for me because I, I think I have some infection because I have talked to my friend about some problem about teenager problem. Like period, but I think you know period? I think I have [inaudible], I suspect I have some infection. Yeah, inside my ... so I leave the doctor but no one help me so ... and now I find one. But ... mmm, I don’t know if they help me or not.’ (Lily, aged 17 years, Vietnamese)

Apart from GPs, all but two of the young people we interviewed did not report knowing about other

outlets for sexual health advice and treatment: ‘No, I don’t know’ (Nora, aged 18 years, Ethiopian). Yan was surprised to hear about existing sexual health services and free contraception/protection being available:

*Reich*: ‘They give you packets.’

*Yan*: ‘Where! In hospital! Ah!’

*Reich*: ‘Say if you want condoms yeah.’

*Yan*: ‘If you ask!’

*Reich*: ‘If you ask, then they’ll give it to you for free. Just say you want condoms, yeah.’

(Yan, aged 17 years, Congolese; Reich, aged 16 years, Jamaican)

## Discussion

The Race Relations Amendments Act (2000) and the Every Child Matters initiative emphasise the need for equity in access and quality of service provision, while the latter also proclaims wanting all minors to achieve universal standards of health and well-being (Department for Education and Skills, 2004). In the face of hostile political and media coverage, our data help question whether the reality matches the aspiration of equity. The data also suggest practices that might contribute towards greater equity and positive sexual health for this group.

### Widening access

Difficulties in access evident from the data illustrate a need for health and social care practitioners to address the features of their services that may maintain or increase their inaccessibility to this group. For example, young people mentioned that their documentation and rights to service access were sometimes contested by health professionals. Particular bureaucratic routines were described as being employed that limited service access and sometimes exacerbated ill health. These included the non-acceptance of official documents issued by social services for registration, non-provision of interpretation, and directing young people to register with other GPs even when spaces had been identified as available. This complements research reporting that GPs and other NHS staff often have an inadequate understanding of refugee and asylum seekers’ rights and entitlements to GP registration and healthcare, a situation that has worsened despite the introduction of the Race Relations Amendments Act (2000) and Every Child Matters (Dar, 2000; Lynch, 2001; Department for Education and Skills, 2004; Heptinstall *et al*, 2004; Kelly and Stevenson, 2006).

Work-based learning informing professionals, including receptionists and GPs, about rights to access health services for young separated asylum seekers,

and GP registration procedures for this client group may help in widening access. Consideration could be given to its development by primary care trusts. The 'mystery shopper' model could also be considered when trying to widen service uptake by contributing to an analysis of existing service access. In this model a person attempts to access a service pretending to be a client and records their experiences (Sykes and O'Sullivan, 2006; Baraitser *et al*, 2008). In terms of policy, multidisciplinary work involving professionals from social services, health services and GPs could be explored to work towards establishing streamlined processes to register with doctors and further open access. Developmental work in improving interpretation provision and improving the quality of service provision would also help. Knowledge sharing amongst multisector providers about existing interpretation could be advantageous, with one option being the utilisation of websites collating information about resources available for those seeking asylum such as that hosted by the Information Centre about Asylum and Refugees in the UK ([www.icar.org.uk](http://www.icar.org.uk)).

Sensitive measures to monitor service access for this client group, and young asylum seekers in general, could also be considered by primary care trusts to identify gaps in uptake. Sexual health services could consider the feasibility of piloting adapted ethnic monitoring forms used in some healthcare outlets, to include immigration status. This would depend on the exact service delivery environment and whether it was felt appropriate. Further research here is recommended in order to minimise the risk of such forms causing stigma and discouraging service access. It would also be illuminating for future research to explore the pressures and circumstances in which some professionals misinterpret the situation on access rights, or directly discriminate against this group and the degree of involvement of senior colleagues. Such issues are especially pertinent now as the Commission for Racial Equality (CRE) has concluded an investigation into the Department of Health by finding it was not complying with its duties under the Race Relations Act 2000 (CRE, 2007).

## Sexual exploitation

An area where lack of access to or availability of services may increase risks for young separated asylum seekers is that of sexual exploitation. Young women may face particular pressures about this. Our data suggest these include continuing insecurities over material needs and possible removal making concentrating on other pursuits such as education seem pointless, and sexual exploitation for economic benefit more attractive. Patel *et al* (2004) argue that asylum

applicants who have had their claims rejected, and those who are not in contact with services, may be at greater risk of sexual exploitation through not having recourse to public funds and, one might add, public care. Our data also support this and the need to tackle not only exploitative networks, but the role of the immigration framework in this by putting young people at fear of removal.

At a local level, consideration could be given to interprofessional working to address sexual exploitation. This could be through the establishment of a multidisciplinary network between community, education, faith, sexual health, social services, teenage pregnancy and youth professionals. One function of this could be the identification of young people believed to be at risk of sexual exploitation. Special consideration could be given to those with no recourse to public funds. Such a network might be particularly important given how the suspected appearance of sexual exploitation is sometimes ambiguous.

## Cohesive service delivery

Refugees and asylum seekers lack knowledge about available services (Gosling, 2000; British Medical Association, 2002; Rogstad and Dale, 2004). This may leave young separated asylum seekers vulnerable to sexual ill health. Young people's accounts illustrate the importance of effective health promotion, outreach, and multi-agency working, so that the primary healthcare interface is more cohesive with other services, and potential clients know about options available to them. Multi-agency work between social care, health, education and youth sectors could be explored to facilitate shared learning and effective signposting of services to this group. To forward this, in the shorter term, consideration could be given to whether primary care trusts and allied colleagues might develop an information pack detailing sexual health and teenage pregnancy support services for these and other vulnerable young people. Such packs could be distributed through educational establishments and social services which should have regular contact with those separated and living under their care, and also community services whose clientele also include young separated asylum seekers.

Making the primary healthcare interface more cohesive through multi-agency working might forge stronger links between professionals. This could forward the possibility of sexual health workers distributing sexual health knowledge and information, and, depending on context, possibly contraception and protection and carrying out forms of pregnancy and sexual infection testing through community outreach.

## Sex education and sexual healthcare in educational establishments

Access to sex education is an important issue that cannot be isolated from access to wider sexual health and pregnancy services and protection from sexual exploitation. Young people visiting sexual health and pregnancy services presupposes, to some degree, a level of knowledge of why they are going there. Knowledge of contraception and protection as well as its correct use may be necessary before some young people see a reason to access sexual health services. Further, given possible exposure of some from this group to both formal and informal sexual exploitation, a gap in knowledge about healthy and unhealthy relationships may need to be filled.

As we saw with our sample, young people did not access sex and relationships education through their colleges. However, this is important for all given that young people from different backgrounds may be engaged in relationships and/or sexual behaviours, and because young people report gaps in knowledge and myths about sex and pregnancy. It is of particular importance, given what some young people described as a different environment in the UK where there were more locations and possibilities to meet potential partners. Whether having sex now or not, education is important in empowering young people to be aware of contraception/protection options and in helping reduce future risks of sexual infection transmission and unintended conceptions.

Young separated asylum seekers under social services care are supposed to be linked into education and English for Speakers of Other Languages courses (ESOL) as part of their care package. Consideration could be given to the development and distribution of sex education packs, including information about services and the integration of sex and relationships education into ESOL courses at further education and sixth form colleges. This could take advantage of the posited need to develop a sexual vocabulary in English. As colleges are one of the few places where groups of young separated asylum seekers meet, they could be used to potentially facilitate this, while such education links into the Department for Education and Skills 'Skills for Life' curricula, which influences what is taught to this group (Department for Education and Skills, 2003).

All of this adds further importance to inter-professional working between health and social care workers and educationalists. Educational establishments might also be places where outreach work could be further considered. However, given existing demands on professionals in sexual healthcare, one option might be the provision of training to professionals such as college or school nurses concerning this care with young separated asylum seekers. It could possibly

be integrated into any existing training available around sexual healthcare for disadvantaged young people.

## Culture and religion

Whilst there are challenges in opening up access to sexual healthcare and sex education for young separated asylum seekers, there are also challenges in improving the quality of its delivery. As the National Strategy for Sexual Health and HIV highlights, one of these is shaping sexual healthcare around people's needs in ways that are sensitive to cultural and religious differences, and this may be required for sex education as well (Department of Health, 2001). Although not always clearly defined, the development of culturally appropriate health information and cultural competence training for health professionals has been advocated by many in relation to asylum seekers (Clark *et al*, 1998; Gosling, 2000; Hinton, 2001; Burnett, 2001; British Medical Association, 2002). We suggest that those catering for these groups' needs might integrate an understanding of culture, religion and any gendered effects as dynamic and contextual into their work (Hall, 1992; Brah, 1996). It may be a case of culture, gender and religion providing ways into understanding an individual's identity and gaining further information about health behaviours. An acknowledgement of this could lead to more appropriate care than might otherwise occur if simple assumptions had been made about sexual behaviour or relationships. Culture, gender and religion are combined with relationships and sexual activities in complex ways. The need to not make assumptions is further underlined because some of these young people may be estranged from the dominant culture and religion of the population group with which we associate them. Indeed, this may have contributed to the reason some are seeking refuge. Research might explore how to produce effective professional training here.

## Conclusion

Professionals face challenges in improving access and the quality of services. This places them at the centre of reforming institutional practices to achieve positive sexual health in the face of wider social and political hostility directed towards this group. Our data suggest this may require measures to facilitate registration with GPs and the development of professional training to integrate an understanding of culture and religion as contextual and dynamic into working practices. It suggests interprofessional working practices to support widening access, explore the delivery of sex education provision and sexual healthcare in

educational establishments, and reduce the risk of sexual exploitation. In addition, it highlights the need to address the problems caused by the role of asylum and immigration, welfare and healthcare structures and practices in increasing the risk of sexual ill health and sexual exploitation for this group.

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#### CONFLICTS OF INTEREST

None.

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