THE SEXUAL HEALTH AND SEXUAL EDUCATIONAL NEEDS OF REFUGEES IN STOCKTON-ON-TEES

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Contents

Abstract and Key Findings	**pg. 3**
1. Introduction	**pg. 4**
2. Background	**pg. 6**
3. Methodology	**pg. 9**
4. Results	**pg. 10**
5. Limitations	**pg. 17**
6. Recommendations and Conclusion	**pg. 18**
7. Appendix 1: Sexual Health Questionnaire	**pg. 20**
8. References	**pg. 30**

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Mr Sacha Bedding,
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Abstract

The purpose of this report is to examine the sexual and educational health needs of refugees living in Stockton-on-Tees. Questionnaires, focus groups, and key informant interviews were used to provide a general overview of sexual activity in the refugee community and consider the essential elements of a sexual health programme. Findings from this study suggest that some of the sexual health needs of the refugee community include:

- Access to services (including HIV/AIDS and STI testing)
- Sexual health education (including information on legislation)
- Support for people who have experience of forced sex or sexual violence
- An integrated approach that addresses an underlying need for community integration

It is hoped that this research can foster discussion amongst health professionals, refugee community leaders, and other community organisations on approaches that best address the needs of the refugee community.

Key Findings

Results from this study show the following sexual health and educative needs in the refugee community:

1. The need for knowledge

- 54% of survey participants do not know where to access information on sexually transmitted infections (STIs)
- 68% stated they did not know the location of the nearest sexual health clinic
- 61% require more advice on contraception

2. The need for accessible and appropriate services

- 40% stated they had never obtained advice or help with sexual health
- 33% stated they had a problem accessing services because they did not know where to go
- 49% agreed with the statement, “It’s hard finding information about sexual health which is relevant to me.”
- 29% agreed with the statement, “I’ve had bad experiences in sexual health services.”

3. The need to promote a safer sex culture

- 43% have paid for sex in the UK
- 39% stated they did not have enough information to practice safe sex
- Participants listed their first and second largest health concerns as HIV/AIDS and STIs
- 50% stated that they would like more information on HIV and STI testing

4. The need for counselling/support and the need for stronger community relations

- 53% have received counselling/support for forced sex (22% have not)
- Refugee interviews revealed a strong need to form relationships and friendships
- Interviews also revealed common feelings of rejection by local women
- Loneliness and boredom were common themes from interviews with refugees

1. INTRODUCTION

Since the government dispersal program began in April 2000, Stockton on Tees has seen the arrival of refugees[1] in larger numbers than ever before. In addition to the housing, education, and employment needs, refugees were arriving with complex health issues that often required additional language and educational support. Additionally, increasing numbers of refugees were arriving at Stockton International Family Centre (SIFC) with feelings of "loneliness" and requesting the need to connect with others in the community. Also at this time, local community and refugee leaders expressed concern over increasing local stories of refugee involvement in both prostitution and underage sex. Although these stories were purely anecdotal, it was felt that if this matter remained ignored the impact of these stories would only encourage tensions and hostility between refugees and the local community.

It was in recognition of these needs that the SIFC was commissioned by the Stockton Borough Council Asylum Support Team to investigate the sexual health needs of refugees in Stockton.

As stated in the Stockton Borough Council proposal:

Aims of this Study

The purpose of this research was to gain an understanding of the sexual and educational needs of refugees living in Stockton-On-Tees and to achieve the following:

- To gain a picture of the sexual activity of the target group
- To work with the target group to consider what are the essential elements of an effective sexual and educative health programme
- To consider anecdotal information regarding the involvement of refugees in child prostitution
- To consider the sexual activity with young people under the age of 19 years

Objectives

As stated in the proposal, the following objectives were identified with regard to these aims:

- How do refugees access sexual health education?
- When refugees access sexual health education how effective do they consider the service?
- How could the service be improved?
- Where would refugees like to access a sexual health service?
- What are the barriers to sexual health and accessing a service?
- What would refugees like to see in a sexual health programme?
- What is the level of understanding of protective sexual activity in the target group?

[1]For the purposes of this report the term "refugee" is used to refer to those currently seeking refugee status and those who have been granted positive refugee status or humanitarian protection.

In relation to sexual activity

- How do refugees view sexual activity in the UK?
- What is the factual information regarding refugee involvement in child prostitution? (Police, SECOS, Health and Social Care)
- What is the sexual involvement of refugees with young people aged 19 and under?
- Is there a need to develop a sexual educative programme to help refugees understand the legislation regarding sexual activity?

Target Groups

This study chose to examine two age groups: those 19 and under and those of all ages. The investigative groups were divided as follows:

- Ages 19 and under: sexual and educative health programme
- All ages:
  - Involvement in child prostitution
  - Sexual activity with young people under age 19

These study aims and objectives were predetermined by funding bodies and Stockton Borough Council Health and Social Care. A panel was then formed to progress the consultation, planning, and implementation of the study. This panel included SIFC staff, local agencies and refugee community leaders.

2. BACKGROUND

Demographics of North East and Stockton Refugees

In the first two years of dispersal (April 2000-February 2002) the North East region saw over 5,500 primary applicant asylum seekers. In June 2002, the total population of asylum seekers in the North East was 17,500 making the region the 4th largest dispersal region in the UK (27).

Latest figures for Stockton on Tees show a total dispersal number of 642 persons seeking asylum (33). However, this figure does not include the larger refugee population including those granted decisions from the Home Office. Once a decision has been granted, National Asylum Support Services (NASS) accommodation and support is discontinued and it difficult to monitor those refugees staying in Stockton. Therefore, there are no reliable estimates of the total refugee population in Stockton.

Table 1: Comparison of populations

Demographics	Study population	Regional refugee population*	Stockton resident population**
Sex: Male Female	 88% 12%	 86% 14%	 50% 50%
Marital Status: Single Married	 73% 24%	 76% 24% (family)[2]	 28% 53%
Age:	76% <30 24% >30	85% <35 15% >35	38% <30 62% >30
Country of origin:	 Iraq =42% Congo D.R =10% Zimbabwe =10% Iran =8.4% Somalia =5%	Stockton only[3] Iraq =35% Congo D.R =3% Zimbabwe =10% Iran =10% Somalia =5%	1.6% = Ethnic Minority

*Source: Wilson, 2002 (34)
**Source: Tees Valley Statistics 2002, and Office of National Statistics

[2]Applicants arriving as a head of the family and not as single applicants
[3]People Seeking Asylum Briefing Paper, 2002

Health Needs of Refugees:

It is well understood that refugees face multiple health related issues. Some are health and nutritional issues which are endemic in their countries. Upon flight from their counties, there are the additional health risks of physical trauma, endemic disease and malnutrition. After arrival to the UK refugees are then confronted with the effects of poverty, dependence and lack of social support. This all serves to undermine both physical and mental health (7,8). Studies of refugee health in the UK have revealed that one in six refugees has a physical health problem serious enough to affect their life and two thirds have experienced anxiety and depression (7).

Community agencies and health providers in Stockton relate findings consistent with the research. Currently, a number of organisations work together to address the physical and mental well being of refugees. Some of these local services include:

- Stockton Borough Council (SBC), provides an Asylum Support Team including caseworkers, a youth worker, and a refugee health care team
- SIFC working with the Asylum Support Team employs a refugee development worker. Activities include social drop in sessions, women's groups, social and leisure activities, support of refugee community organisations (RCOs) and other refugee-led initiatives
- The Sehat Health Project is a community-based health programme of SIFC, that provides advocacy, information and education; it also provides a comfortable, and confidential setting for condom distribution
- Advice sessions are provided by inter-agency liaisons. Some of these include the North of England Refugee Service (NERS), Jobslink, Citizens Advice Bureau, the police service, and volunteer services.
- Roselodge employs support workers and offers an advice service for refugees
- The Stockton GP arrivals practice provides newly arrived refugees with a GP registration and a health assessment and consultation addressing any health concerns
- A number of faith groups have also offered support to the refugee community. For example, various local Christian churches as well the Hartington Road Mosque in Stockton and the Abu Bakr Mosque in Middlesbrough

Sexual Health Demographics

The Department of Health document "*The National Strategy for Sexual Health and HIV*" states that (10):

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

Our community and nation as a whole faces numerous challenges. Some of the issues that affect the North East region and Teesside in particular are an increased teenage pregnancy rate, rising sexually transmitted infections (STIs), and poor access to sexual health services (21,29, 30).

However, this region is not alone. The government has recognised the burden of poor sexual health and has identified targets to address the issues. These strategies include plans to improve sexual health, improve services, and reduce inequalities (10).

An example of some of the national sexual health issues include:

- 30,000 people are living with HIV in the UK with one third still undiagnosed
- An increase in risky sexual behaviour and ignorance about the consequence
- A lower average age at which people start having sex. (Average age of 17)
- Between one third to one half of all teenagers do not use contraception
- Surveys of GUM clinics showed delays of up to a week for urgent appointments and four weeks for routine appointments
- England's teenage birth rates are the highest in Western Europe

Further, it is acknowledged that these issues are not equally distributed among the population. Women, gay men, teenagers, young adults and black and minority ethnic groups bear the highest burden (10). Other examples include:

- People from minority ethnic groups are over-represented in AIDS cases (29)
- Rates of gonorrhea among some inner city BME groups are 10 to 11 times higher than among whites (36)
- Advice on contraception is often provided in a manner culturally inappropriate to the needs of minority ethnic populations (29)

Clearly, sexual health needs are not limited to the refugee population of Stockton-on-Tees. This report will examine the sexual health and education needs of refugees in Stockton in the context of the larger community and national sexual health issues.

3. METHODOLOGY

Focus Groups, Questionnaire, Interviews

Design

SIFC was informed of the aims and objectives of the study and set up an initial focus group of community development workers, SIFC staff and refugee community leaders to further explore the scope of the research.

As an outcome of focus group discussion, an initial pilot self-completing questionnaire was devised. SIFC staff and refugee community leaders designed a questionnaire that was relevant to the issues voiced in refugee interviews and addressed the scope of the study. This questionnaire was then translated from English into the four most common refugee languages in Stockton: French, Arabic, Kurdish and Farsi (33). This was then distributed to a small group of refugee participants. The results of this initial study highlighted some necessary modifications. A final questionnaire was then drafted and translated.

Distribution

Geographically, Parkfield and Mill Lane were the primary areas of distribution. Door to door distribution occurred in areas of National Asylum Support Services (NASS) accommodation, such as Hartington Road, Shaftsbury Street, Yarm Lane, Yarm Road and other areas, as well as the area hostel. Participants ranged in age, sex, marital status, and language. Upon distribution, multilingual representatives of the refugee community explained the aims and objectives of the research, and also offered a remuneration/incentive (a £5 ASDA voucher) for each participant's time. Due to the sensitive nature of the questions, all questionnaires were provided in envelopes that respondents could then take away and return sealed to SIFC.

Interviews

Interviews were initially held with key representatives of the refugee community to gain an understanding of how refugees view sexual activity in the UK, and to explore the issues and needs in a sexual health context. Next, in meeting the predetermined objectives, a series of semi-structured interviews were conducted with key informants of the Police, SECOS (Sexual Exploitation of Children on the Streets) and Health and Social Care Services to identify any factual information of refugee involvement in child prostitution in the Stockton area. Information was then documented and then transferred into a database.

4. RESULTS

1. How do refugees access sexual health education?

Respondents of the questionnaire show that:

- 40% have never accessed any kind of sexual health advice
- 25% did not understand what is meant by the term sexual health
- 68% did not know where the nearest NHS sexual health clinic was

Answering this question first involves recognition that that many refugee respondents (40%) do not access sexual health education at all.

Refugee interviews revealed informal advice is sometimes received from friends or other housemates. Also, there was a general unease in discussion on requesting sexual health services. When asked how refugees access sexual health education, respondents stated, "I am not sure where or why I would need to go." And "I think most people are not comfortable asking about that [sexual health education]," and "Maybe they see their GP, but I don't know."

Many health professionals thought that GPs, the family planning clinics, TPA (Teesside Positive Action), and Sehat project were the primary sexual health services used by refugees. Health professional interviews also pointed out that access difficulties may be more universal in the wider community. It was stated that many people in Stockton do not know the location of the nearest sexual health clinic. This is consistent with literature that shows other population sub-groups experience difficulties accessing sexual health services. A variety of factors can influence behaviours to access. Some issues include embarrassment, fear, insensitivity by health care professionals, or lifestyle factors (11,18, 32).

2. When refugees access sexual health education how effective do they consider the service?

According to the sexual health questionnaire, the statement, "It's hard finding information about sexual health which is relevant to me." (Question 30) showed that nearly half of respondents (49%) agreed. Further, in the statement, "I've had bad experiences in sexual health services," 29% of respondents agreed and 59% disagreed.

Refugee interviews stated that privacy and trust were the most important issues for those seeking sexual health services. Most respondents said they would need to be "one to one" or with someone they can trust. Provision of same sex advice was also discussed as an important factor. Comments on the effectiveness of interpreters were mixed. It was felt that in general interpreters help to convey ideas. However, both health professionals and refugees pointed out that occasionally interpreters or clients of the opposite sex may be uncomfortable discussing personal issues related to sex. Another issue that was highlighted by health professionals is that in refugee communities such as Stockton, interpreters are well known and serve the community in multiple roles such as lay leaders. Therefore, discussing sensitive and confidential information with the use of an interpreter may be uncomfortable for some refugees.

3. What are the barriers to sexual health and accessing a service?

Results from the questionnaire show that when asked what were the problems accessing sexual health services (Question 25):

- 32% do not know where to go
- 29% state that they had a language problem
- 17% were embarrassed
- 9% state staff were mostly of the opposite sex
- 7% stated they were fearful
- 6% fear a breach of confidentiality

Barriers to accessing sexual health have been examined with other populations. For example, a study of sexual health in the Muslim community found that some access issues included language difficulties, or the inability to

access workers from a similar cultural or faith background for support. Additionally, this study found that some Muslim men would commonly not feel comfortable accessing a female worker and vice versa (18). Another study examining access issues in the African community found that many people living with or affected by HIV may not access sexual health services due to anxieties about confidentiality or their HIV status becoming known to authorities like the Home Office, or many Africans may be unaware of the services they are entitled to. This study found that a community development model of sexual health promotion is seen to better address some of the needs of the various religious, tribal, and national groups (31).

4. What would refugees like to see in a sexual health programme? How can existing services be improved?

Questionnaire results are as follows:

When asked what sexual health services participants would like more information on (Question 30):

- 24% stated HIV testing
- 16% would like screening for STIs
- 16% would like testicular examination
- 16% would like relationship counselling
- 14% advice for erection problems
- 10% would like advice on fertility/pregnancy or insemination
- 3% would like advice about smear tests

In another question: "What were you seeking advice about the last time you obtained advice about your sexual health?" (Question 26) Of those respondents who answered the question:

- 27% were seeking advice or education (not specified)
- 18% STI information
- 18% contraception information
- 18% AIDS/HIV information

These responses agree with the key informant interviews. Many refugees interviewed would like advice on relationships or about HIV/AIDS and STIs. Interviewees stated that forming relationships were difficult and were sometimes received by negative response by local women. Some interviewees stated that they were told to "go away" or that "they don't want to talk to refugees". This highlights that refugees would like to see a sexual health programme that addresses both the physical issues (HIV, STIs, testicular exam) as well as psychological health issues (relationship counselling, communication skills, general advice and education). These are some of the identified areas in which existing services can be improved.

5. Where would refugees like to access a sexual health service?

Questionnaire results as to the desired location of services are as follows (Question 27):

- 34% from their GP
- 33% from a Sexual Health Clinic
- 19% from a Private Clinic/Doctor
- 18% from Family Planning
- 14% from a Charitable Advice Centre

Since this study took place, one recent change in addressing sexual health needs is the start of a new GP Arrivals Practice in Stockton. This practice is for all newly arriving refugees. A sexual health component is included as part of the initial health assessment. Patients are asked about sexual health concerns and offered confidential HIV testing services.

This question was also addressed by key informant interviews. Participants suggested many venues such as English for Speakers of Other Languages (ESOL) classes, or colleges and cultural centres such as SIFC. However, one issue that was emphasised is that the place of service is much less important than content. Addressing privacy, same sex education and translation was found to be much more important than the facility. Most participants stated that unless these areas were addressed, they would not seek treatment regardless of facility.

6. What is the level of understanding of protective sexual activity in the target group?

Questionnaire results found that within the 16-19 year old target group (23 respondents):

- 30% did not know what type of protection/contraception devices were available
- 70% use contraception, 30% do not use contraception
- 48% used condoms
- 61% required more information on contraception

Results from this target group indicate that both groups have educative needs regarding protective sex. The results also show both from the survey and the interviews that condoms are the predominant form of contraception. Key informant interviews with the 16-19 year old group showed a mixture of responses regarding protective sex. Some were very aware of the risks involved in unprotected sex, whilst others disagreed by saying, “I don’t think AIDS is such a big problem here.”

Another source on youth refugee health states that sexual health information is often gained from peers and role models in the family or community. It states that the refugee setting is often one of disconnectedness where these role models are not accessible for teens. This creates a setting where sexual risky behaviour is less socially controlled. Therefore, there is a greater risk of pregnancy, STIs and other sexual health problems (28).

Findings from another study of teenagers of Teesside show that this group also has a high burden of STIs and tend to engage in more risky sexual activities than older people. For example, incidences of gonorrhea and genital warts among teenage boys and girls were statistically higher than that of non-teenagers and condom use was also lower. Only 13% of teen girls had ever used condoms (18% for older women) and 26% of teen boys had ever used condoms (32% for older men) (22).

7. How do refugees view sexual activity in the UK?

Key informant interviews showed that common perceptions were that “freedom” was sometimes associated with promiscuity. One participant explained as an example that Iranians might look at Turkey as a society that is more sexually liberated than some countries, but stated in relation the “UK was at the top of the list”.

These interviews also emphasised a need to form relationships for friendship as well as sexual relations. A great many of the refugees interviewed found forming relationships difficult. One interviewee stated that when they tried to talk to local women they were often told, “to go away” or “that they did not want to talk to refugees.” It was suggested that these negative attitudes were supported by media representations of refugees. Another stated, “It wasn’t as bad a few years ago because there weren’t so many refugees and people would talk to you.” There was also a common theme of boredom and loneliness. The lack of social interaction and integration with refugees and the larger community may have health related implications.

8. What is the factual information regarding refugee involvement in child prostitution with the Police SECOS, Health and Social Care?

Police:

Key informant interviews revealed that there have been no prosecutions for underage sex in Stockton at the time of interview (March 2003). There was a general awareness of refugee sexual involvement with young people but ages and specific details were not identified. It was also pointed out that in relation to underage sex, there may be

confusion of the legal age of consent. Currently, there are no programmes in Stockton that explain legislation regarding sexual activity to newly arrived refugees.

SECOS:

SECOS considers the term "child prostitute" a mislabelling and considers the involvement of young persons in prostitution as child abuse and sexual exploitation. There is supporting evidence that this problem is not uncommon on Teesside. Studies by SECOS identified persons as young as 12 who were being sexually exploited. In a study of 30 young people, 57% were under 18 years and 10% were under 16. Additionally, it is not limited to one population or type of community (32). It is a worldwide problem and strategies are needed to rescue these children. It is estimated that 20% of these children will end up with AIDS (21).

Key informant interviews showed that SECOS does not have any documented evidence of refugee involvement in under age sex. All information is anecdotal. Concerns were primarily about young girls being found in refugees' accommodation the past two years. SECOS reported that from 2001 to 2003, there were 31 concerns[4] involving young people. It was felt there is not a strong enough support mechanism for teens in Stockton and this may be related. There was also an identified need for refugees and young people to socialise with members of the opposite sex.

Health and Social Care:

Interviews conducted with Health and Social Care showed that there was no factual or documented information of refugee involvement in child prostitution. Some professionals stated an awareness of refugees with "younger girls" amongst some interviewees but not all. Further, the ages of those involved were not confirmed. Some interviewees suggested this might be related to teens with a drug problem. These suggestions agree with research conducted with children in Middlesbrough that showed 87% of the children who were sexual exploited also admitted to the use of drugs in the past and present. Drugs are often the force that drives young people to work in the first instance and is used as a coping response to the exploitation (32).

9. What is the sexual involvement of refugees with young people aged 19 and under?

To answer this question, a distinction has been made between the sexual involvement with young people under age 16 and between 17 and 19 years old.

- **Sexual involvement of refugees with young persons aged 16 and under:**

As stated by Beere, "Sexual intercourse before the age of consent, 16 years, is technically breaking the law, not by the girl, but by her male partner" (5). Key informant interviews with local refugees revealed that those involved in the exploitation of children were of a minority. Most explained that although they had no information regarding this issue they felt that there was a "grapevine" method whereby those that knew of someone would pass on information to other refugees.

Despite anecdotal information from key informant interviews, there is no factual evidence of refugee involvement in the sexual exploitation of children. It is highly likely that this issue has surfaced in other areas of Stockton before the arrival of refugees given that research suggests nearly 1 in 5 girls and 1 in 4 boys have sex before the legal age of 16 (5). Historically, concerns about sexual involvement with children surfaced in the UK long before the arrival of refugees. In fact, "research suggests that at least 2-4% of men have had actual sexual contact with a child or children at some time in their lives" (13). It was also found that an expressed sexual interest in children appears to be relatively common in the male population in general. Finally, in a review of literature, this study also revealed that "males in a normal adult population will disclose a sexual interest in children if asked in confidential questionnaires" (13).

- **Sexual involvement of refugees with young persons ages 17 to 19:**

As stated earlier, key informants described only anecdotal information of refugees with girlfriends and no ages were included. Currently in the UK, the average age at which people start having sex is 17 years old (5). Therefore, it is likely that there is some sexual involvement of refugees with young persons 17 to 19.

[4]Reports made by professionals about individuals involvement or risk of prostitution.

10. Is there a need to develop a sexual educative programme to help refugees understand legislation regarding sexual activity?

Results from the questionnaire asking about the age of sexual consent show the following (Question 15):

- 3% answered under 16 years old
- 94% of respondents answered 16 years and older
- 3% gave no answer

Questionnaire results show that, for the majority of respondents, there is no confusion about the age of consent. In the past, various programmes have offered information on child protection and other legislation issues to the refugee community. For example, at Roselodge Hostel, police provided information on legal issues. These seminars discussed laws and regulations in relation to sex. The Sehat project also places translated literature into condom packs informing the community of the sexual age of consent.

The Children's Fund Research Project hosted training around issues of child protection and legislation. These were offered to the Teesside refugee community to raise awareness around child protection and identify sources of support and information. This project hosted 2-hour group sessions with same sex refugee settings. Content focused on awareness raising, indicators of abuse, and how to keep children safe. The groups were given case scenarios, and taught how to identify abuse and to report concerns to authorities. These sessions highlighted some difficulties of providing training to a group with multiple languages and often fewer support systems. These sessions also showed that there is often the need for general legislation information such as television licensing. It was also acknowledged that many refugees find the subject of child protection difficult due to personal experiences and emotional trauma. It was therefore recommended that support persons should be available for the needs of traumatised individuals (15).

11. Forced Sex

Questionnaire results highlighted concerning issues of forced sex in the refugee population (Question 23).

- 18% of respondents have been forced to have sex
- Of those respondents, 53% have received counselling

Health professional interviews suggested that this problem might be more prominent than it is reported. Some key informant interviews in the refugee community also discussed issues of forced sex and acknowledged that they knew of people this had happened to. Others suggested that this may be an ongoing issue in Stockton and suggested elements of coercion or domination amongst some in the male refugee accommodation.

Issues of rape, forced sex and sexual violence are often documented in refugee literature. One source states that young girls and women are particularly vulnerable, however sexual violence happens to both women and men and in all age groups. It occurs during conflict, flight from conflict and even in the place of asylum. Figures from refugee camps in Africa show that up to 27% of females had been targets of sexual violence since they became refugees (35).

People who have experiences of sexual violence may experience a profound humiliation, and also confusion about their sexuality. While some social and legal networks exist for women, there is rarely anything comparable for men (35). In another study of people with experience of violence it was noted that sexual violence is often difficult to detect because of the lack of long-term physical signs and strong feelings of shame (6).

12. Paid sex

Questionnaire results show the following results in relation to paid sex (Question 19):

- 43% of respondents have paid for sex, 56% of respondents have not paid for sex

Of those respondents who have:

- 18% 'Once only', 46% 'Sometimes',
- 24% 'Often', and 10% 'Regularly'
- 61% of have exchanged money, and 30% have exchanged gifts
- 6 were HIV infected, 3 Genital herpes and 1 Hepatitis

On the subject of paid sex, most refugee interviews suggested that the majority of paid sex is from local sex workers that come to the houses. The interviews also stated that this issue could cause "problems" and fighting among housemates and other sex workers. There was not a perception or belief of the sex worker as a victim. Nor was there a perception of wrongdoing on the part of the client. One participant explained the situation as, "it is the prostitute that asks, so it must be OK." None of the interviewees knew of anyone who had been arrested or prosecuted for involvement. Some were shocked to learn that a person who purchases sex could be arrested. A common theme from these discussions was that there was no stigma attached to paid sex. It was explained that sex workers sometimes provide a break from the experiences of isolation and loneliness and that was an attempt to fulfil an emotional need as well as physical need. Some explained it as an extension of a "relationship". Some key informant interviews with health professionals and other agencies agreed that the sex industry in Stockton is seen as a major issue. As stated by one interviewee, "Wherever there is prostitution there will be crime. To me refugees could be a big market not just as purchasers of sex but sellers as well in the future."

In a review of existing research of clients seeking sex workers, Monto found that the primary reason for seeking a sex worker is because of interest in sexual practices to which they do not have access. It may be an attraction to the illicit nature of the encounter, a need for greater control over sexual experiences, or because they have difficulty becoming involved in conventional relationships. Finally, the need for companionship, intimacy or love was cited as a primary motivation in some clients (17). Other studies found that there is no one "type" of client. A study of arrested clients show a wide range of ethnicities, level of education, marital and work status (17). Other studies suggest that the largest group of people involved tend to be servicemen. For example, the greatest number of sex workers in the US is also in the same town as the Air Force Academy (12). Another study from the UK examined the number of contacts with prostitutes and the time elapsed since last contact. Most men in this study reported to have multiple contacts and with a median time elapsed since last contact of 60 days (3).

13. STI and HIV/AIDS

In the questionnaire results show the following:

When asked if you have or have ever had a STI (Question 21):

- 88%= no
- 9%= yes

Of those answering yes (30 respondents):

- 33% = gonorrhea
- 23% = HIV/AIDS
- 13% = genital warts
- 10% = chlamydia
- 10% = genital herpes

When asked about the biggest health concern (fill in the blank) (Question 24):

- 91% stated HIV/AIDS or STIs (84% = HIV/AIDS, 7% = STIs)

When asked about the content of the last sexual advice attended (Question 26):

- 36% stated HIV/AIDS and STIs (18% = HIV/AIDS, 18% = STIs)

When asked what would you like to see in a sexual health programme (Question 30):

- 40% stated HIV/AIDS and STI testing (24% = HIV/AIDS, 16% = STIs)

Questionnaire results highlight a health concern of HIV/AIDS and STIs among refugee respondents. This topic was also raised in interviews with both refugees and health professionals. Interviews with refugees showed there was general knowledge of others living with HIV amongst some persons. It was explained by one that because refugees are a large heterogeneous group there might be differing levels of HIV/AIDS knowledge and education prior to coming to the UK. Interviews with health professionals revealed a general consensus that HIV/AIDS is thought to be a bigger problem in the refugee community than is reported. Some others felt that the refugee community does not largely access HIV testing services and believed this may be due to fears of confidentiality.

Literature on refugee health state that HIV/AIDS and STIs spread fastest where there is poverty, powerlessness, and social instability. Stable relationships and communities and families are broken in refugee situations often leading to the disruption of social norms governing sexual behaviour. Some refugees also come from countries with higher HIV rates. Also, some refugees are also at risk as a result of sexual violation or resorting to sex work order to survive during their flight (6, 28).

Sexual health findings from UK studies show that HIV/AIDS and STIs have also had a more severe impact on some BME communities (10, 11, 26). For example, rates of gonorrhea among some inner city London BME groups are 10 to 11 times higher than among whites (36), some black ethnic minorities have the highest rates of bacterial STIs, and over 70% of heterosexually acquired HIV infections diagnosed in the UK in 2000/2001 were in people from or associated with exposure in Africa (26). Specifically, in relation to HIV/AIDS in the African community, Terrence Higgins Trust identified some of the difficulties with HIV in the African community. Some of these are a low uptake of counselling and testing, accessing services late, and people living with HIV can be stigmatised within African communities (31).

Tees Health Authority has also examined regional figures of HIV/AIDS and STIs. Figures from 2001 show 314 persons diagnosed HIV infected patients in the North East. (84% White, 13% Black African and 3% Indian/Pakistani or other Asian background) (30). In relation to STIs, from 1996 to 2001, statistics from GUM clinics in the Northern and Yorkshire region show a five year increase of 206% in syphilis cases (gonorrhea 104% increase and genital chlamydia 106% increase) (30).

Although it is important to acknowledge ethnic disparities in sexual health, interventions must have a focus on empowering communities. Special attention must be given so that ethnic differences should not be used as a tool for stereotyping and exploitation (11).

5. LIMITATIONS

Some of the limitations of this study include a limited body of evidence on refugee sexual health, research methods and use of surveys, and issues relating to wording of survey questions.

Accessing information on the sexual health needs of refugees produced minimal information. Online literature searches were performed using Medline, CINAHL, and Social Science Citation Index. There is however, a larger body of literature on refugee sexual health as it relates to people with experience of sexual violence and torture and reproductive health and HIV/AIDS in refugee camps in the majority world. This report used existing literature on sexual health in Britain, the North East and Teesside where available, sexual health in amongst BME groups, and general refugee health to place the sexual health of refugees in a wider context.

Another limitation of this study was the difficulty in making comparisons with other populations or with that of regional or national statistics. For example, figures from the questionnaire that show less than 3% of respondents thought the legal age of sexual consent was under 16 years. Questionnaire results also show that 43% of respondents have paid for sex. However no information was located on the age of consent knowledge and use of paid sex in the general population. It is impossible to make an informed judgement on these issues raised without reference to similar or the larger population. Interpretation and evaluation can only take place when figures can be established in light of larger demographics.

Other limitations involved the questionnaire and the use of questionnaires as a research tool. The questionnaire was translated into the five most commonly spoken and read languages of refugees in Stockton. Speakers of other common languages such as Lingala and Amharic, or for those persons unable to read would have been excluded from the survey. Other difficulties with the survey include the wording and terminology used. For example, in the question about counselling or support received for forced sex (Question 23), this term does not specify whether this was formal support with a professional or simply support of a friend. Additionally, when asked to specify the frequency of paid sex (Question 19), the terms “sometimes”, “often” and “regularly” may be confused without any quantification.

The questionnaire also covered a broad range of topics such as access, education, HIV/AIDS, and age of consent. It was designed to present an overall picture of sexual health in the refugee population. One of the limitations is that the topics were not discussed in detail. For example, 29% of respondents stated they exchanged gifts for sex. However, this question was not probed further as to the nature of these gifts. This issue was discussed during the questionnaire design and it was decided that maintaining a brief questionnaire of 30 broad questions might produce a higher response rate than that of a longer in-depth questionnaire.

6. RECOMMENDATIONS AND CONCLUSION

It is recommended that this research serve the following purposes:

- Empower the refugee community to address sexual health issues
- Foster discussion amongst health professionals
- Explore ways to improve sexual health services for refugees

The next step should be a discussion amongst refugee leaders, health professionals, and community agencies on approaches to addressing health issues. The development of a refugee sexual health forum can be established to discuss common issues of concern, a local strategy for sexual health work and share good practice. The questionnaire and key informant interviews have identified some of the key areas for future efforts. Those include:

- Access to sexual health services (including HIV/AIDS and STI testing)
- Education provision (including legislation)
- Support for people with experience of sexual violence and forced sex
- An integrated approach to sexual health that addresses the underlying need for better community relations

Access to sexual health services (including HIV/AIDS and STI testing)

As highlighted in the questionnaire and interviews, some of the difficulty in refugees receiving sexual health education is the issue of access. 40% of respondents stated they had difficulties in accessing services and over half (62%) was related to not knowing the location of services or from language problems. Similar difficulties have also been identified in other BME literature showing that many people from BME communities felt that sexual health services were not sensitive to their needs, or were unaware of the existing services (9, 18, 31). Some approaches to this include use of well-publicised materials in community languages. Also, one study found that young men often wait longer before seeking sexual health services, and used the approach of introducing HIV/AIDS and STI screening at primary health services regardless of the presenting complaint (2, 18, 31).

Utilisation of existing programmes a sexual health education program for refugees could be linked to existing health promotion work presently provided for refugees. Promoting the existing community resources in multiple spaces across the community is a way to ensure information is disseminated an accessible. Also, encouraging the collaborative work from these existing agencies such as the GP arrivals practice, SIFC's Sehat project, asylum support health care team, family planning and GUM clinics will ensure service is consistent and addresses a variety of linguistic, cultural and religious needs.

Education Provision (Including Legislation):

This research also confirms that a large part of sexual health needs is for basic advice and education. Previous research in health promotion and health education has also focused on use of "community champions" or peer educators to be actively involved in the design and delivery of health education (9, 18, 31). Using refugee leaders throughout this research project proved to be highly successful in producing a high response rate and a representative sample population. Some studies have found that the use of peer educators has shown to build a level of support and resources, and services to the community. This can also ensure that programmes are addressing some of the cultural or religious needs of the community (18, 31).

Other means of education provision with issues such as legislation may include the re-introduction of "orientation" style sessions at accommodation centres. Information from community leaders, the police and other services can explain legal issues in the UK and offer support for those with concerns or questions. This will provide a consistent message is reaching all refugees new to the community.

Support for people with experiences of forced sex or sexual violence:

The questionnaire highlights an area of need in relation to forced sex and counselling for people with experience of it. Studies show that presenting complaints of many people with experience of forced sex can present to the medical community with complaints of sleeplessness, nightmares, lethargy, headaches, or other complaints that appear to have a physical basis (6). It is important that special attention is given to their psychosocial needs. Suggestions of ways to address the psychosocial needs include (28):

- Identification and training of community-based support workers
- Developing support groups specially designed for survivors of sexual violence and their families
- Creation of drop in centres for confidential and compassionate care

These suggestions are not population specific, but are applicable in other groups and settings.

Integrated approach to sexual health:

A sexual health programme for refugees cannot be isolated from other initiatives. It must be implemented in coordination other community-wide initiatives such as the Refugee Integration Strategy for Stockton and Community Cohesion. Because of the many physical and mental health issues facing refugees, a sexual health programme must not only address broad health concerns but also the underlying causes of problems. Unless the underlying issues of poverty, joblessness, racism, and social isolation are addressed, a sexual health strategy alone will be unsuccessful. The poor social conditions of refugees must be dealt with from multiple levels. By addressing integration issues and providing means for socialisation and belonging a far greater impact can be achieved.

Conclusion:

Finally, the purpose of this research is to inform the community and to foster discussion on how to improve services to refugees. Careful attention must be given that this original purpose is maintained. In many instances vulnerable groups who assist in research or projects are left with fewer services and damaging media ramifications. Previous media representations of asylum seekers and refugees have also confirmed this. SIFC and other Stockton community agencies are dedicated to serving those groups in need. Maintaining this integrity and a high level of trust in the community is of the highest importance.

7. APPENDIX 1: SEXUAL HEALTH QUESTIONNAIRE

Number of Questionnaires returned by language

	Kurdish	English	French	Arabic	Farsi
No. of questionnaires	78	64	48	32	28
% of questionnaires	31.2%	25.6%	19.2%	12.8%	11.2%

QUESTIONNAIRE RESPONSES

1. (Gender) are you?

	Female	Male
No. respondents	29	221
% of respondents	11.6%	88.4%

2. How old are you?

	16-19	20-25	26-30	30+
No. respondents	23	107	59	61
% of respondents	9.2%	42.8%	23.6%	24.4%

3. What is your country of origin?

	Iraq	Congo	Zimbabwe	Ivory Coast	Iran
No. respondents	104	26	25	24	21
% of respondents	41.6%	10.4%	10.0%	9.6%	8.4%

	Somalia	Cameroon	Burundi	Afganistan	Ethiopia
No. respondents	12	6	6	5	5
% of respondents	4.8%	2.4%	2.4%	2.0%	2.0%

	Eritrea	Rwanda	Nigeria	Uganda	Turkey
No. respondents	4	4	3	3	2
% of respondents	1.6%	1.6%	1.2%	1.2%	0.8%

4. To which religious group do you belong to?

	Islam	Christianity	None	Hinduism	Judaism
No. respondents	150	93	3	2	2
% of respondents	60.0%	37.2%	1.2%	0.8%	0.8%

5. (Refugee Status) Are you?

	Seeking asylum	Refugee	Extended leave to remain
No. respondents	143	68	39
% of respondents	57.2%	27.2%	15.6%

6. Do you have a disability?

	No	Yes	No Answer
No. respondents	215	29	6
% of respondents	86.0%	11.6%	2.4%

7. How would you describe your sexuality?

	Heterosexual	Homosexual	Don't use term	Bisexual	No Answer
No. respondents	199	20	17	11	3
% of respondents	79.6%	8.0%	6.8%	4.4%	1.2%

8. (Marital status) Are you?

	Single	Married	Separated	Divorced	No Answer
No. respondents	182	59	4	2	3
% of respondents	72.8%	23.6%	1.5%	0.8%	1.2%

9. Do you understand the term 'sexual health'?

	No	Yes	No Answer
No. respondents	185	62	3
%of respondents	74.0%	24.8%	1.2%

10. Are you a parent?

	No	Yes	No Answer
No. respondents	161	81	8
% of respondents	64.4%	32.4%	3.2%

11. Would you like children in the future?

	Yes	Don't Know	No	No Answer
No. respondents	190	41	16	3
% of respondents	76.0%	16.4%	6.4%	1.2%

12. Do you know what types of protection/contraception devices are available?

	Yes	No	No Answer
No. respondents	190	56	4
% of respondents	76.0%	22.4%	1.6%

13. Do you use contraception?
Total response = 250

	Yes	No	No Answer
No. respondents	184	52	14
% of respondents	73.6%	20.8%	5.6%

13. If yes which?
Of those that answered yes (some of the respondents used more than one method)
Total responses = 198

	Condom	Natural	Pill	Injection	Coil	Sterilisation
No. responses	160	14	12	6	3	3
% of responses	80.8%	7.1%	6.1%	3.0%	1.5%	1.5%

14. Do you require more advice on contraception?

	Yes	No	No Answer
No. respondents	153	73	24
% of respondents	61.2%	29.2%	9.6%

15. What do you think is the age of sexual consent/permission in the UK?

	12	14	16	18	18+	No Answer
No. responses	5	2	54	143	39	7
% of responses	2.0%	0.8%	21.6%	57.2%	15.6%	2.8%

16. Would you have sex with a person under 16 if they gave their consent/permission?

	No	Yes	No Answer
No. respondents	226	22	2
% of respondents	90.4%	8.8%	0.8%

17. Do you have a regular sexual partner?

	No	Yes	No Answer
No. respondents	178	62	10
% of respondents	71.2%	24.8%	4.0%

If more than one, how many (tick as many as apply)?
Total responses = 69

	2 partners	3 partners	3+ partners
No. responses	32	15	22
% of responses	46.4%	21.7%	31.9%

18. Have you had sex outside of marriage/regular partner?

	No	Yes	Not Applicable	No Answer
No. respondents	111	70	56	13
% of respondents	44.4%	28.0%	22.4%	5.2%

19. Have you paid for sex in the UK?

	No	Yes	No Answer
No. respondents	139	107	4
% of respondents	55.6%	42.8%	1.6%

If yes,
Total responses = 107

	Once only	Sometimes	Often	Regularly	No Answer
No. respondents	19	49	25	11	3
% of respondents	17.8%	45.8%	23.4%	10.3%	2.8%

If yes, did you exchange?
Total responses = 107

	Money	Gifts	Other	No Answer
No. respondents	65	31	1	10
% of respondents	60.8%	29.0%	0.9%	9.3%

20. Do you know where to go to find information about sexually transmitted infections?

	No	Yes	No Answer
No. respondents	134	107	9
% of respondents	53.6%	42.8%	3.6%

21. Do you, or have you ever had a sexually transmitted infection?

	No	Yes	No Answer
No. respondents	219	23	8
% of respondents	87.6%	9.2%	3.2%

If yes, which infection?
Of those that answered yes (some of the 23 respondents had more than one STI ?
Total responses = 30

	Gonorrhea	HIV/AIDS	Genital Warts	Chlamydia	Genital herpes	Hepatitis B/C	Pubic lice
No. respondents	10	7	4	3	3	2	1
% of respondents who answered(out of 30)	33.3%	23.3%	13.3%	10.0%	10.0%	6.6%	3.3%
% of total respondents (out of 250)	4.0%	2.8%	1.6%	1.2%	1.2%	<1%	<1%

22. Do you feel you have enough information to practice safe sex?

	Yes	No	No Answer
No. respondents	132	98	20
% of respondents	52.8%	39.2%	8.0%

23. Have you ever been forced to have sex?

	No	Yes	No Answer
No. respondents	196	45	9
% of respondents	78.4%	18.0%	3.6%

If yes, have you ever received counselling/support as a result of this?
Total responses = 45

	Yes	No	No Answer
No. respondents	24	10	11
% of respondents	53.3%	22.2%	24.4%

Was this counselling/support?
Total responses = 33

	In Country of origin	In the UK	In Stockton
No. respondents	13	13	7
% of respondents	39.4%	39.4%	21.2%

24. What are your biggest sexual health concerns?
1st biggest health concern
Total of respondents who answered question = 77
Total respondents = 250

	HIV/AIDS	STIs	Contraception	Sexual performance	Unwanted pregnancy	No Answer
No. respondents	65	5	4	2	1	173
% of respondents who answered(out of 77)	84.4%	6.5%	5.2%	2.5%	1.2%	---
% of total respondents (out of 250)(out of 250)	26%	2.0%	1.6%	0.8%	0.4%	69.2%

2nd biggest health concern
Total of respondents who answered question = 34
Total respondents = 250

	STIs	Unwanted pregnancy	HIV/AIDS	Sterilisation
No. respondents	22	4	4	1
% of respondents who answered(out of 34)	64%	11.8%	11.8%	2.9%
% Total of respondents (out of 250)	8.8%	1.6%	1.6%	0.4%
	Emotional trauma	**Treatment**	**Death**	**No Answer**
No. respondents	1	1	1	216
% of respondents who answered(out of 34)	2.9%	2.9%	2.9%	---
% of total respondents (out of 250)	0.4%	0.4%	0.4%	86.4%

3rd biggest health concern
Total of respondents who answered question = 20
Total respondents = 250

	Unwanted pregnancy	STIs	Rape
No. respondents	11	7	1
% of respondents who answered(out of 34)	55.0%	35.0%	5.0%
% of total respondents (out of 250)	4.4%	2.8%	0.4%
	Adultery	**Sexual performance**	**No Answer**
No. respondents	1	1	229
% of respondents who answered(out of 34)	5.0%	5.0%	---
% of total respondents (out of 250)	0.4%	0.4%	91.6%

25. Do you have a problem accessing sexual health services?

	No	Yes	No Answer
No. respondents	125	101	24
% of respondents	50.0%	40.4%	9.6%

If yes, why?
Of those that answered yes (some of the 101 respondents had more than one problem)
Total response = 164

	Don't know where to go	Due to language problems	I am embarrassed
No. respondents	54	47	27
% of respondents	32.9%	28.6%	16.5%
	Staff mostly of opposite sex	**I am fearful**	**Fear a breach of confidentiality**
No. respondents	15	11	10
% of respondents	9.1%	6.7%	6.1%

26. When was the LAST TIME you obtained any kind of advice or help about your sex life or sexual health?

	Never	In the last month	In the last year	Last five years	Five years ago	No Answer
No. respondents	100	29	53	22	17	29
% of respondents who answered(out of 30)	40.0%	11.6%	21.2%	8.8%	6.8%	11.6%

What were you seeking advice or help about?
Total of respondents who answered question = 22
Total respondents = 250

	Advice/ education	STIs	Contraception	HIV/AIDS
No. respondents	6	4	4	4
% of respondents who answered(out of 22)	27.3%	18.2%	18.2%	18.2%
% of total respondents (out of 250)	2.45%	1.6%	1.6%	1.6%
	Pregnancy	**Smear**	**Sexual performance**	
No. respondents	2	1	1	
% of respondents who answered(out of 22)	9.0%	4.5%	4.5%	
% of total respondents (out of 250)	0.8%	0.4%	0.4%	
	Relationship	**Sexuality**	**No Answer**	
No. respondents	1	1	226	
% of respondents who answered(out of 22)	4.5%	4.5%	---	
% of total respondents	0.4%	0.4	90.4%	

27. Where would you like to access sexual health advice or help?
(some of the respondents chose more than one service)
Total responses = 295

	GP/Doctor	Sexual health clinic	Private clinic/doctor	Family planning	Charitable advice centre
No. responses	84	83	48	45	35
% of responses	33.6%	33.2%	19.2%	18.0%	14.0%

28. Do you know where your nearest NHS sexual health clinic is?

	No	Yes	No Answer
No. respondents	170	65	15
% of respondents	68.0%	26.0%	6.0%

29. Indicate whether you agree or disagree with the following statements:
'It's hard finding information about sexual health which is relevant to me'

	Agree	Disagree	No Answer
No. respondents	123	105	22
% of respondents	49.2%	42.0%	8.8%

'I've had a bad experiences in sexual health services'

	Agree	Disagree	No Answer
No. respondents	73	147	30
% of respondents	29.2%	58.8%	12.0%

30. Which of the following sexual health services would you like more information about: (tick as many as apply) some of the respondents chose more than one service.

	HIV testing	Screenings for STIs	Testicle examination	Relationship counselling
No. respondents	97	66	65	64
% of respondents	23.8%	16.2%	16.0%	15.7%
	Advice for erection problems	**Fertility and pregnancy insemination**	**Smear test**	**Other**
No. respondents	55	40	13	7
% of respondents	13.5%	9.8%	3.2%	1.7%

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