

asylum seekers and refugees
resource pack
for health care professionals

National Resource Centre for Ethnic Minority Health

The aim of the resource pack

- To provide useful information for frontline staff such as health visitors, practice nurses and general practitioners.
- To develop cultural competence in the services they provide.
- To enable each health professional to broaden their knowledge base in relation to asylum issues.
- To give guidance to health professionals on useful resources and where to access further information.

Acknowledgements

This publication was edited by Ann McDonald with support from Eleanor Wilson.

The editors would like to acknowledge the support and advice provided by many colleagues during the course of its preparation. There is not enough space here to mention everyone who has contributed and we therefore apologise in advance for any glaring omissions. Comments and suggestions from colleagues have played a central role in the shaping of this tool. This process of consultation is, we believe, the guarantee that the resource pack will be a tool that is genuinely useful to staff working on the frontline of service delivery to asylum seekers and refugees.

Special thanks to Fernando Boero for supplying the maps.

We would like to thank all those who appear in the pictures in this publication which were taken at the North Glasgow Sighthill Festival in 2004.

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'Ordinary people in extraordinary circumstances'

Preface

Every year brings new challenges to those of us who work in the health service in Scotland. With our professional training and working experience, we are well equipped to meet most of these challenges head on.

The arrival of substantial numbers of asylum seekers and refugees in the last few years has been a new challenge for many of us. Those of us working with these communities have done our best to fit their needs into our existing practices and help them access the services that they require. However, many of us have also felt a need for a ready source of information on the health needs and cultural background of such individuals. This would help us serve these patients much more effectively.

The project to develop an Asylum Seekers and Refugees Resource Pack has required more time and effort than we perhaps imagined at the start. The National Resource Centre for Ethnic Minority Health has been very fortunate to have had the services of Ann McDonald and Eleanor Wilson to carry out the work. I am very grateful for the dedication that they have shown to this task.

They have also been fortunate in the advice and support provided by many colleagues working in the health field and working with the new communities of asylum seekers and refugees in Glasgow. Their input has ensured that the end result is something that will be genuinely useful for its users.

In the first place, the resource pack is primarily aimed at colleagues working in Glasgow, as this is where the majority of asylum seekers and refugees in Scotland have been based. However, we hope it will also be useful to colleagues in other parts of Scotland with patients from these communities.

The loose-leaf format that has been adopted is intended to make the resource pack easy to access for frontline health staff and also to allow regular updating and revision and insertion of materials relevant to local circumstances in different parts of the country.

We are delighted to recommend the resource pack for your use. We look forward to receiving your feedback on the pack so that it can be made even more useful to frontline staff. We hope very much that it will assist all of us in making our health services more accessible to asylum seekers and refugees and in providing a better service to them.

Dr Rafik Gardee
Director
National Resource Centre for Ethnic Minority Health
NHS Health Scotland

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Introduction

Scotland has had the pleasure of welcoming groups of people from all over the world, many having come to Glasgow. Some of these arrive as asylum seekers and refugees – terms that can evoke strong emotions as they are both stigmatising and misleading. Research has shown how confusing these terms can be and how they have a tendency to create negative images, especially in the media. Perhaps a broader and more caring name could be considered – how about ‘new communities’?

Asylum seekers and refugees remind us that they are trying to rebuild their lives in a positive way, integrating with and actively taking part in the existing communities as they establish new roots in Scotland. These are ordinary people who have been forced to seek asylum through extraordinary circumstances. Many have fled political oppression, war and conflict in their home countries.

From experience of working with asylum seekers and refugees, the National Resource Centre for Ethnic Minority Health has gained insights and knowledge, which has prompted us to compile this toolkit for health care professionals and those interested in providing culturally competent care for patients and clients seeking asylum in Scotland.

Why Glasgow?

Although the government has a policy of dispersing asylum seekers throughout the UK, Glasgow is the only city in Scotland to contract with the National Asylum Seekers Support Service (NASS) and as a result almost all asylum seekers in Scotland live in Glasgow. Once granted refugee status, some families do move away but a significant number of refugees remain in or around Glasgow.

For this reason, most of the asylum seekers and refugees with whom we have been working live in Glasgow and this is reflected by the pack’s focus on Glasgow. However, as the refugee community gradually moves out of Glasgow and into other areas of Scotland, the issues with which we have been dealing in Glasgow will become issues that other areas have to tackle – as such this resource pack will have to be revised to encompass the ‘Scottish experience’.

Summary

Over the past number of years, working with asylum seekers and refugees has been one of the topic areas for discussion both in health settings and in the wider community. Some health professionals have described it as a steep learning curve.

As asylum seekers and refugees are not a homogeneous group of people, they have individual needs in terms of the asylum process, which can subsequently lead to many health challenges. In working with these groups, health professionals are sometimes faced with a complexity of care provision.

The compilation of materials for this resource pack was instigated by this experience – and a variety of questions being asked by frontline staff who are working in primary care with asylum seekers and refugee communities within Glasgow.

The aims of the pack are:

- to provide useful information for frontline staff such as health visitors, practice nurses and general practitioners
- to develop cultural competence in the services they provide
- to enable each health professional to broaden their knowledge base in relation to asylum issues
- to give guidance to health professionals on useful resources and where to access further information.

How to use the resource pack

This resource pack is neither prescriptive nor exhaustive; it offers a starting point of practical information for staff working with asylum seekers and refugees. As this is an ever changing and evolving area for government policy new materials will be added to keep health professionals up to date with the latest developments that will shape their clinical practice.

The National Resource Centre for Ethnic Minority Health (NRCEMH)

The founding principle of the NHS is that everyone is entitled to fair access to health care and has the right to opportunities for better health.

'Fair For All' stocktaking was commissioned by the Scottish Executive Health Department in February 2000 to consider to what extent NHS Boards and Trusts were delivering culturally appropriate services and promoting race equality.

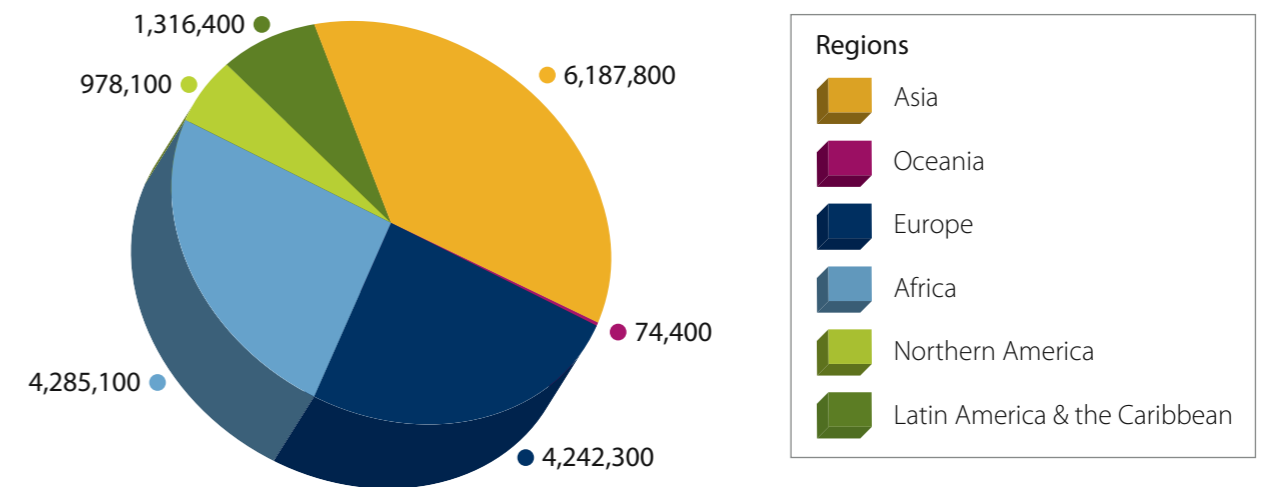
The **Scottish Refugee Integration Forum** (SRIF) was established in January 2002. Working in partnership with the Scottish Executive, and in consultation with the wider public and voluntary sector, action plans were developed to integrate refugees into Scotland. Although much of this work concentrated on Glasgow, the actions have a national focus.

The **National Resource Centre for Ethnic Minority Health** (NRCEMH) supports the work of SRIF in developing a National Action Plan for the integration of refugees and asylum seekers in Scotland. As part of the wider Fair For All agenda, the NRCEMH has a key role in supporting NHS to take forward the SRIF report on health and social care actions.

The global picture

Estimated number of dispersed persons who fall under the mandate of UNHCR – 1st January 2003. **Total: 20,556,781**

The global refugee crisis affects every continent and almost every country in the world. Throughout history, people have fled their homes to escape persecution. In the aftermath of World War II, the international community included the right to asylum in the 1948 Universal Declaration of Human Rights. In 1950 the position of High Commissioner for Refugees (UNHCR) was created to protect and assist refugees and in 1951 the United Nations adopted the Convention Status relating to refugees. This is a legal and binding treaty that has been ratified by 140 countries.



Refugees, asylum seekers and others of concern to UNHCR - 1st January 2003

Who is an asylum seeker?

An asylum seeker is 'a person who has submitted an application for protection under the Geneva Convention and is waiting for that claim for asylum to be decided by the Home Office.'

Who is a refugee?

Under international law, the word 'refugee' has a very precise meaning, as set out in the 1951 United Nations Convention Relating to Refugees.

In the Convention, a refugee is defined as someone who:

has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion;

is outside the country they belong to or normally reside in;

and

is unable or unwilling to return home for fear of persecution.

The 1951 United Nations Convention Relating to Refugees was drafted in the context of the millions of refugees in post-war Europe, and only applied to European nationals. However, in 1967, a UN protocol extended the Convention to cover any person, anywhere in the world, at any time. These two documents remain the foundation of refugee law today, committing its 130 signatories, including the UK, to certain obligations.

However, the interpretation of the Convention varies from country to country. In the UK, whilst someone is waiting for their application for refuge to be considered by the government, they are known as an 'asylum seeker'.

Some asylum seekers and refugees have fled from countries where they have been persecuted simply for being a member of a religious or ethnic group; some have taken a deliberate stand against an oppressive government; others were already in the UK as visitors or students when political changes in their home country made it extremely dangerous for them to return.

Myths and facts

Key facts

- Many of those arriving in Scotland are families with children who are fleeing violence and persecution in their own country.
- They are coming here because they are vulnerable. We are well-equipped to help. A support structure is already in place for all nationalities seeking asylum.
- Central government will be meeting the reasonable costs of looking after asylum seekers, so local services will not suffer.
- Limited numbers will be moving to each of the locations and their stay will be limited while the Home Office looks at their case for asylum.
- Refugees are nothing new. They have been coming to Scotland for hundreds of years and have contributed to the country's achievements.
- Scotland already supports a number of asylum seekers. The arrangements will ensure that arrivals are planned for and controlled.

Common myths

Fears, rumours and half-truths abound in many people's understanding of the asylum seekers issue. Here, we put the record straight:

Myth	Truth
They are illegal immigrants rather than people who have genuinely applied for asylum at the port of entry.	Many refugees were forced to leave their country illegally, leaving their papers and possessions behind. However unconventional their arrival in the UK they deserve fair consideration of their case. Many of them are eventually granted full refugee status.
Britain is swamped with millions of asylum seekers.	UNHCR estimate that there are 19,783,100 people seeking asylum in the world, of that number 88,300 people applied for asylum in the UK in 2001. The UK receives less than 0.5% of the world's refugee population.
They are being given a high standard of housing while locals are homeless and living in run-down homes.	Council taxpayers' money is not used to house asylum seekers therefore local people are not being disadvantaged. We are meeting our obligations under international law to treat asylum seekers fairly and decently.

Myth	Truth
They are not real refugees like the Kosovans were.	Like the Kosovans, many asylum seekers come from war-ravaged countries.
They cannot all be genuine.	The criteria for granting refugee status are decided by the Home Office.
Asylum seekers are taking our jobs and benefit payments.	Asylum seekers are not allowed to work until they are granted refugee status. They get only 70% of UK benefits.
They will jump the queue for housing.	Councils are using properties that do not have a waiting list and are readily available. Many will be placed in private housing.
If we gave them less they'd stay away.	This is not so – many faced persecution or death if they remained in their own country and had no alternative but to seek asylum. They should not be punished further by being allowed to simply exist in this country.
They'll never be like us and we risk losing our identity.	Asylum seekers and refugees are ordinary people in extraordinary situations. Many of the things we take for granted came from abroad. For example, Russian immigrants introduced fish and chips to the UK in the 19th century.
They come to the UK because of the benefit system.	Home Office research in 2002 revealed that asylum seekers do not have advance knowledge of the UK welfare system and very often don't know that the UK is their destination.
Scotland has no capacity to accept new citizens.	Over 2 million UK citizens went to live abroad between 1991 and 2000. Scotland's population has dipped below 5 million. This is a major area of concern for Scottish business and the Scottish Executive.

Source <http://www.asylumscotland.org.uk/mythsfacts.html>

Asylum applications in the UK

In 2003 the number of people applying for asylum fell by 41% to 61,050¹, compared with a total of 103,100 in 2002.

There were 7,920 applications for asylum in the UK in the second quarter of 2004 (April to June). This was 11% less than the previous quarter and 26% less than the second quarter of 2003. 49,405 asylum applications were received in 2003, 41% lower than in 2002 (84,130).

Including dependants, there were 9,210 asylum applications in the second quarter (13% less than the previous quarter) and 60,045 in 2003 (42% less than 103,080 in 2002).

Who is applying for asylum?

Home Office statistics indicate that the ten countries of origin of asylum seekers coming to the UK in the first quarter of 2003 (in order of magnitude) were:

- | | |
|----------------|----------------------------------|
| 1. Iraq | 6. Iran |
| 2. Somalia | 7. Turkey |
| 3. Zimbabwe | 8. Pakistan |
| 4. Afghanistan | 9. India |
| 5. China | 10. Democratic Republic of Congo |

These nationalities accounted for 58% of all asylum applications.

- | | | |
|--|---------------------------|------------------|
| 1. Albania | 20. Ghana | 39. Nigeria |
| 2. Angola | 21. Guinea | 40. Palestine |
| 3. Argentina | 22. Guyana | 41. Russia |
| 4. Armenia | 23. Israel | 42. Rwanda |
| 5. Azerbaijan | 24. Ivory Coast | 43. Senegal |
| 6. Bangladesh | (Côte D'Ivoire) | 44. Serbia |
| 7. Belarus | 25. Jamaica | 45. Sierra Leone |
| 8. Bosnia | 26. Kazakhstan | 46. South Africa |
| 9. Burkina Faso | 27. Kenya | 47. Sri Lanka |
| 10. Burundi | 28. Kyrgystan | 48. Sudan |
| 11. Cameroon | 29. Kosovo | 49. Syria |
| 12. Cape Verde | 30. Liberia | 50. Tajikistan |
| 13. Central African Republic | 31. Libya (Arab Republic) | 51. Tanzania |
| 14. Congo | 32. Macedonia (FYR) | 52. Turkmenistan |
| 15. Cyprus (Northern Turkish Republic) | 33. Malawi | 53. Yemen |
| 16. Egypt | 34. Mauritius | 54. Yugoslavia |
| 17. Eritrea | 35. Mongolia | 55. Zambia |
| 18. Ethiopia | 36. Montenegro | |
| 19. Georgia | 37. Morocco | |
| | 38. Nicaragua | |

Represented countries with numerically < 2%

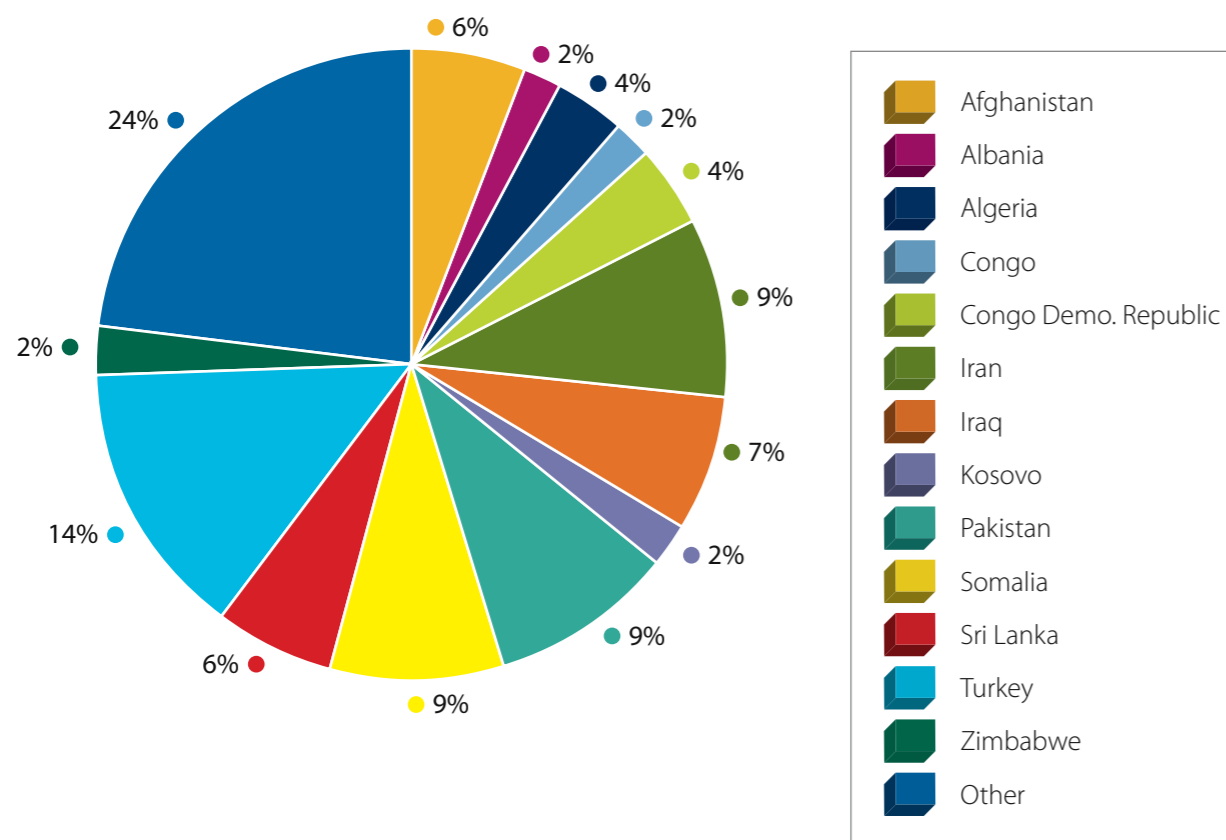
¹Source: Home Office. This figure includes applicants, families and dependants.

The Scottish picture

The only health board areas in Scotland which do not have asylum seekers are the three island authorities.

All other health boards have asylum seekers although some will only have very small numbers. However, refugees are increasingly moving to different parts of Scotland.

Nationality of asylum seekers living in Glasgow



The Glasgow picture

In 2000 the Glasgow Asylum Seekers Support Project (GASSP) was set up to provide a wide range of services to asylum seekers and refugees dispersed to Glasgow through the National Asylum Support Services (NASS). GASSP is an autonomous unit within Glasgow City Council's Social Work Services.

Its aim is to facilitate the City Council's contract with NASS for the procurement of 2,500 units of accommodation and support for asylum seekers. It is responsible for: meeting dispersals; accommodation and furniture; orientation; advice and assistance; education and primary health care services.

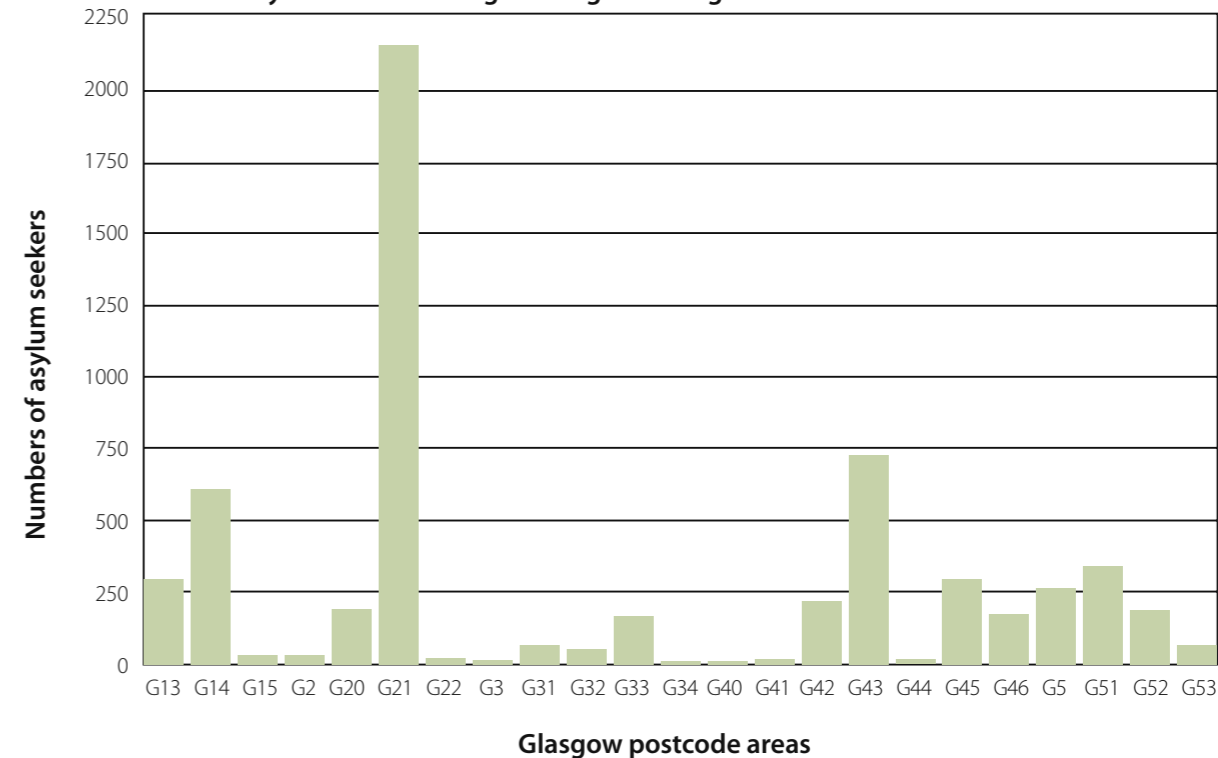
GASSP is a unique working partnership fostered to provide connected services with Greater Glasgow Primary Care Division (GGPCD) and colleagues from the City Council Housing/Social Work and Education Department, and police services.

A Health Co-ordinator, from GGPCD and based in Kelvinhaugh Street, works closely with colleagues from the GASSP Project Team to provide accessible health services to asylum seekers dispersed across the city.

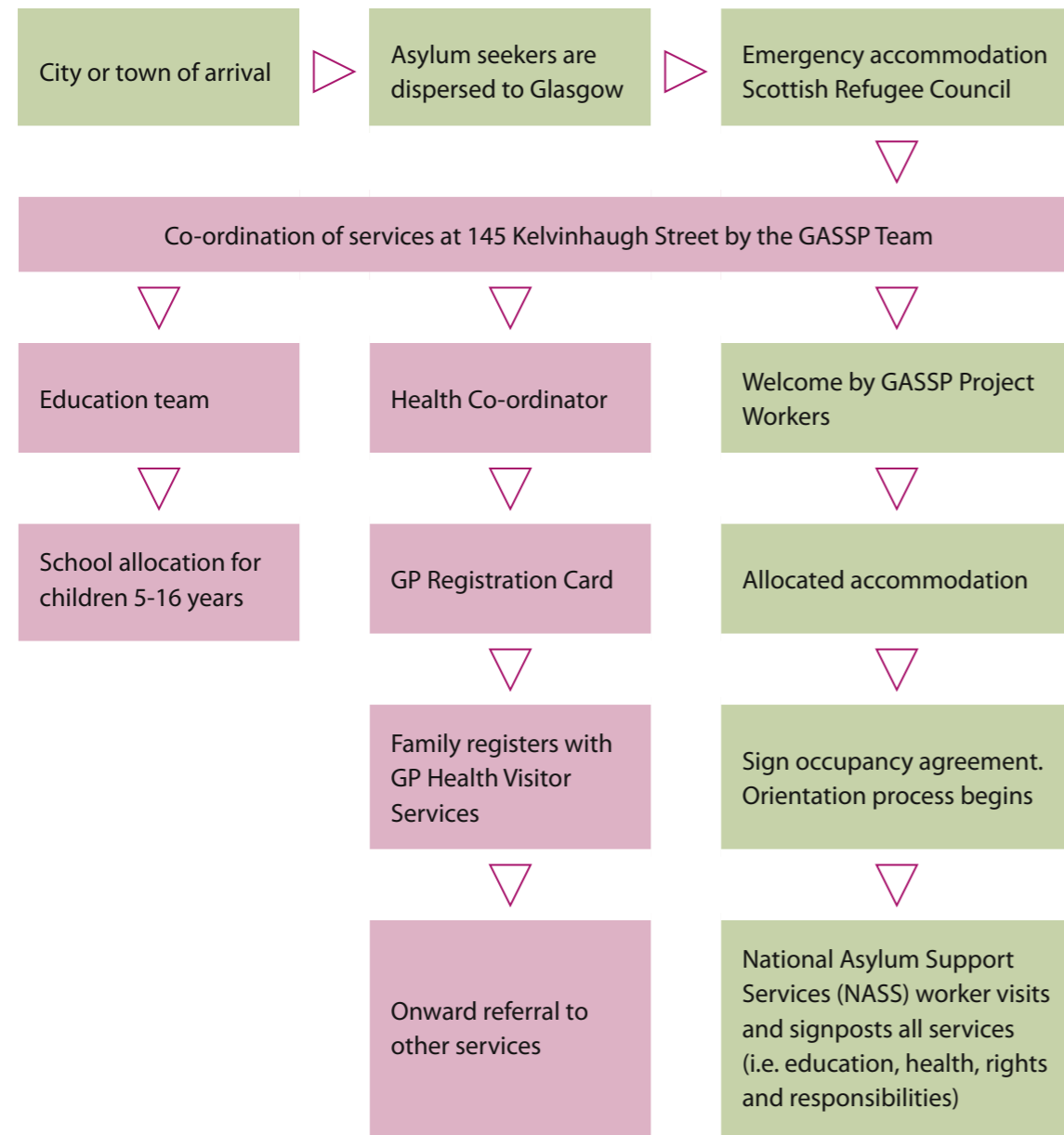
In 2001 the partnership was commended by the Office of Public Management Leadership Awards. These Awards are run by the Office of Public Management to promote and honour excellent management practice, recognising the unique social purpose of public service organisations.

The GASSP Project Team is managed by Brian O'Hara.
 145 Kelvinhaugh Street
 Glasgow G3 8PX
 Tel: 0141 222 7300

Numbers of asylum seekers living in Glasgow at August 2003



Multi-agency approach to offering services to asylum seekers



Recent asylum legislation

- 1993** Britain had no specific asylum legislation.
- 1996** The Asylum and Immigration Act 1996 restricted rights to cash benefits.
- 1999** The Immigration and Asylum Act 1999 came into force in Scotland in April 2000. It brought in dispersal of asylum seekers from the south of England to Glasgow. All benefit entitlements were removed and a voucher system was put in place. The Home Office set up the National Asylum Support Services (NASS).
- 2002** The National Immigration and Asylum (NIA) Act 2002 removed support from those asylum seekers who did not immediately apply for asylum on reaching the UK. Until this act, asylum seekers could work after six months of waiting for their application to be considered; now they are not allowed to work.
- 2003** The Asylum and Immigration Bill was introduced in the House of Commons on 27 November 2003.
- 2004** The Asylum and Immigration Act 2004 (Treatment of Claimants Act) introduced:
- Sanctions against asylum seekers who destroy their travel documents.
 - A single-tier appeal system.
 - An end to welfare support for families unwilling to return home after a failed asylum application.
 - Restrictions on legal aid for appeals.

Who are National Asylum Support Services (NASS)?

The service NASS provides

NASS is a department of the Home Office Immigration and Nationality Directorate responsible for providing support, accommodation and financial help for asylum seekers who would otherwise be destitute, whilst their claim is being considered.

The role of Immigration Services is to regulate entry to, and settlement in, the United Kingdom. It provides a work permit system to meet economic needs and skills required. It also offers fair and fast effective programmes for dealing with visitors, citizenship and long term immigration applicants including those seeking refuge or asylum.

Specifically, the aim of NASS is to provide an effective support system to asylum seekers who qualify until a final decision is made on their claim. In order to meet its obligations, NASS provides the following services:

- emergency accommodation
- dispersal accommodation
- financial support provided in cash
- co-ordinated input from the voluntary sector and stakeholders.

Key functions within NASS

- Ensuring only those eligible to receive support receive it.
- Providing guidance to caseworkers within NASS and others to ensure delivery of an effective system support.
- Contracting with accommodation providers from the private and public sector to provide a sufficient supply of accommodation for those who need it.
- Setting up NASS support for eligible asylum seekers.
- Providing emergency accommodation whilst an application for support is determined.
- Moving asylum seekers from short-term emergency accommodation to longer term dispersal accommodation until their claim is decided.
- Facilitating the issue of financial support to asylum seekers.
- Working in partnership with local authorities, the voluntary sector and other agencies to ensure the delivery of an effective system of support.

In Glasgow, the local office is at

NASS Scotland
 Festival Court III
 200 Brand Street
 Glasgow G51 1DH
 Tel: 0141 555 1528
www.homeoffice.gov.uk/ind/assd.htm

NASS teams operational in Scotland and their functions

Outreach

Outreach is responsible for visiting clients when they arrive in Glasgow, normally within five days. Outreach officers also carry out visits to those clients who choose to live with relatives, rather than in NASS-funded accommodation. They also attend drop-in centres at various venues throughout Glasgow.

Outreach officers also have the responsibility of delivering financial support to clients whilst their regular support is being arranged. They deliver information packages to those clients who have had their final immigration decision, explaining what options are available to clients.

Outreach officers also take responsibility for liaison with other stakeholders such as YMCA, GGPCD and the Scottish Refugee Council.

Housing management

Duties include carrying out housing inspections and interviewing clients, addressing housing concerns. Housing inspectors check NASS accommodation to ensure that health and safety issues are properly adhered to in accordance with housing legislation. Officers complete inspection forms and deal with referrals from officers of other work streams who have been made aware of a housing problem whilst visiting a client. Housing officers liaise extensively with Glasgow Asylum Seeker Support Project (GASSP) officers to negotiate that housing repairs are carried out timeously. In common with their colleagues in Outreach and Investigations, housing field officers have access to the interpreting service 'language line' which provides a range of nearly 50 languages.

Investigations

Investigations officers deal with incidences of anti-social behaviour, public harassment, undisclosed earnings, alleged fraud, false representation and domestic violence. This list is by no means exhaustive, but these are the main areas of concern for investigating officers. Investigators receive specialist training to enable them to deal in a sensitive and supportive way, when incidents of domestic violence take place. Their first priority is to provide safe and secure accommodation for victims whilst ensuring financial support remains in place. Like their colleagues in the other three work streams, investigating officers attend extensive cultural awareness and interviewing skills training, prior to taking up their posts.

Casework (going live in November 2005)

This team will deal with the processing of new applications, amendments to current applications and issuing of HC2 forms (see p. 75).

All NASS enquiries should be directed to the NASS Duty Officer on 0141 555 1515.

The process of seeking asylum

An application for asylum may be made at the port of entry; these are known as port applicants. This can be any air or seaport. 'In country' applicants are those people who apply for asylum after they have entered the country.

In Scotland 'in country' applicants have to travel to Croydon, Solihull or Liverpool to have their documentation recorded and their application lodged with the Home Office. Immigration services in Scotland can only register claims made in exceptional circumstances.

Screening interview

The Home Office conducts these interviews to gather information from the applicant on issues such as how they travelled to the UK, including which countries they have come through. Personal details are logged. This process involves fingerprints and photographs being taken, and rights and responsibilities explained. Home Office interviews are conducted in Liverpool, Leeds or Croydon.

Statement of Evidence form

This is a 19-page document in *English* that must be completed by the applicant, and returned to the Home Office within ten working days.

Detention

Some of the reasons why asylum seekers may be detained are because they are:

- designated high-risk absconders
- from 'white list' countries
- the responsibility of the third country under the Dublin Convention.

The Dublin Convention provides a framework to determine which European Union member state is responsible for considering asylum claims and introduced the 'Safe Third Country' rule. This allows European Union countries to return applicants to other safe EU countries they have travelled through.

White list countries

Certain countries are referred to as 'white list' countries (section 94 of the Nationality, Immigration and Asylum Act 2002). This allows the government to deduce that any applications made from these countries are clearly unfounded, and so reject them unless the applicant can provide evidence to rebut that assumption. The following 24 countries currently make up the 'white list':

Republic of Cyprus	Republic of Latvia	Slovak Republic
Republic of Hungary	Republic of Poland	Bulgaria
Republic of Malta	Republic of Albania	Romania
Republic of Slovenia	Republic of Moldova	Brazil
Macedonia	Bolivia	South Africa
Bangladesh	Sri Lanka	Serbia and Montenegro
Ecuador	Ukraine	including Kosovo
Jamaica	Republic of Estonia	
Czech Republic	Republic of Lithuania	

International status

Exceptional leave to remain (ELR)

This category was replaced by the following two categories on 1 April 2003:

Humanitarian Protection (HP)

Awarded to people who have been refused refugee status. They cannot be returned to their country of origin as they face serious risk to life or person because of the death penalty, unlawful killing, torture, inhuman or degrading treatment or punishment.

After three years of Humanitarian Protection (or earlier if original leave granted was for less than three years), the circumstances of the case will be reviewed. If circumstances are found to still exist, then either an extension will be granted to bring the period of Humanitarian Protection up to three years, or if they have already had three years of Humanitarian Protection they can apply for Indefinite Leave to Remain (ILR).

During this period the person can access mainstream welfare services and is allowed to work.

Discretionary Leave (DL)

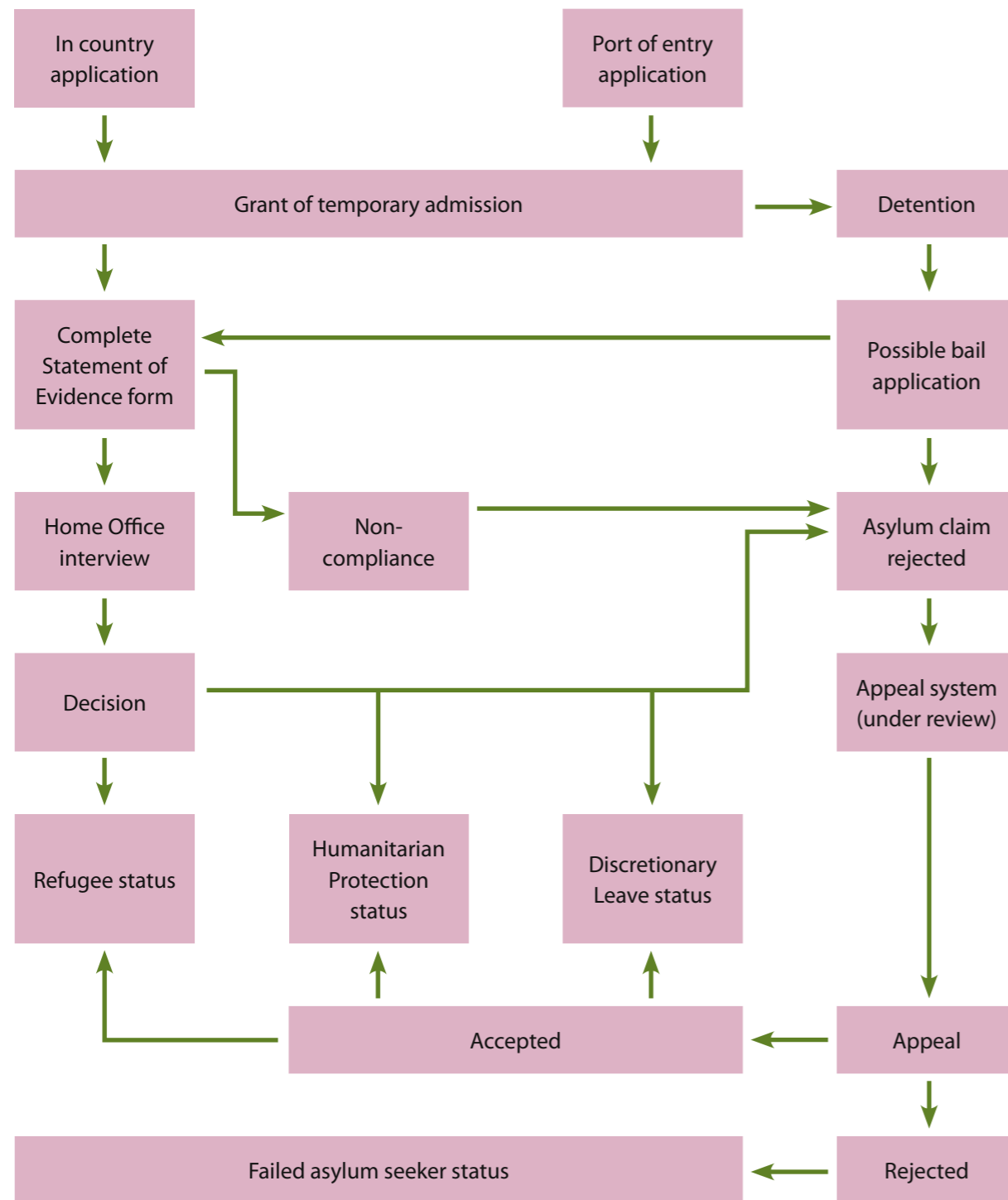
This is awarded to those people who have been refused refugee status and who do not fill the criteria for Human Protection, but are allowed to remain for other reasons. Discretionary Leave is only awarded in very limited circumstances and lasts up to three years; it will be reviewed at the end of that period. At that point it can be extended for a further three years. After six years on Discretionary Leave, an application can be made for Indefinite Leave to Remain (ILR).

Illegal asylum seeker

By definition there is no such thing as an illegal asylum seeker.

The UK has signed the 1951 United Nations Convention on Refugees, which means that anyone has the right to apply for asylum in the UK and remain until a final decision on their asylum application has been made.

The process of asylum



Smart Cards for asylum seekers

In January 2002, the government introduced identity smart cards for asylum seekers. Since then, every new asylum seeker has received a smart card – or Applicant Registration Card (ARC-card) – for identification purposes.

These plastic cards are the same size as a credit card and contain personal details, a photograph and fingerprints. Possession of an ARC-card is proof that an application for asylum has been made in Britain, replacing the Standard Acknowledgement Letter, and is the main form of proof of identity when collecting NASS payments from the Post Office.

The Home Office claims that ARC-cards are ‘a more robust and secure form of identification than the Standard Acknowledgement Letter, which had become very easy to forge.’



The journey to Glasgow from other parts of the UK

Asylum seekers are dispersed to Glasgow on a 'no-choice' basis. As part of their asylum package, NASS will allocate them to a regional dispersal area in the UK. This accommodation is usually in high-rise flats. The standard is similar to a homeless person's accommodation.

Asylum seekers are transported to Glasgow from London by overnight bus. They arrive in Glasgow early in the morning, when project workers from the Glasgow Asylum Support Services Project Team (GASSP) meet them.

They are offered hot drinks and allowed to rest after the journey. Relevant documentation is checked and the process of orientation begins by giving vital information about the local area.

They are then transported to their prepared accommodation, and they begin the process of settling into a new community.

Their project workers demonstrate how the white goods and heating systems work and will point out local shops and doctors' surgeries.

A welcome pack is available in 17 languages, informing them about services in Glasgow and what facilities they can access.

A member of the NASS team in Glasgow visits the family shortly after they arrive in the city to meet the family members to signpost and give information on a variety of subjects such as education, health and rights and responsibilities. Vital information is given about their asylum claim process and the legal implications that are involved in this process.

Project workers from the GASSP Team return to their headquarters at Kelvinhaugh Street to start the process of communicating with the Health Co-ordinator about the family composition, where they are housed, language requirements and if any immediate health needs have been identified. This service allows immediate health needs to be addressed.

From this action, the Health Co-ordinator will send out an invitation card to the family, in the appropriate language, giving them details of the nearest family general practitioner who will provide medical services. They are advised to go along and register with that particular doctor.

The GP Registration Card is sent out within two working days of the asylum seekers arriving in Glasgow. From this registration process, referrals to other health services, if required, may be accessed.

An HC2 certificate (see What are HC2 certificates?, p.75) entitles asylum seekers to access dental and ophthalmic services, but the Health Co-ordinator does not automatically put these services in place.

Colleagues from the Education Department are also part of the GASSP team. Information collected by the project workers during the first meeting is given to the education team who allocate a school place for all children between the ages of 5 and 16 years. If a child presents with special educational needs, an assessment is completed and an appropriate placement sought.

Together with statutory organisations, the voluntary sector, churches and faith groups play an enormous part in providing services. Much needed items are offered through the drop-in centres. Items such as warm extra clothing, bedding, toys and clothes are available.

Drop-in centres offer a meeting place and friendship, welcoming asylum seekers and refugees into local communities.

Provisions for asylum seekers and refugees

Accommodation provided to asylum seekers is no better than that provided to UK nationals. The National Asylum Support Service (NASS), which is part of the Home Office, does not have tenancy agreements with asylum seekers, as is sometimes claimed. It has a model contract for use with housing providers.

NASS requires the provision of:

- human-habitable accommodation as described in the Housing Act 1985 or the equivalent in Scottish law
- safe electrical equipment
- furniture to a reasonable standard, including cot/high chair for babies/young children (all soft furnishings must comply with fire and safety regulations)
- gas
- electricity
- water
- signposting to local services.

NASS does **not require** the provision of:

- telephones (landlines or mobile)
- televisions, television licences or hi-fi equipment
- new electrical goods
- new furniture
- cars
- cleaning
- gym or leisure club membership
- computers.

Cash payments to asylum seekers

Asylum seekers get weekly cash payments worth 70% of Income Support (for adults) and 100% for children. The current amounts (from April 2004) are set out in the following table.

Qualifying couple	£61.11
Lone parent aged 18 or over	£38.96
Single person aged 25 or over	£38.96
Single person aged at least 18 but under 25	£30.84
Person aged at least 16 but under 18 (except a member of a qualifying couple)	£33.50
Person aged under 16	£42.27

An unaccompanied asylum seeking child

An unaccompanied asylum seeking child is a person who, at the time of making the asylum application:

- is, or (if there is no proof) appears to be, under eighteen
- is applying for asylum in his or her own right
- has no adult relative or guardian to turn to in this country.

The Immigration Nationality Directive (IND) does not consider a child to be unaccompanied if he or she is being cared for by an adult prepared to take responsibility for them. IND staff will involve social services in any case where there is concern about the child's relationship with the responsible adult.

Social work services have a duty of care for unaccompanied asylum seeking children within the Children Act (Scotland) 1995. Support will include both accommodation and financial assistance.

Accommodation provision may include:

- residential care
- foster care
- hostel with support
- independent living with support.

A significant number of unaccompanied minors between the ages of 16 and 18 years are given ELR and therefore are able to qualify for state benefits.

If there is a problem in determining the age of a young asylum seeker, it will then be the responsibility of the Social Work Department to make a decision.

Dungavel

Across Britain, there are a small number of specialist detention centres where people can be detained under the British and EU Immigration Laws.

Britain currently has around 2,000 immigration detainees in these specialist centres, which are called reception centres or removal centres. Most detainees, like most asylum seekers, are men. However, women and children are also detained on some occasions and there is provision for up to 1,000 women and children to be detained in family units in the specialist detention centres in Yarlswood, Harmondsworth, Oakington and **Dungavel**, Scotland's only detention centre.

Dungavel is located in Strathaven in South Lanarkshire. Initially a hospital, it was converted to a prison and, after further conversion, became a Removal Centre in September 2001.



Communication

Although communication is essential to the delivery of health care, asylum seekers and refugees may have only a basic knowledge of written English and little understanding of the services provided.

The translation of existing health-related material might be problematic as meanings may be lost and material may be culturally inappropriate. There is a need for targeted information but, as needs and health beliefs may vary, cultural considerations are important.

Oral traditions are strong in many refugee cultures. Word of mouth is often the best way to get messages across to these communities. Video and audio cassettes are useful tools and are a popular choice among groups for conveying health promotion messages – but always consider the appropriateness of images for your audience.

Tips

- Body maps can be used to complement the existing interpreting service.
- Sharing materials is a good way for statutory bodies and voluntary organisations to work in partnership to develop a resource of health promotion.
- Translation of materials can be costly, try to share costs.
- Leaflets in several languages can be confusing – always print in the corner of a document (in English) which language is being used.

Using interpreters

Language and communication challenges are major barriers for asylum seekers and refugees.

In order to prevent misdiagnosis and inappropriate treatment for these patients, good communication is essential and this is when interpretation is often required. However, the use of family, friends or other asylum seekers as informal interpreters should be discouraged, except in exceptional circumstances, as this denies the patient the right to confidentiality within their family or community.

The Glasgow Translation and Interpreting Service (GTIS) is a multi-agency partnership created to meet the interpreting demands and facilitate access to services by minority ethnic groups in Glasgow. The six partners are Glasgow City Council Social Work Services, Greater Glasgow Health Board, Strathclyde Police, the Scottish Refugee Council, Asylum Support Project and Glasgow City Council Education Services.

GTIS offers a 24-hour service, 365 days a year. Over 200 sessional interpreters, speaking over 35 languages, provide language support, with all interpreters having been recruited through the standard Glasgow City Council procedures and screened through SCRO (Scottish Criminal Records Office).

Glasgow Translation and Interpreting Services
 Napiershall Centre
 39 Napiershall Street
 Glasgow G20 6EZ
 Tel: 0141 341 0019
 Fax: 0141 334 7276

Out of hours: After 4.45pm on working days and over the weekend and public holidays, contact Social Work Standby Services to arrange an interpreter in an emergency. Tel: 0141 305 6930.

Remember to give details such as language, dialect, gender, etc. of the client. Wait for the availability of the interpreter to be confirmed.

How to book an interpreter

Before booking an interpreter, find out

- Which language and any specific dialects the patient may use.
- Full details of the patient's name, country of origin, age, language and, if possible, dialect.
- The gender requirements/cultural needs of the patient.
- The purpose and expected length of the consultation.
- Any specific medical terminology that may be required to be explained in written material.

Before the session

- Remember that sessions with an interpreter will take longer than sessions where you can speak directly to patients so allot enough time for the session.
- Try to meet with the interpreter shortly before the session to brief them on what they will be required to interpret, check they understand any medical terminology that may be used and are comfortable with any sensitive or cultural issues that may arise out of the consultation.
- Define the interpreter's role and responsibilities.
- Eliminate distractions such as mobile telephones.

During the session

- Check seating arrangements – ensure that everyone can see each other and that eye contact will be easy.
- Speak directly to the patient, using their name.
- Only say things to the interpreter that can be translated to the patient, as the patient may feel alienated if the interpreter and clinician have a private conversation.
- When the patient is talking, show by your body language that you are listening.

- Speak in manageable chunks, allowing the interpreter sufficient time to translate.
- Use straightforward language – avoid jargon.
- Encourage the patient to ask questions and check they have understood what you are saying.
- Take regular breaks, particularly if the patient has been talking about distressing experiences.
- If you need to leave the room, check that the interpreter is comfortable with the patient.

After the session

- Have a short debrief.
- Enquire how the interpreter is feeling, particularly if the session was emotionally charged.
- Complete and sign the interpreter's job record sheet.

Check...

- That the interpreter understands the purpose of the interview.
- That you are using simple, jargon-free language.
- That the interpreter is translating exactly what you and your patient are saying.
- That you are allowing the interpreter enough time to translate.

Language Identification Card

If English is not their first language, this useful tool can help to establish which language the patients may understand as the text is translated into 49 languages.

Please see example on Pages 39 and 40.

Fast facts (cont'd)

Country	Capital	Languages	Religions
Mozambique	Maputo	Portuguese	Christian Muslim
Pakistan	Islamabad	Urdu, Punjabi Pushtu, English	Muslim Christian Hindi
Rwanda	Kigali	French, English	RC Traditional beliefs
Sierra Leone	Freetown	English, Creole	Muslim Traditional beliefs
Slovakia	Bratislava	Slovak, Hungarian Czech	Christian
Somalia	Mogadishu	Somali, Arabic	Muslim
Sri Lanka	Colombo	Sinhalese, Tamil English	Buddhist Hindu Muslim
Sudan	Khartoum	Arabic	Muslim
Syria	Damascus	Arabic, Kurdish	Muslim Christian
Turkey	Ankara	Turkish, Kurdish	Muslim
Uganda	Kampala	English, Swahili	Christian
Ukraine	Kiev	Russian, Ukrainian	Orthodox, RC
Yemen	Sana'a	Arabic	Muslim
Zambia	Lusaka	English	Christian
Zimbabwe	Harare	English, Shona	Christian

Names

To avoid confusion or offence, when communicating with patients, it is important to use the right name and method of address.

When asking patients their names, ask:

- What surname and personal names they use for official purposes in the UK.
- How they would like to be addressed.

After obtaining this information you must:

- Establish the correct order of the names.
- Make sure you know exactly how to spell each name.
- Make an effort to pronounce each name correctly.

For example, Iranian names.

All Iranians use the same naming systems:

- Iranians have one or more personal names and a surname.
- Iranian women do not change their surname on marriage.
- Children take their father's family name.

Examples of common Iranian names

Name type	Examples
Personal names: Female	Giti, Simin, Nooshin
Male	Dariush, Abbas, Koorush
Surnames	Jafarzaden, Sadegei, Fazli

Nigerian names

Examples of Nigerian names

Yoruba (Western Nigeria) tribe

Personal names: Female	Yetunde
Male	Babtunde
Unisex	Damilola
Surname	Adebiyi

Igbo (Eastern Nigeria) tribe

Personal names: Female	Ngozi
Male	Chukwuma
Unisex	Adeyema
Surname	Okoro

Hausa (Northern Nigeria) tribe

Personal names: Female	Amina
Male	Ibrahim
Unisex	Adebola
Surname	Yusuf

Somali naming system

The Somali naming system differs from most Muslims. Somali names have three parts. The first name is the given name, and is specific to an individual. The second name is the name of the child’s father, and the third name is the name of the child’s paternal grandfather. Thus siblings, both male and female, will share the same second and third names. Women, when they marry, do not change their names. By keeping the name of their father and grandfather, they are, in effect, maintaining their affiliation with their clan of birth. A typical male name is:

Personal	Father	Grandfather
Mohammed	Jama	Abdi

A typical female name is:

Personal	Father	Grandfather
Sashra	Omar	Hassan

Chinese names

Chinese names are usually made up of three parts (characters of one syllable each).

The surname comes first and is followed by a middle (or generational) name – which is often shared by siblings, or cousins, of the same generation. The third name is personal to the individual.

An example of a Chinese name is Mao Zedong: Mao is the surname so he could be Mr Mao (although you would have done better to call him Chairman Mao or Comrade Mao!).

Surname	Middle or generational name	Personal name
Mao	Ze	Dong

Some Chinese people have only two names: the surname and the personal name.

Spellings of Chinese names in the Roman alphabet may vary: i.e. Mao Zedong may become Mao Tsetung. The second and third parts of the name are usually (but not always) written as one word in the Roman alphabet (i.e. Zedong rather than Ze Dong).

Many young Chinese people also take a Western personal name and may, for example, call themselves David Wang or Joyce Chang and seldom if ever use their full Chinese name.

Food laws of some religions

	Buddhism	Christianity	Hinduism	Judaism	Islam	Sikhism
Eggs	Some people	Yes	Some people	Yes, but not with blood spots	Yes, but not with blood spots	Yes
Dairy products: milk, butter, cheese, etc.	Yes	Yes	Not if made with rennet	Not if made with rennet and not within three hours of eating meat	Not if made with rennet	Yes
Chicken	Some people	During Lent some people do not eat meat	Some people	Kosher	Halal	Yes, but not if Kosher or Halal
Lamb	Some people	Some do not eat meat on Fridays and will eat fish instead	Some people	Kosher	Halal	Yes, but not if Kosher or Halal

Food laws of some religions (cont'd)

	Buddhism	Christianity	Hinduism	Judaism	Islam	Sikhism
Beef	Some people	Personal choice	No	Kosher	Halal	Not usually
Pork	Some people	Most	Rarely	No	No	No
Fish	Some people	Yes	With fins/scales	With fins/scales and backbone	Yes	Some types
Shellfish	Some people	Yes	Some people	No	Yes	Some people
Animal fats	Some people	Yes	Some people	Kosher	No	Some people
Alcohol	Some people	Some people	No	Yes, but wine should be Kosher	No	Some people
Tea, coffee	Yes	Yes	Yes	Yes	Yes	Yes
Nuts, vegetables, pulses, etc.	Yes	Yes	Yes	Yes	Yes	Yes
Fruit	Yes	Yes	Yes	Yes	Yes	Yes
Fasting	Some people	Some people	Some people	Yes, during Yom Kippur	Yes, during Ramadan	No

Brief notes on Buddhism

Buddhism is based on the teachings of the Buddha Shakyamuni who lived in Northern India about 2,500 years ago.

A Buddha is revered, not as a god, but as an example of a way of life to which all should aspire.

Buddhahood is attained through sincere practice of the eight-fold path contained within the three main qualities of:

Wisdom (Panna)

Right view.
Right thought.

Morality (Sila)

Right speech.
Right action.
Right livelihood.

Meditation (Samadhi)

Right effort.
Right mindfulness.
Right contemplation.

Buddhism is a way of life that lays out ten qualities that must be perfected, viz. Generosity, Morality, Renunciation, Wisdom, Energy, Patience, Truthfulness, Resolution, Loving-Kindness and Equanimity.

Buddhism is not a centralised religion with centralised institutions although it does have a hierarchical form of organisation within each of the three main groups (see overleaf).

Many Buddhists are believers in **spiritual rebirth** but this is understood as a causal connection between lives rather than the transmigration or reincarnation of an unchanging soul.

The term **worship** is not really appropriate to Buddhism, where there is no belief in a separate god.

Buddhist temples, centres or meeting places are where Buddhists gather to meditate, study, chant or pray.

Although Buddhism is particularly strong in northern areas of the Indian subcontinent and in some parts of Southeast Asia, Buddhism is a worldwide religion. The spread, over a period of approximately 1,500 years, has led to the development of three different strands:

Theravadan Tradition

Originally mainly from Myanmar/Burma, Cambodia, Laos, Sri Lanka and Thailand which hold meditation groups.

Tibetan Tradition

Has a wide influence through northern India, China and Mongolia.

Zen Buddhist Tradition

Which originated in China and spread to Korea, Japan and Malaysia.

Buddhists have many festivals throughout a year. These generally commemorate particular events in the Buddha's life. The dates of these events are usually expressed through the lunar calendar and there may be variations between the different traditions. Some Buddhists may fast on New Moon and Full Moon days. Although the high valuation of life and rejection of violence means that some Buddhists are vegetarian, this is not always the case.

Death

The most important issue when there is a Buddhist death is to inform a Buddhist priest as soon as possible. Normally the time before committal depends upon the lunar calendar. This can vary between 3 and 7 days.

Further information

<http://www.buddhaweb.org/4436.html>

<http://www.fundamentalbuddhism.com/buddhism.htm>

<http://www.accesstoinsight.org/theravada.html>

<http://www.fwbo.org/buddhism.html>

Brief notes on Islam

Muslims regard Islam as an integral part of daily life, resulting in an ordered society in which social, spiritual and economic status is clearly defined. The way of life is drawn from the Quran (Koran).

- Greetings and replies are formal.
- The Arabic equivalent of Mr is Sayyid (for Muslims) and Khawaja (for all Westerners).
- Married women should be addressed as Sayyida or Sitt and girls as Anissa.
- In Islam, it is encouraged to call any Muslim man 'my brother' and any Muslim woman 'my sister' irrespective of family relationship by blood ties.
- Manners and courtesy reflect a deep convention of hospitality and mutual respect.
- Giving and receiving is always by way of the right hand. To offer gifts with the left hand is considered disrespectful, as is positioning the soles of the feet towards anyone.

- It is customary for Muslim households to extend hospitality to people whom Western society would socially disregard. Tradition dictates that anyone who appears at meal times must be invited to share the meal – whatever the reason for the call.
- Muslims are encouraged to have close relationships; to keep an open heart; to cultivate an understanding of others and to try to help anyone with their problems.
- Arab families are 'close-knit'. Family unity is paramount and family disputes are a cause for public concern, shame, requiring immediate attention.

Alcohol

The consumption of alcohol is forbidden although many non-practising Muslims will drink alcohol and offer it to guests when outside of their own country. Alcohol must *never* be drunk whilst eating. Drunkenness is considered to be disgraceful.

Drug use

Although many countries in the Arab world cultivate hashish or marijuana, it is not culturally acceptable. The possession, use or trading of drugs is severely punished. Drug abuse is not permitted in Islam, particularly hard drugs such as cocaine, heroin or morphine but is not limited to these. The *abuse* of any drug that interferes with consciousness, reasoning or judgement that could affect work, study or family life is unlawful.

Food

Islamic law forbids the consumption of pork. All meat is killed by cutting the animal's throat and allowing the blood to drain naturally. This is called Halal meat.

Whole items of food are cut up and the most succulent and best pieces of food are offered to guests.

Gambling

Considered by most Islamic countries to be evil. It is strictly outlawed.

Smoking

This is discouraged in Islam because of the associated health hazards; however a cigarette is often offered as a compliment. It is extremely impolite/insulting to rebuff such a gesture. Guests may be invited to smoke a narghileh (Hookah pipe). This is an essentially social activity, acceptance is honourable and the exhibited behavioural ritual should be followed. (This offered courtesy can be a dilemma for health workers who, for health reasons, are trying to encourage smoking cessation.)

Women and Islam

Probably the aspect of Islam that non-Muslims find most difficult to understand is the treatment of women. Muslim women are generally advised to show face and hands only. The demand, that women should dress and behave modestly, is seen by Muslims as symbolic of the importance, and value, placed on women as mothers and guardians of the family. Women invariably rule the household and the family.

The theory behind modest dress and veil is to preserve respect, dignity and virginity and safeguard them from abuse and interference by men. For some time this religious practice has slowly been disregarded as other cultures influence Islam. Also, today, many Arab and Muslim women are working, either by reason of financial need or because of the liberalising of religious practice and observance.

Some other traditions, in some countries, may still be rigidly adhered to, e.g. arranged marriages or the seating separation of men/women in restaurants.

The difference between the measure of adherence to Quranic (Koranic) practices of one country and another is said to be most easily judged by the degree of freedom afforded to women.

For more information

Women in Islam, published by the Islamic Foundation, is an excellent source of information for those who wish to pursue this subject further.

www.islamworld.net
 www.islam-guide.com
 www.al-islam.com
 www.islam-online.net
 www.islam.org

Brief notes on Judaism

There are five main forms of Judaism in the world today and, as is common among many of the great religions of the world, the most conservative forms do not necessarily recognise the most liberal forms as being part of Judaism.

Judaism has no dogma, other than the most important foundation of the Unity of God; no formal set of beliefs that must be held to be a Jew.

In Judaism, actions are as important as beliefs.

Judaism is studied in Religious Studies courses and taught to Jewish children in Hebrew schools. It centres on a set of ideas about the world and the way in which lives should be lived – yet there is much flexibility and disagreement about certain aspects of those beliefs.

Judaism focuses on relationships: those between God and mankind, between God and the Jewish nation, between the Jewish nation and the land of Israel, between human beings. It is not, however, just a set of beliefs about God and the universe – rather it is a comprehensive way of life, filled with rules and practices that affect every aspect of life; what to do on awakening in the morning, personal grooming, dietary code, dress code, business conduct, marriage partners and how to observe holidays and Shabbat (festivals). Most importantly, Judaism deals with how to treat God, other people and animals.

Life cycle events commence with

- Birth and the first month of life: when customs relating to birth, naming, circumcision, adoption and redemption of the (male only) firstborn are of importance. Bar Mitzvah/Bat Mitzvah – the Coming of Age ceremonies – comprise the second stage of life events, followed by;
- Marriage – the process of acquiring a spouse, Jewish weddings and
- Life, death and mourning, all have particular associated procedures, practices and customs.

Kashrut (dietary laws)

The Jewish dietary laws are derived, either directly or indirectly, from verses in the Bible. All are, therefore, more than 3,000 years old and have rules for the consumption, or otherwise, of animals, fish, birds, reptiles, amphibians and invertebrate animals.

A variety of reasons have been offered in explanation, for example:

- Chukim: a Chok is a law from God which therefore does not require an explanation;
- Health reasons: in warm climates like those where Judaism originated, and prior to refrigeration, both pork and shellfish were notorious as sources of food/water-transmitted illness. This continues to this day with a link between hepatitis A virus infection and a history of eating shellfish.
- Eastern view of holiness: creatures forbidden in Mosaic Law are almost the same as those prohibited to priests and saints in the ancient Hindu, Babylonian and Egyptian laws.
- Ethical ideals: not eating birds of prey symbolises the abhorrence of human beings preying on each other.
- Prohibition of pagan customs: applies most to the law against consuming blood as in reported tales of tribes who ceremonially ate the blood of their victims to gain power.

Life, death and mourning

In Judaism, death, although a tragedy, particularly if it occurs early in life or through unfortunate circumstances, is cushioned by the knowledge of the existence of an after-life. Mourning practices are extensive and have two purposes:

- to respect the dead and
- to comfort the bereaved.

Upon death the body should remain undisturbed for 20 minutes. The eyes are then closed, the body is covered and laid on the floor; candles are lit next to the body and the body 'guarded' until the time of burial. Autopsies are, in general, discouraged but where performed should be minimally intrusive. The body is not embalmed and no organs or fluids should be removed. (According to some sources, organ donation is now permitted.) The body must be buried in the earth and not cremated. The body is never displayed at funerals. Open caskets are forbidden by Jewish law, which considers the exposing of a body to be disrespectful. Judaism requires prompt burial. It is not customary to have floral tributes at Jewish funerals. Non-Jewish friends are advised to donate to a charity instead.

Jewish mourning practices are broken into several periods of decreasing intensity. Condolence calls or visits should not be made to a family from the time of death until after the burial (usually 1–2 days). During the seven days after burial, friends and relatives visit the bereaved. If strictly observant of Jewish custom, the mourners are required, among other things, to:

- not leave the house
- sit on low stools
- not shave
- not do business or any manual work
- not bathe or anoint themselves other than for hygienic reasons
- observe customs including the burning of a light for seven days, the covering of mirrors, refrain from emptying of any water bowls.

The reasons for some practices remain unclear and are thought to be folk practices rather than Jewish ritual.

The land of Israel is central to Judaism. Living outside of Israel is viewed as an unnatural state for any Jew and considered as being 'in exile'.

For more information

www.jewfaq.org

www.rigal.freeseerve.co.uk/jewish/customs

Brief notes on Middle East and Arab customs

Manners and customs in the Middle East go back to the beginning of civilisation. Long established practices and conventions govern interactions between and among individuals.

The practice of civility and respect demonstrates an underlying concept that guides behaviour within Middle Eastern Muslim circles. A courteous and gracious attitude is critical. *Kindness, humility, moderation* and *sincerity* are the bywords. Foreigners are forgiven a great deal when it is realised that motives are good. A kind, honest, humble approach naturally opens the way for agreeable exchanges.

Honour and status are important in the Middle East. A perceived standing within a group demonstrates God's will that must be protected from public criticism or insult. Individuals therefore maintain 'face' at all costs. Appearance in front of others is of crucial importance.

Greetings – Right hand leads

Use the right hand to eat, touch and present gifts. The left hand is generally regarded as 'the less important hand' – it is used for cleaning and the more menial of tasks.

Shaking hands

These do not usually possess the same firmness as the handclasps of Europeans or Americans but it is the Arab custom to shake hands at every meeting and leaving – even if this is ten times per day and applies wherever Arabs meet – be it in the street, office, conference, restaurant or at home. Outwith the family circle, shaking hands is only between the same gender. Shake hands with a woman only if she is the first to extend a hand.

Sitting

It is important to realise that position is all important as showing 'the sole of one's shoes or bottoms of feet' is regarded as insulting due to these being 'the lowest and dirtiest part of the body, outstretched legs are therefore best avoided. It is equally unwise to 'sit higher' than anyone else.

Conversation

It is better to follow the direction initiated by an Arab in conversation. Avoid asking personal questions and never ask questions about an Arab's wife or other female family member.

Small talk/ritual greetings

Middle Easterners often greet each other with a number of ritual phrases and responses prompted by ancient customs that comprise profuse greetings, enquiries about health and well-being, etc. These can use an inordinate amount of time but are essential to establish friendly relations.

Hospitality

Demonstrating friendliness, generosity and hospitality are expressions of personal honour/sacred duty. Giving a warm reception to strangers dates back to the *desert culture* when survival of/from thirst, hunger and sudden attack depended on such attributes from others. Many Middle Eastern peoples continue with this custom.

Touching

Touching and close contact with members of the same gender is common and acceptable among Arabs and demonstrates friendship – not sex.

Touching/kissing

Touching or kissing a member of the opposite sex in public is considered close to obscene.

Distance/personal space

Arabs stand very close to each other when talking which makes many Westerners feel uncomfortable. Do not back away as this could cause hurt feelings.

Eye contact

During conversations this can be long and direct and is very important. Staring is not necessarily rude except when gazing at women.

Photography

Seek permission first.

Eating

The actual eating comes at the end of an evening's festivities. In some areas it is impolite to eat everything on one's plate. Leaving food becomes a symbol and serves to compliment the host.

Gestures

Arabs, like most people, use gestures and body movements to communicate. However, Arab gestures differ markedly from 'Western' ones, e.g. the 'thumbs up' gesture of the West is, historically, offensive to many Arabs. Gestures are best left to those who understand 'the language'. Depending on circumstances and country, incorrect usage could result in serious offence.

As in many countries, pointing the finger is impolite.

For more information

www.globalsecurity.org/military/library/report/call/call_90-7_chp8.htm

<http://wrc.lingnet.org/mec.htm>

Brief notes on Sikhism

Sikh origins

No consensus exists on the origins of this religion.

History

The name of the religion means *learner*. It should be pronounced 'se-ikh', with the final 'kh' sound like the 'kh' in Mikhail.

Its founder was Shri Guru Nanak Dev Ji (1469-1538) who taught a strict monotheism, the brotherhood of humanity, rejected idol worship and the Hindu concept of caste.

Sikhs number about 22.5 million worldwide. Most live in the Punjab (Pakistan), with close to 500,000 living in North America – of whom about 150,000 live in Canada.

Sikh holy texts

The holy granth (the Shri Guru Granth) consists of hymns and writings by the first nine Gurus, along with religious text from different Muslim and Hindu saints. The Shri Guru Granth is the Sikh's holiest religious text.

Sikh beliefs**Goal**

The goal of Sikhs is to build a close, loving relationship with God.

Deity

Sikhs believe in a single, formless God, with many names, who can be known through meditation.

Reincarnation

They believe in samsara – the repetitive cycle of birth, life and death; karma – the accumulated sum of one's good and bad deeds; and reincarnation – the belief of a rebirth following death.

Status

Sikhs believe that everyone has equal status in the eyes of God. This is a very important principle that permeates all Sikh beliefs, behaviours and rituals.

Code of conduct

The Sikh code of conduct and conventions is the Reht Maryada. This defines a Sikh as any human being who faithfully believes in:

- one immortal being
- ten Gurus
- the Guru Granth Sahib
- the utterances and teachings of the ten Gurus
- the baptism bequeathed by the first Guru who does not owe allegiance to any other religion.

There are a number of traditions within Sikhism. Thousands of Sikhs, both in India and worldwide, follow living gurus who have lineages traceable back to Guru Gobind Singh.

Sikh practices**Prayers**

Repeated multiple times each day.

Worship

Sikhs are prohibited from worshipping idols, images or icons.

Temples

There are over 200 Gurdwaras (temples, shrines or holy places) in India alone. The most sacred is at Amritsar.

The five Ks

These are clothing practices followed by stricter Sikhs, called Khalsa saints:

- Kesa – long hair, which is never cut

- Kangah – comb
- Kacha – short pants
- Kara – metal bracelet
- Kirpan – a ceremonial dagger.

The Khanda is the main Sikh symbol and is composed of five items, all traditional Sikh weapons:

- a vertical double-edged sword with a broad blade, also called a Khanda
- two curved swords, called kirpans. They are called miri and piri
- a ring called a chakker (aka chakram). It is a very effective weapon.

Sikhs sit on the floor while eating after religious services. This practice, which dates back to when the religion was founded 500 years ago, demonstrates the rejection of elitism and belief in each person being of equal value.

For more information

<http://www.destinationsaachkhand.com>

<http://www.ikonkar.com>

<http://www.punjabonline.com>

<http://www.sikhs.org> (This site contains an English translation of the Sikh holy book which can be found at: http://www.sikhs.org/english/eg_index.htm)

<http://www.sikh.net> (This website states that it is the largest resource about Sikhism on the Internet)

Sikhism: Its history and customs contains an excellent description of Sikhism and its past.

See: <http://members.aol.com>

Brief notes on the Russian Orthodox Church

The Russian Orthodox Church is that body of Christians who are united under the Patriarch of Moscow, who, in turn, is in communion with the other patriarchs of the Eastern Orthodox Church. In this way Russian Orthodox believers are in communion with all other Eastern Orthodox believers.

The Russian Orthodox Church traces its roots to the Baptism of Kiev (988), when Prince Vladimir officially adopted the religion of Byzantium as the religion of the Russian State. It therefore traces its apostolic succession through the Patriarch of Constantinople. Today, it is the largest of all the Eastern Orthodox Churches. The most ancient of the European Orthodox churches is the Greek Orthodox Church.

The Russian Orthodox Church should not be confused with **The Russian Orthodox Church Outside Russia** (also known as *The Russian Orthodox Church Abroad*), which was founded by Russian communities outside of Russia and which refused to recognise the authority of the, then, communist-dominated Russian Church.

The formal division of the church into Eastern and Western churches is regarded as having occurred in 1054, in what is historically known as '*The Great Schism*', although the distinction between the largely European Orthodox Church and the Oriental Orthodox Church occurred centuries before this.

As with all religions, customs/habits/rites are important parts of a believer's life. The funeral rites of deceased members of the Eastern Orthodox Church (Bulgarian, Czech, Greek, Macedonian, Polish, Romanian, Russian, Serbian) differ from those of other Christian denominations.

It is therefore important to be aware of the specific needs that should be honoured on such an occasion and the advisability of a conversation, between priest and undertaker, to allow for attention to these specific customs, prior to finalising funeral details.

- 1) **The Orthodox liturgy** for the dead consists of three main services, of unequal length for different occasions.
 - a) The funeral service: This is a comprehensive service (40 minutes or more) that is taken, usually and preferably in a church building, within a few days of the death
 - b) The Panichida: This is the memorial service (20 minutes), sung commonly and especially on certain memorial days and
 - c) The Litia: This is a short prayer (5–10 minutes) that is sung, especially in conjunction with another service
- 2) **Burial.** It has been the rule to inter Orthodox people although cremation is now permitted in certain circumstances. Where this is the case the normal funeral service is conducted in church and a Litia may be sung at the Crematorium.

Orthodox services tend to be longer than Western counterparts. Due allowances must be made in the timetable for the funeral and the interment by cremation.

Upon a person's death: It is important that a priest be called to the location of a death where the Panichida or Litia will be sung. Thereafter, the family may proceed to wash and dress the body in the person's clothes before removal by the undertaker **or** the undertaker may be called to remove the body and undertake the preparation of the body for the funeral.

In either situation detailed arrangements for the funeral will be discussed.

At the undertaker's: The family or priest will provide an icon that will be placed either in the hands or on the chest of the deceased. The priest may also supply a sheet of paper containing a prayer of absolution. This is placed in the coffin along with a paper 'crown' that is placed on the forehead and on which is written a short prayer.

At the church: The coffin may be brought to the church as soon as the body has been made ready. This may be several days before the funeral service is conducted (this is more costly), on the eve of the service or on the day of the funeral in time for the service.

The coffin lid may be positioned to allow viewing of the body from 'head-to-waist' or it may be entirely removed to allow for 'full viewing' until after the funeral service and farewells have been completed. Should the family/priest so desire the coffin may be closed throughout.

At the cemetery: If not already performed, the Litia is sung and the grave blessed. The coffin is then lowered into the prepared grave after which some earth (in the shape of a cross), is scattered by the priest, followed by the mourners. As a last act before the grave is in-filled, some oil and ashes from the censer are thrown onto the coffin.

At the home: After the services are complete it is customary for family, friends and priest to meet for offered refreshments as a last memorial feast that is given, by the deceased, in his/her earthly home.

Acknowledgements and thanks to Father Alexander Williams for contributing this information.

For more information

www.nationmaster.com/encyclopaedia/Greek-Orthodox-Church
www.nationmaster.com/encyclopaedia/Eastern-Orthodox
www.nationmaster.com/encyclopaedia/Russian-Orthodox-Church
www.ethnicityonline.net

Brief notes on Chinese culture, customs and traditions

The Chinese community is one of Britain's oldest, dating back to the mid-nineteenth century. Yet, despite numbering around 300,000; the Chinese population remains one of Britain's least known communities.

Ancient Chinese customs still play a part in modern China despite recent changes having had an effect on family lifestyles. There is a long history of out-migration from China.

The concept of being Chinese is not based on race. Rather, it is a cultural concept of behaviour, speech and acceptance of the Chinese system of cultural values. The isolation of China during the 19th and for a large part of the 20th century has resulted in China often being misunderstood, with culture and customs shrouded in mystery. In these notes the term Chinese refers to all those of Chinese ancestry irrespective of origin, e.g. Taiwan, Mainland China, Hong Kong or living abroad.

In China there are 56 officially recognised ethnic groups with an additional 55 minority groups from a diverse range of ethnic and linguistic backgrounds. Religions encompass Buddhism, Christianity, Confucianism, Islam, Taoism and folk religions.

The Chinese language is one in which the written form remains constant despite various spoken forms – there are eight major language groups with 600 dialects. All of the languages use tones to distinguish different words and meanings.

Chinese culture is rich in customs, traditions and superstitions. The extent to which these will be observed varies between areas and amongst Chinese communities worldwide. Some traditions are now observed only within small pockets of very traditionalist Chinese adherents. It is these traditionalists who may find it most difficult to adapt to a Western lifestyle.

Culture and social relations

The primary theme, in social structure, is the centrality of the family – the structure of which is traditionally hierarchal and patriarchal – the oldest adult male being the decision maker. Males take precedence over females in the ranking system as do older over younger members. In family matters, elders, including women, have significant influence. Families tend to be private and few are willing to discuss family issues or confide in non-family members. Values are based on:

- filial duty – manifested by respect/ reverence for parents
- conformance to norms – adherence to family and societal norms and not bringing shame to the family
- emotional self-control – having reserved, formal, public verbal/non-verbal communications with minimal disagreements

- family recognition through achievement – striving to succeed but not expecting/accepting personal praise for achievement
- family focus point – more important than self
- humility – manifested by a lack of striving for individual achievement.

Speech and greeting conventions

In public, Chinese conversations tend to be loud and highly audible. However, Chinese etiquette states that speech should be soft with head slightly bowed. Whilst it is acceptable for Chinese males to talk loudly, a female doing likewise is considered to be ill-mannered.

The correct manner of greeting/address is important. In a formal context, it is rude to use the individual's 'given name'. The correct format is: Mr Soh/Dr Lah/Chairman Tee, etc. Among strangers or at formal occasions the greeting (in Mandarin) Ni Hao (literally – you good) is used. In more familiar settings the phrase for 'have you eaten' is common. This form of address testifies to the Chinese consideration that others may feel hungry.

Dining/table etiquette

Round dining tables are preferred – this eliminates any status differentiation – however, special guests may receive special treatment.

Chopsticks should not be used for pointing, left standing up in a rice bowl or used to 'root around' in a dish for chosen food (the idea is to locate the chosen food then remove cleanly).

It is acceptable to 'stand and stretch' to reach a particular morsel, spit bones on to the table, belch, slurp soup/noodles and to smoke whilst eating.

It is bad manners to mix serving and personal cutlery/chopsticks, play with chopsticks, clear one's plate or to sip wine without first proposing a toast to some other guest.

Formal Chinese banquets may last several hours but, when the host stands to offer the final toast, the meal is over. Guests are expected to leave. Lingering at the table and drinking coffee is not Chinese practice.

In business circles

- Business/name cards are ubiquitous and will almost always be exchanged in such meetings. Hold card with both hands.
- Handshakes are now rarely used. The traditional 'Chinese handshake' consists of interlocking the fingers of the hands and waving them up and down several times. The 'Western style' handshake has been adopted, often accompanied by a nod or slight bow – the deeper the bow the greater the respect/reverence.
- Punctuality is essential.
- The exchange of gifts is not common but, if given, should be small. The Chinese never give a clock as a gift. (The phrase 'to give a clock' sounds like the phrase 'to be buried'.)
- Dining: reciprocating with an invitation to one's host is appreciated. Note that an invitation to the 'Business Director' will translate to include various other staff members to accompany 'the boss'. The meal is likely to be a twelve-course affair with various 'toasts' throughout. Business is not generally discussed.

- Publicity materials: due to the significance of different colours in Chinese culture it is preferable to use white paper.

Marriage

In a culture where the perpetuation of family ancestral lineage and the family as a social institution are central, marriage is an important institution with associated, intricate customs. A marriage is not simply a love match between two people but also the establishment of a relationship between two families. A Chinese wedding can be very expensive and, with the two important components of Chinese culture – the need to avoid embarrassment and the need to display wealth and prosperity – failure to provide a lavish wedding is likely to bring shame.

Traditionally, couples who are closely related or who share the same surname cannot marry each other – by reason of possible, shared ancestral lineage. The degree to which this prohibition is observed varies considerably between ethnic/regional groups in China.

Divorce is discouraged among Chinese society and is quite rare. Couples are encouraged to resolve disagreements/disputes. Parents may act as mediators.

Pregnancy and childbirth

Many customs and superstitions abound, the function being to protect the pregnant woman and child from malign influences.

Male descendants are essential to ensure continuity of family lineage and name. Females cannot inherit, the wife living with, and being the property of, the husband's family. She is deemed as no longer part of her own family. Female offspring are thus viewed as 'a temporary', rather than 'the permanent' family member attributed to male offspring.

During pregnancy, customs relate to the behaviour and environment, the need for certain nutritious foods and the avoidance of others. After delivery, a 40-day period of confinement is advised during which time the mother may be reluctant to shower/bath in the earliest days. (This belief probably stems from the fact that, in village lifestyles, this activity would require enormous effort.)

A Chinese baby is considered to be one-year-old at birth, as age is calculated from the date of conception and not parturition. Celebrations are delayed until four weeks have passed after which close friends/relatives provide gifts for mother and child. Special small cakes and hard-boiled eggs (painted red) are traditional items for the feast. The following day there is the ritual shaving of the baby's hair.

Death and funeral practices

Cremation is traditionally uncommon. The burial of the dead is taken very seriously. Improper funeral arrangements wreak ill fortune and disaster upon the bereaved family.

To a certain degree, Chinese funeral rites are determined by: age; manner of death; status/position in society and marital status. According to Chinese custom, an older person should not show respect to one who is younger. (Therefore, when the death is of a baby/child, no rites are performed and the burial is performed in silence.) Conversely, funeral rites for an elderly person must follow a prescribed form and convey relevant respect: rites befitting age; status, etc. must be performed despite any possible, future financial hardship.

A wake is customary and is overseen by the undertaker. The coffin is not sealed during the wake, which lasts no less than a day, to permit the offering of prayers and chanting from the scriptures. Traditional observances relate to position of the coffin; special clothing and colour restrictions; personal items; hair cutting; the avoidance of jewellery and wailing. An altar, burning incense, lighted

white candle, joss paper, prayer money and donation box are offered as signs of respect while the corpse is 'guarded' by a group of people until the coffin is sealed prior to burial.

Following the sealing of the coffin and cessation of the 'wailing', the coffin is transported to the burial site accompanied throughout by family members, relatives and mourners.

The burial: Chinese cemeteries are generally located on hillsides that have improved 'feng shui'. Family members and relatives throw a handful of earth into the grave prior to filling in. After the funeral, all clothes worn by the mourners will be burned to avoid bad luck associated with death.

Mourning for family members will continue for a further 100 days and is signified by the wearing of a coloured arm-band, coded according to position within the family.

Chinese belief holds that seven days after death, the departed soul returns to his/her home. A red inscribed plaque is positioned outside of the house to guide the returning soul.

Health beliefs and practices

Most Chinese find it possible to combine aspects of both Western and traditional medicine although many are too shy to pursue questions about their conditions. Physical modesty and integrity being important in Chinese culture, gender issues may be problematical. Physical contact between the genders is normally avoided, other than in the husband–wife relationship.

Blood transfusions, organ donations and transplant surgery are acceptable procedures as are consideration of abortion and use of family planning methods. Nevertheless it is unwise to mention family planning matters in the presence of other Chinese persons.

Traditional Chinese medicine (TCM)

The first concept to understand in the approach to health and illness is the balance expressed by 'yin-yang'. These are dynamic and complementary forces between which there must be harmony otherwise, if either reaches its extreme, it will become 'the other'.

Traditional Chinese medicine is one of the oldest systems of medicine known, dating back to 2000 BC. The principles of TCM are different to those of Western medicine although in China the two are practised side-by-side. Whilst Western medicine concentrates on anatomical structures, disease organisms/categories/processes, TCM concentrates on the 'energetics-based' medicine and the flow of 'chi' – a vital force/energy which is seen to control the workings of the human body and mind – via the 12 'meridians' that correspond with 12 major organs.

Other

- Chinese customs and traditions are rich and colourful.
- Food is central to their cultural inheritance with attention paid to colour, flavour, aroma and texture.
- Festivals, of which the most important is the Spring Festival (Chinese New Year) but also Qing Ming (Pure Brightness), Duan Wu (Dragon Boat), Zhong Qui (Mid-Autumn) and many others throughout the year.
- Legends, music, circus and opera are part of the Chinese heritage.

For more information

<http://www.chinatown-online.co.uk>

Multicultural Information Sheet – Greater Glasgow Primary Care NHS Division

Afghanistan

The official languages are Pashto and Dari (Afghan Persian/Farsi). Turkic languages (Uzbek and Turkmen) and numerous other languages (Baluchi, Pashai and Nuristani) are also spoken. Bilingualism is very common.

Outside of Kabul Afghanistan is still, very much, a tribal society. Religion and traditional customs have a strong influence within the family.

- There are strong male and female rules in society.
- Religious beliefs are primarily Islamic with Hindu, Jewish and Sikh minorities. (See also *Brief notes on Islam*, *Brief notes on Judaism* and *Brief notes on Sikhism*.)
- It is considered insulting to show the soles of the feet.
- Giving and receiving is always by way of the right hand. To offer gifts with the left hand is considered an insult.
- Handshaking is an acceptable form of greeting although nose rubbing and embracing are traditional.
- Guests may have to share a room as specific accommodation is rarely set aside.
- Women are advised to wear trousers or long skirts and avoid revealing clothing.
- Smoking is a common social habit. It is a compliment to accept an offered cigarette from a host. (This can present as a dilemma to visiting health care professionals.)



Albania

The official language is Albanian although Italian and English are also spoken. Greek is spoken in districts in south Albania. Any attempt to speak Albanian is much appreciated.

- Three religions co-exist: Muslim, Catholic and Orthodox.
- One third of the population live in urban areas with the remainder pursuing a relatively quiet rural existence.
- Some Albanian characteristics and mannerisms resemble those of the Greek mainland, most notably in the more rural areas.
- A nod of the head means no and a shake of the head means yes.
- Handshaking is the accepted form of greeting.
- Albanians should be addressed as Zoti (Mr) or Zonja (Mrs).
- Small gifts, though not flowers, are customary when visiting someone's house.
- Visitors should accept offers of raki, coffee or sweets.
- Smoking is permitted except where the sign 'Ndalohet pirja duhanit' is displayed.
- Dress is generally informal. Women are expected to dress modestly.



Algeria

The official language is Arabic but French is used for most official business. Berber dialects are spoken in the south of the country. Businessmen generally speak Arabic or French.

- Islamic culture predominates. See also 'Brief notes on Islam'.
- French-style courtesy should be adopted with new acquaintances. The provision and acceptance of hospitality are as important a part of Algerian culture as elsewhere in the Arab world.
- Alcohol is not encouraged.
- Algerian women have strict social and dress codes. Western women should respect this Muslim tradition and cover themselves as much as possible or otherwise incite hostility.
- If possible it is courteous to avoid visiting during Ramadan.



Angola

The official language is Portuguese although French and Spanish may also be spoken.

Roman Catholicism is the main religion with Anglican minorities.

Normal social courtesies are observed.



Congo

The official language is French.

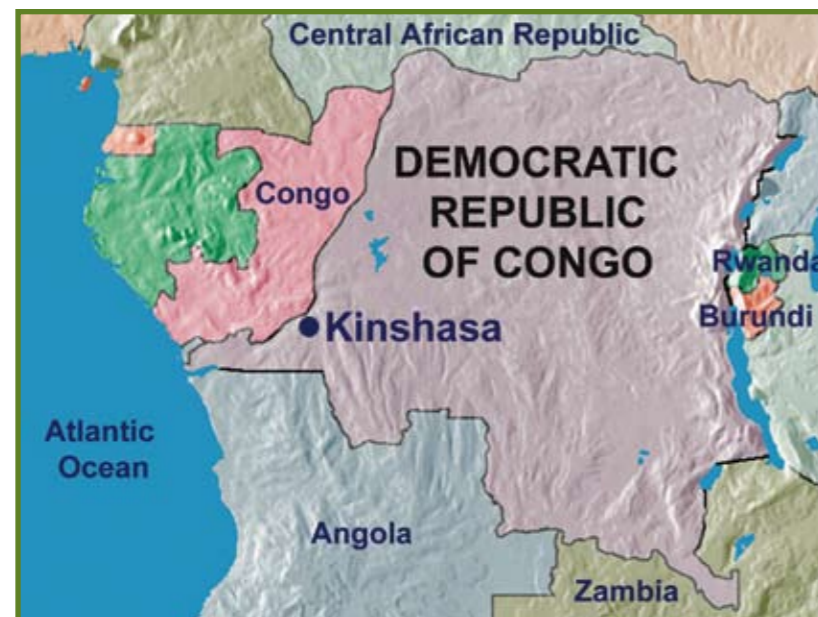
- The main religion is Christianity with 93% of the population following a belief in Roman Catholicism, Protestantism or African Christianity. Around 5% follow traditional African beliefs whilst the remainder of the population are Muslim.
- Normal European courtesies should be observed when visiting people's homes.
- Gifts are acceptable as a token of thanks.
- Dress is casual and informal attire is acceptable.
- Artistic carving, traditional and modern dance as well as folk songs play an important part in Congolese culture that is strongly based on tradition.



Congo – Democratic Republic

The official business language is French although many dialects are spoken: Lingala, Swahili, Tshiluba and Kikongo.

- Religious beliefs are mainly Roman Catholic (50%), Protestant (20%) with minority numbers representative of Kimbanguist, Muslim, other syncretic sects and traditional beliefs.
- There are over 200 African ethnic groups of which the majority are Bantu.
- Normal social courtesies should be observed.



Iran

The national official language is Persian (Western Farsi) with many other languages spoken, e.g. Azari, Kurdish, Luri, Balochi, Arabic and Turkish.

- Ethnic groups covered are Persians, Turks, Arabs, Baloch and Kurds.
- Iran is a mainly Muslim religious country although Zoroastrianism, Christianity, Judaism and Bahá'í faiths are also observed.
- Koranic law exercises a traditional influence over the populace.
- Feelings about certain countries (such as the USA and UK) still run high so contentious subjects should be avoided.
- Handshaking is customary but not with members of the opposite sex.
- Hosts are addressed by surname or title.
- Iranians are very hospitable and like to entertain. It is customary to be offered tea and guests are expected to accept such hospitality.
- Because of Islamic custom, dress should be conservative and discreet.
- During Ramadan, smoking, eating and drinking in public is prohibited between the hours of sunrise and sunset.
- If possible it is courteous to avoid visiting during Ramadan. (See also *Brief notes on Islam*.)



Iraq

The official languages are Arabic (80%) and Kurdish (15%).

Traditional Islamic culture predominates with Koranic law playing an active role in day-to-day life. Visitors should be careful to respect this and act accordingly.

- Hosts should be addressed by full name and title.
- Traditional Arab hospitality, in accordance with religious law, is the rule.
- Conservative and discreet dress is worn in observance of Islamic law.
- As Muslim law does not permit the representation of human or animal images in any form, photography is a delicate issue.
- There is strict adherence to Islamic laws on the consumption of alcohol. During the lunar month of Ramadan, drinking, eating and smoking in public is not permitted.
- If possible it is courteous to avoid visiting during Ramadan. (See also *Brief notes on Islam*.)



Kosovo

The autonomous province of Kosovo (within the Federated States of the former Yugoslavia) was the scene for a protracted and bloody conflict between 1998–1999 and comprised several nationalities, viz. Kosovan Albanians; Kosovan Serbs; Roma; Muslim Slavs; Turks; Gorani and Croats.

Kosovo now sits as part of Serbia and Montenegro and, whilst over 150,000 Kosovar Albanians returned to the province in 2002, only a few ethnic Serbs and other minorities did so.

The official languages are Albanian and Serbo-Croatian as well as Turkish in areas of Turkish population.

All regulations are issued in Albanian, Serbian and English whereas, in education, the policy tends towards the recognition of five languages: Albanian, Serbian, Bosniac, Turkish and Roma.

Gender equity issues are to the forefront of current concerns by Oxfam, which has a presence in the area. Kosovo is a strongly male-dominated society.



Pakistan

The official languages are Urdu and English with regional languages of Sindhi, Balochi, Punjabi and Pushto with numerous local dialects.

- Pakistani society is divided into classes and, within each group, there is a subtle social grading.
- Most Pakistanis are Muslim therefore Islamic customs and beliefs should be respected and observed.
- The Koranic law influences every aspect of daily life.
- Shaking hands is the usual form of greeting.
- Mutual hospitality and courtesy are of great importance at all levels, whatever the social standing.
- If invited to a private home a gift, or national souvenir, is welcome.
- The national drink is tea, served with milk and often very sweet.
- There are strict laws on alcohol and it is illegal to drink in public.
- Informal dress is acceptable for most occasions. Women should avoid wearing tight clothing and should ensure that arms and legs are covered in accordance with Islamic custom.
- If possible it is courteous to avoid visiting during Ramadan. (See *Brief notes on Islam.*)



Somalia

The official languages are Somali and Arabic but Italian and English are also used. Swahili is spoken, particularly in the south of the country. As the majority of the population is Muslim, Arabic is the most common second language.

- Somalia is a mainly Muslim (Sunni Muslim) culture with a Christian (Roman Catholic) minority.
- Ethnic groups comprise Somali (85%), Bantu and Arabs.
- Women should dress modestly and are expected to cover their bodies – including their hair. Only hand and wrist should be exposed. (See *Brief notes on Islam.*)
- In accordance with Islamic tradition, social customs are in keeping with this.
- The usual form of greeting is to shake hands although this is confined to the same gender. Men and women do not shake hands with each other.
- The accompanying 'Salam alechem' means 'God Bless You'. On departing the phrase for Goodbye is 'Nabad gelyo'.
- The right hand is considered clean and polite for all daily tasks and for giving and receiving.
- The elderly in the community are treated with great respect and are addressed as Aunt or Uncle irrespective of any family relationship.



Sri Lanka

Sri Lanka has a mainly Buddhist culture with Hindu, Christian and Muslim minorities. (See *Brief notes on Buddhism, Hindu and Islam.*)

- Shaking hands is the normal form of greeting.
- It is customary to be offered tea when visiting and it is considered impolite to refuse.
- Punctuality is important.
- In appreciation of hospitality a small token is always welcome.
- Informal Western dress is acceptable.



Turkey

The official language is Turkish, with Kurdish, Arabic, Armenian and Greek also in common usage. French, German and English are widely spoken as second languages. Any attempt to speak even a little Turkish is much appreciated.

- Religion: Primarily Islam >99% (mostly Sunni), with minority beliefs of Christianity and Jewish religions.
- Ethnicity is estimated as Turkish 80% and Kurdish 20%.
- Traditional Islamic culture predominates. Women are expected to cover their body (including hair) and dress conservatively/modestly.
- Shaking hands is the normal form of greeting although confined to same gender use in accordance with Islamic tradition.
- Hospitality is very important and visitors should accept and respect Islamic customs. (See *Brief notes on Islam.*)
- Turkey is a secular state and alcohol is permitted, although, during Ramadan, it is considered polite for a guest to avoid this.
- If possible it is courteous to avoid visiting during Ramadan.



Zimbabwe

The official language is English with the other national languages of Ndebele and Shona also being taught in schools and recognised in business. Fourteen minority indigenous languages co-exist.

- Religions: Christian and indigenous beliefs comprise around 90% of the population. Muslim and other forms comprise the remaining minority.
- Urban culture is influenced by Western culture but traditional values and crafts continue in rural areas.
- Shaking hands is the customary form of greeting.
- European courtesies and codes of practice should be observed when visiting a private home. Giving a token of appreciation is welcomed. Return invitations are appreciated.
- Casual wear is suitable for daywear.



Primary care services Glasgow

Asylum seekers are advised to register with a general practitioner (GP) as soon as possible as registration is essential to access primary health care services and onward referral to secondary care services.

Asylum seekers who come through NASS (National Asylum Support Services) are entitled to the same health care system as the indigenous population, although additional services may be required, such as interpreting, to help them access all the necessary services. All emergencies are treated in the same fashion as in the indigenous population.

Greater Glasgow Health Board and Primary Care Division took the decision to provide GP registration to all asylum seekers dispersed to the area from London and an innovative multi-agency system was set up to inform families of their GP within two working days of arriving in Glasgow. A Health Co-ordinator sends out a registration card (in the family's language where possible), informing the family of the address and contact details of the GP surgery or health centre they are to attend for registration. When the family registers with a GP, a health visitor assesses the family's health needs and refers them, as required, to other services.

Currently 36 GP practices and associated staff are providing this service throughout the city. Glasgow was the first city in Britain to adopt this system and, in 2001, the Office of Public Management commended this multi-agency approach.

What are HC2 certificates?

HC2 certificates are official documents issued on behalf of the Department of Health. They are issued to the main applicant but details of dependants are included on the certificate in order to enable the whole family to access NHS services.

The initial certificate is issued by NASS as part of the support package and lasts for a period of six months. It is renewed by NASS Scotland after that period.

NASS Scotland

Festival Court III
200 Brand Street
Glasgow
G51 1DH
Tel: 0141 555 1528

Translated materials available to GPs and health visitors

- Adult health questionnaires.
- Information on tuberculosis.
- Child health questionnaires.
- Information on meningitis.
- Immunisation information sheets.
- A variety of health promotion material.
- How To Take Your Medicines leaflets.
- An immunisation protocol.
- Sexual Abuse Clinic leaflet.
- How To Register With A Dentist leaflet.
- BCG letters.
- General appointment letter.

Adult/child medical health questionnaires

Albanian	Arabic	Dari
Farsi	French	Kurdish
Punjabi	Pushto	Russian
Serbo-Croat	Sinhalese	Slovak
Somali	Swahili	Tamil
Turkish	Urdu	

Languages sourced from Primary Care Division

In addition, posters are displayed in each GP surgery with information about how to make an appointment and what to expect from services provided by the NHS. A poster is also available for dentists providing information about the dental treatments available from the NHS. In addition, relaxation tapes are available in 18 languages.

These materials are available from GP Distributions

GP Distributions

Clutha House
120 Cornwall Street South
Kinningpark
Glasgow
G41 1AD
Tel: 0141 427 8246

Health entitlements

Under the Immigration and Asylum Act 1999 and the Asylum and Immigration Act 1996, most asylum seekers are not entitled to welfare benefits. However, asylum seekers who are supported by NASS are issued with HC2 certificates for full help with health costs and they may qualify for:

- free NHS prescriptions, dental treatment, wigs and fabric support and sight tests
- the full value of an NHS optical voucher towards the cost of glasses or contact lenses
- necessary public transport costs to and from hospital appointments.

Non-NASS asylum seekers

The NASS Dispersal Programme does not support all asylum seekers and those who are not supported by NASS can access health information through the Scottish Refugee Council, who will advise them on how to register with a GP. However, registration is not an automatic process for non-NASS asylum seekers, although Glasgow Health Board is trying to facilitate families with the appropriate health services.

Doctor Registration Card

Translated and produced by

*Health & Housing Resources Ltd, Unit 39, Concourse House, Dewsbury Road, Leeds LS11 7DF
Tel: 0113 277 0999 Fax: 0113 270 4753*

Details of Health Co-ordinator

145 Kelvinhaugh Street
Glasgow
G3 8PE
Tel: 0141 222 7300

Public Health Protection Unit

The Health Protection Unit forms part of the services within Greater Glasgow NHS. In accordance with all public health protection units it provides equality of care to each individual. This ensures immediate attention to any acute situations, chronic illnesses and vaccination schedules.

Functions of the Unit

- Surveillance and control of communicable diseases.
- Co-ordination of the immunisation programme.
- Environmental hazards control.
- Emergency planning.
- Medical advice on rehousing, concessionary travel and specialist environmental control equipment for the disabled.

Role of the Health Protection Nurse Specialist

- Works closely with consultants in public health medicine.
- Liaises with other agencies, e.g. environmental services, education services, etc.
- Works with Tuberculosis Liaison Specialists.
- Provides information and advice to public and primary care staff on a variety of issues.
- Advises nursing and residential homes on communicable diseases and infection control.
- Provides information, advice and counselling, e.g. food poisoning and infestations.
- Facilitates contact tracing in areas such as meningitis, hepatitis B and other blood-borne viruses.
- Provides immunisation advice, infection control advice.

Dr Syed Ahmed, Consultant in Public Health Medicine
Public Health Protection Unit (PHPU)
Dalian House, 350 St Vincent Street
Glasgow G3 8YZ
Tel: 0141 201 4917

Tuberculosis Nurse Specialists are based in four Glasgow general hospitals

Mary Waldermichael	Southern General Hospital 1345 Govan Road, Glasgow G51 4TF	0141 201 1176
Norma Brewster	Gartnavel General Hospital 1055 Great Western Road, Glasgow G12 0YN	0141 211 3062
Alice Bennett	Victoria Infirmary Langside Road, Glasgow G42 9TY	0141 201 5250
Una Lees	Glasgow Royal Infirmary 16 Alexandra Parade, Glasgow G4 0SF	0141 211 4958
Sharon Murray	Dalian House 350 St Vincent Street, Glasgow G3 8YZ	0141 211 4958

BCG immunisations

Since April 2004, the Public Health Protection Unit (PHPU) has been organising the BCG services for at risk children under 5 years. There are two clinics per month in both William Street and Govanhill community building.

A new clinic, which has been set up at The Princess Royal Maternity Unit (PRM), is offering BCG to babies born in the hospital who have been identified as in the category of special risk.

Extra clinics will be arranged from time to time to meet demand.

Who should be given BCG?

- Babies whose parents come from areas where there is a high incidence of TB.
- Those with close contact with known TB sufferers.
- Anyone travelling to a high risk country.
- Those with family members who have been diagnosed with TB within the past two years.
- Children whose parents have requested BCG immunisation for their children.

Health professionals are asked to refer at risk babies as soon as possible after birth. The PHPU will try to give appointments to these babies before they reach 3 months of age as no pre-BCG skin testing is required (only one clinic appointment). Over 3 months of age, children require skin testing and, therefore, two clinic appointments.

BCG clinic at The Princess Royal Maternity Unit.
Tel: 0141 201 4518

Vaccination of individuals with uncertain/ incomplete immunisation status

This is directed towards the provision of the complete vaccination protection afforded by the United Kingdom National Schedule.

Arrival age – aged less than 12 months	Arrival age – aged 1–10 years	Arrival age – aged 10+ years
<p>1. DTaP/IPV/Hib + *Men C ----- 1 month interval</p> <p>2. DTaP/IPV/Hib + *Men C ----- 1 month interval</p> <p>3. DTaP/IPV/Hib + *Men C</p> <p>* Two doses only Men C if course started over 4 months of age.</p> <p>At risk/special categories: Contact Public Health Dept. Tel: 0141 201 4917</p> <p>BCG; hepatitis B – can be administered from birth.</p> <p>Influenza – from 6 months of age.</p>	<p>1. DTaP/IPV/Hib + *Men C + tMMR ----- 1 month interval</p> <p>2. DTaP/IPV ----- 1 month interval</p> <p>3. DTaP/IPV ----- 1 month interval</p> <p>4. + MMR</p> <p>* One dose only Men C if course started over 12 months of age. + MMR – minimum 12 week interval.</p> <p>At risk/special categories: BCG; hepatitis B – can be administered from birth. Influenza – from 6 months old. Pneumococcal – contact Public Health Dept. Tel: 0141 201 4917</p>	<p>1. Td/IPV + tMMR + *Men C ----- 1 month gap</p> <p>2. Td/IPV ----- 1 month gap</p> <p>3. Td/IPV ----- 1 month gap</p> <p>4. + MMR</p> <p>* 1 dose only up to 24 years of age + Minimum 12 week interval</p> <p>At risk/special categories: BCG; hepatitis B – can be administered from birth Influenza – from 6 months old Pneumococcal – contact Public Health Dept. Tel: 0141 201 4917</p>
Booster	Booster	Booster
<p>Hepatitis B – contact Public Health Dept. Tel: 0141 201 4917</p>	<p>MMR at pre-school – minimum 12 week interval. 1st DTaP/IPV or dTaP/IPV – 1–3 years after primary course. 2nd dT/IPV 5–10 years later. Hepatitis B – contact Public Health Dept. Tel: 0141 201 4917 Influenza – annually. Pneumococcal – contact Public Health Dept. Tel: 0141 201 4917</p>	<p>1st dT/IPV can be administered from 1 year after primary course. 2nd dT/IPV – 5–10 years later Hepatitis B – contact Public Health Dept. Tel: 0141 201 4917 Influenza – annually. Pneumococcal – contact Public Health Dept. Tel: 0141 201 4917.</p>

As advised by Dr Syed Ahmed, Public Health Consultant, Health Protection Unit, Greater Glasgow Health Board.

Tuberculosis²

Infection and transmission

Tuberculosis (TB) is a contagious disease. A person needs only to inhale a small number of bacilli to be infected.

Left untreated, each person with active TB disease will infect on average between 10 and 15 people every year. Someone in the world is newly infected with TB bacilli every second. Overall, one third of the world's population is currently infected with the TB bacillus. 5–10% of people who are infected with TB bacilli (but who are not infected with HIV) become sick or infectious at some time during their life.

Global and regional incidence

The table below shows the estimated TB incidence (the number of new cases arising each year) and mortality in each of the WHO regions.

The largest number of cases occurs in the Southeast Asia region. However, the estimated incidence per capita in subSaharan Africa is nearly twice that of Southeast Asia. It is estimated that two million deaths resulted from TB in 2002.

Estimated TB incidence and mortality, 2002						
WHO region	Number of cases (thousands)		Cases per 100,000 population		Deaths from TB (including TB deaths in people infected with HIV)	
	All forms (%)	Smear-positive	All forms	Smear-positive	Number (thousands)	Per 100,000 population
Africa	2354 (26)	1000	350	149	556	83
The Americas	370 (4)	165	43	19	53	6
Eastern Mediterranean	622 (7)	279	124	55	143	28
Europe	472 (5)	211	54	24	73	8
Southeast Asia	2890 (33)	1294	182	81	625	39
Western Pacific	2090 (24)	939	122	55	373	22
Global	8797 (100)	3887	141	63	1823	29

HIV and TB form a lethal combination, each speeding the other's progress.

²Extract from WHO fact sheet 104 as revised March 2004.
www.who.int/mediacentre/factsheets/fs104/en/

TB in refugees and migrants

According to UNHCR, there were an estimated 20 million refugees and displaced and needy people in 2003. Many refugees originate from countries with high TB incidence rates. Poor nutrition and health mean that refugees are at particularly high risk of developing TB. Untreated TB spreads quickly in crowded refugee camps and shelters.

It is difficult to treat mobile populations, as treatment takes at least six months and should, ideally, be supervised.

In many Western European countries, and in the USA, over 50% of TB cases notified in 2001 were among people who were not born in and/or were not citizens of the country.

Hepatitis B

Hepatitis B infection is caused by the hepatitis B virus (HBV), an enveloped virus containing a partially double stranded, circular DNA genome. It is classified within the family hepadnavirus. The virus interferes with the functions of the liver while replicating in the hepatocytes. The immune system is then activated to produce a specific reaction to combat, and possibly eradicate, the infectious agent. As a consequence of pathological damage, the liver becomes inflamed.

Hepatitis B virus may be the cause of up to 80% of all cases of hepatocellular carcinoma worldwide, second only to tobacco among human carcinogens.

Incidence/epidemiology

The hepatitis B virus is a ubiquitous virus with a global distribution. Hepatitis B is one of the world's most common and serious infectious diseases.

It is estimated that more than one third of the world's population has been infected with the hepatitis B virus. About 5% of the population are chronic carriers of HBV and nearly 25% of all carriers develop serious liver diseases such as chronic hepatitis, cirrhosis and primary hepatocellular carcinoma (HCC). HBV infection causes more than one million deaths every year.

The HBsAg carrier rate varies from 0.1 to 20% in different populations around the world. The incidence of the HBsAg carrier state in populations is related most importantly to the incidence and age of primary infection.

In low risk areas of the world, the highest incidence of the disease is seen in teenagers and young adults. Despite the low incidence of disease seen in the general population, certain groups, who are sexually promiscuous or who have frequent contact with blood or blood products, have a high rate of HBV infection. Nevertheless, the availability of an effective vaccine, optimised blood donor screening and better sterilization procedures for blood derivatives have substantially lowered the infection risk.

In endemic areas of Africa and Asia, the epidemiological patterns differ from those seen in North America and Western Europe. In these regions, most infections occur in infants and children as a result of maternal–neonatal transmission or close childhood contact, although percutaneous exposure with contaminated needles or following unsafe injections is always a possibility.

The chronic liver disease and HCC associated with HBV infections are among the most important human health problems in high prevalence regions.

HBV is transmitted through percutaneous or parenteral contact with infected blood, body fluids and by sexual intercourse.

HBV is able to remain on any surface it comes into contact with for about a week, e.g. tabletops, razor blades, blood stains, without losing infectivity.

HBV does **not** cross the skin or the mucous membrane barrier. Some break in this barrier, which can be minimal and insignificant, is required for transmission.

HBV is a large virus and does not cross the placenta, hence it cannot infect the foetus unless there have been breaks in the maternal-foetal barrier, e.g. via amniocentesis. Still, pregnant women who are infected with HBV can transmit their disease to their babies at birth. If not vaccinated at birth, many of these babies develop lifelong HBV infections, and many develop liver failure or liver cancer later in life.

Sexual intercourse with multiple partners or with persons who have multiple partners can be dangerous. One should not judge by appearance, most infected people look perfectly healthy and have no symptoms of disease, yet may be highly infectious.

All persons who are **hepatitis B surface antigen (HBsAg) positive** are potentially infectious. The many millions of people around the world who become HBV carriers are a constant source of new infections for those who have never contracted the virus.

Blood is infective many weeks before the onset of the first symptoms and throughout the acute phase of the disease. The infectivity of chronically infected individuals varies from **highly infectious (HBeAg positive)** to often **sparingly infectious (anti-HBe positive)**. Hepatitis B is the only sexually transmitted infection for which there is a protective vaccine.

<http://www.who.int/emc-documents/hepatitis/docs/whocdscrlyo20022/disease/prevalence.html>
<http://www.who.int/emc-documents/hepatitis/docs/whocdscrlyo20022/virus/nomenclature.html>

Source: Adapted from and with acknowledgement to various WHO documents related to hepatitis B infections – September 2004.

Prevalence of hepatitis B in various areas

Area	% of population positive for		Infection	
	HBsAg	anti-HBs	Neonatal	Childhood
Northern, Western, and Central Europe, North America, Australia	0.2–0.5	4–6	Rare	Infrequent
Eastern Europe, the Mediterranean, Russia and the Russian Federation, Southwest Asia, Central and South America	2–7	20–55	Frequent	Frequent
Parts of China, Southeast Asia, tropical Africa	8–20	70–95	Very frequent	Very frequent

Source: With acknowledgement to, and adapted from, the World Health Organization Department of Disease Surveillance and Responses September 2004.

www.who.int/emc-documents/hepatitis/docs/whocdscrlyo20022/disease/

Poliomyelitis

An acute infectious disease of humans, particularly children, caused by any of three serotypes of human enterovirus – poliovirus. There is no cure for poliomyelitis – it can only be prevented by means of immunisation. Vaccine, given multiple times, almost always protects a child for life. Full primary immunisation will markedly reduce any individual risk of developing paralytic poliomyelitis.

The virus enters the body through the mouth and multiplies in the intestine. 1 in 200 infections leads to irreversible paralysis – usually in the legs – and amongst those so paralysed 5–10% will die as a result of respiratory muscle failure. Usually the infection is limited to the gastrointestinal tract and nasopharynx, and is often asymptomatic. The central nervous system, primarily the spinal cord, may be affected, leading to rapidly progressive paralysis. Motor neurons are primarily affected. Encephalitis may also occur. The virus replicates in the nervous system and may cause significant neuronal loss, most notably in the spinal cord.

Since mid-2003, 13 countries have suffered importations of wild poliomyelitis virus linked to virus circulating in northern Nigeria. In four of these countries – Burkina Faso, Chad, Cote d'Ivoire and the Sudan – wild poliovirus transmission has been re-established (i.e. continued circulation for > 6 months).

The six remaining polio-endemic countries are Nigeria, India, Pakistan, Niger, Afghanistan and Egypt. As at 5 January 2005 the global figures for new cases in 2004 had reached 1170 in the following endemic countries:

Nigeria (760 cases), India (126), Pakistan (44), Niger (25), Afghanistan (4), Egypt (1).

Since 2003 the following importation countries have been affected:

Benin (8), Botswana (1), Burkina Faso (17), Cameroon (4), Central African Republic (11), Chad (41), Côte d'Ivoire (15), Ghana (8), Guinea (1), Lebanon (1), Mali (2), Sudan (9), Togo (1).

An extract from the Weekly Epidemiological Record, 7 January 2005.

www.who.int/wer

A current poliomyelitis outbreak in the Sudan, caused by an imported type 1 poliovirus, continues to escalate. A total of 105 cases has now been confirmed from 17 of the country's 26 states (as at 6 January 2005), since the first case was identified in Darfur in May 2004. In addition, a 2 year old Sudanese girl from Port Sudan experienced onset of paralysis on November 6, 2004, 1 day post- arrival in Saudi Arabia from the Sudan.

Although genetic data on the virus isolated from the case in Saudi Arabia are not yet available, almost all other viruses identified in 2004, in the Sudan, are closely related to polioviruses originating in northern Nigeria and Chad. The escalating outbreak in the Sudan and the case in Saudi Arabia further underline the high risk posed to polio-free areas by the continuing epidemic in west and central Africa. This risk is compounded by the growing vulnerability of populations to poliomyelitis globally, following the cessation of preventative immunisation campaigns in many polio-free countries in 2002–2003.

Children, globally, will continue to be at risk of poliomyelitis from such importations until the disease is eradicated everywhere.

Following four mass immunisation programmes in the Darfur region between July and November 2004 and two nationwide campaigns in October and November 2004, planning is under way for the next rounds of nationwide immunisations in January, February and March 2005.

The World Health Organization (WHO) has notified countries neighbouring the Sudan of the high risk for further importations and has urged strengthening of surveillance for poliomyelitis, high immunisation coverage of infants and, if appropriate, supplementary poliomyelitis immunisation campaigns.

Never before has commitment and effort been so focused on this final push to rid the world of polio. Not only is the world on the verge of reaching a global health goal – the eradication of polio will also leave behind a legacy of what can be achieved through an extraordinary demonstration of global co-operation.

The Global Polio Eradication Initiative

The Global Polio Eradication Initiative is spearheaded by WHO, Rotary International, CDC and UNICEF. It includes:

- governments of countries affected by polio
- private foundations, for example the United Nations Foundation, the Bill & Melinda Gates Foundation
- development banks, for example the World Bank
- donor governments (e.g. Australia, Austria, Belgium, Canada, Denmark, Finland, Germany, Ireland, Italy, Japan, Luxembourg, the Netherlands, New Zealand, Norway, the United Kingdom and the United States of America)
- the European Commission
- humanitarian and non-governmental organisations, for example the International Red Cross and Red Crescent societies
- corporate partners, for example Aventis Pasteur, De Beers
- volunteers in developing countries.

From 1988 to 2005, an estimated 5 million people who would otherwise have been paralysed will be walking because of the Global Polio Eradication Initiative. Through polio eradication efforts, a significant investment has been made in strengthening health service delivery systems in many countries. Hundreds of thousands of health workers have been trained, millions of volunteers have been mobilised to support immunization campaigns, and cold-chain transport equipment has been refurbished.

HIV/AIDS – Global³

Worldwide, AIDS kills more than 8,000 people every day; 1 person every 10 seconds.

- HIV accounts for the highest number of deaths by any single infectious agent.
- Since the beginning of the epidemic, AIDS has claimed more than 25 million lives; more than 14 million children have lost one or both parents to AIDS.
- Every year, an estimated 3 million people die of AIDS of whom 500,000 are children under the age of 15 years.
- Nearly 5 million persons (4.2 million adults and 700,000 children) are newly infected with HIV each year; more than 95% of them belong to developing countries.
- Almost 50% of newly HIV-infected adults in 2003 were women and 50% were young adults in the 15–24 years age group.
- Unsafe sex is the predominant mode of transmission of HIV worldwide accounting for 80–90% of infections.
- There are 40 million persons living with HIV/AIDS worldwide. Of these, 2.5 million are children less than 15 years of age.
- Six million people in developing countries have HIV infections that urgently require antiretroviral treatment to keep them alive and healthy but fewer than 300,000 are being treated.

The 2004 Annual Report can be accessed through www.unaids.org/en/default.asp

³Taken from the WHO publication *2004 Annual Report on HIV & AIDS*.
www.who.org/hivaids/fact1.htm

Adults and children estimated to be living with HIV/AIDS

Total: 39.4 million (35.9–44.3 million)

Regional HIV/AIDS statistics and features, end of 2004.

Region	Adults and children living with HIV/AIDS	Adults and children newly infected with HIV	Adult prevalence (%)*	Adult and child deaths due to AIDS
SubSaharan Africa	25.4 million (23.4–28.4 million)	3.1 million (2.7–3.8 million)	7.4 (6.9–8.3)	2.3 million (2.1–3.6 million)
North Africa and the Middle East	540,000 (230,000–1.5 million)	92,000 (34,000–350,000)	0.3 (0.1–0.7)	28,000 (12,000–72,000)
Asia	8.2 million (4–11.8 million)	1.2 million (720,000–2.4 million)	0.4 (0.3–0.6)	540,000 (350,000–810,000)
Latin America	1.7 million (1.1–3.2 million)	240,000 (170,000–320,000)	0.6 (1.5–0.8)	95,000 (73,000–120,000)
Caribbean	444,000 (270,000–780,000)	53,000 (27,000–140,000)	2.3 (1.4–4.0)	36,000 (24,000–61,000)
Eastern Europe and Central Asia	1.4 million (920,000–2.1 million)	210,000 (110,000–480,000)	0.8 (0.5–1.2)	60,000 (39,000–87,000)
North America, Western and Central Europe	1.6 million (1.1–2.2 million)	64,000 (34,000–140,000)	0.4 (0.3–0.6)	23,000 (15,000–32,000)
Oceania	35,000 (25,000–48,000)	5,000 (2,100–13,000)	0.2 (0.1–0.3)	700 (<1000)
TOTAL	39.4 million (35.9–44.3 million)	4.9 million (4.3–6.4 million)		3.1 million (2.8–3.5 million)

Source: Taken from *Global Summary of the HIV/AIDS Epidemic December 2004*
www.unaids.org/wad2004/EPIupdate2004_html_en/Epi04_05_en.htm

*The ranges around the estimates in this table define the boundaries within which the actual numbers lie. These ranges are more precise than those of previous years, and work is under way to increase even further the precision of the estimates that will be published mid-2004.

HIV/AIDS surveillance system for Scotland

(Health Protection Scotland SCIEH Database – June 30 2004)

In Scotland, the national surveillance of AIDS began in 1982 and, following the confirmed availability of HIV antibody tests, was expanded in 1985 to include HIV-positive diagnosis.

HIV-infected non-Scots presumed to have been infected outwith Scotland by country of exposure. Cumulative number at 30 June 2004 = 1003

Total number = 1003 persons of whom 229 persons are/were native to the Channel Isles, England, Northern Ireland, Republic of Ireland and Wales. Subtraction of these United Kingdom figures from total cases results in imported, confirmed infection numbers of 774 cases. 15 cases have no known nationality whilst a group of 29 are generally classified as from Africa with a further 22 grouped as Europe. The following countries represent specific nationalities for the remaining 708 cases:

Algeria; Angola; Argentina; Australia; Austria.
Barbados; Belgium; Botswana; Brazil; Burundi.
Cameroon; Canada; Cote D'Ivoire; Cape Verde; China; Congo; Cuba.
Denmark.
Eritrea; Ethiopia.
France.
Gabon; Gambia; Germany; Ghana; Greece.
Haiti; Holland; Hong Kong.
India; Indonesia; Israel; Italy.
Jamaica; Japan.
Kenya; Kuwait.
Libya.
Madagascar; Malawi; Malta; Mauritania; Mexico; Middle East.
Namibia; Nigeria; Norway.
Oman.
Pakistan; Philippines; Poland; Portugal.
Romania; Russia; Rwanda.
Saudi Arabia; Sierra Leone; Somalia; South Africa; Spain; Sudan; Swaziland.
Tanzania; Tenerife; Thailand; Trinidad; Tunisia.
United Arab Emirates; Uganda; United States of America.
Vietnam.
West Indies (island unstated).
Zaire (now Democratic Republic of Congo); Zambia; Zimbabwe.

Acknowledgements are made to G Codere, K Roy and L Shaw of the Scottish Centre for Infection and Environmental Health (SCIEH), for the use of the SCIEH data.

Local services**Confidential counselling and testing for HIV and hepatitis**

CAST Team offer a comprehensive client-centred service for people living with HIV or hepatitis infection.

Brownlee Centre
1053 Great Western Road
Glasgow
G12 0YS
Appointments and enquiries: 0141 211 1075
Helpline: 0141 211 1089

GUM Clinic

Testing and advice
The Sandyford Initiative
6 Sandyford Place
Sauchiehall Street
Glasgow
G3 7NB
Tel: 0141 211 8601/8602

TRAVAX**Travel Medicine Services NHS**

TRAVAX Database is an on-line computerised database for professional use only. It is provided, maintained and continually updated by a dedicated team of professionals of the Travel Medicine Section at the Scottish Centre for Infection and Environmental Health (SCIEH).

Information is derived from many sources including the World Health Organization (WHO) and the associated regional offices (Africa, Americas, Eastern Mediterranean, Europe, Southeast Asia, and Western Pacific), non-governmental relief organisations and other Global Surveillance Units (SCIEH is the Surveillance Unit for Scotland).

Originally designed to provide pre-travel guidance to professional advisers, the individual country records and infections and illnesses sections also serve as a reminder to receiving physicians/clinicians of the travel history and clinical investigatory pathway to follow when presented with patients from outwith the United Kingdom.

The contents are separated into 24 individual categories, many of which have subsections.

Information is available for:

- **Country destinations**
Requirements and recommendations based on geographical disease presence, transmission routes and likely circumstances of exposure.
- **Immunisable diseases and infections**
Prevention, clinical picture, signs/symptoms, investigations and treatment.
- **Vaccines**
Composition, availability and use of vaccination procedures.
- **Non-immunisable illnesses**
Prevention, clinical picture, signs/symptoms, investigations and treatment.
- **Malaria**
Prophylactic drugs and their use, the illness, clinical picture, signs/symptoms, investigation and treatment.
- **Advice sheets**
Special travellers, e.g. diabetic, transplant, pregnant, HIV+ or the elderly.
Special circumstances, e.g. occupational, altitude, cruises, diving.
- **Outbreak news**
Entered on a daily/more frequent basis as information/alerts received.
- **Discussion forum**
Serves as a 'debating chamber' for professionals to interact/discuss topical issues.

The average, monthly access rate is 35,000 user log-ins (300,000 hits). Registration is not confined to the United Kingdom. In Scotland it is free of charge to all NHS professionals. Registration is available on-line at the website www.travax.nhs.uk

Ante-natal care and birth

Effective communication systems are essential if pregnant asylum seekers and refugees are to be offered seamless ante-natal care.

Health care staff may wish to consider the following when engaging with these women.

- They may not realise that ante-natal care is important or that they are entitled to routine care for themselves and their unborn babies under the NHS. Women should be encouraged to take up the opportunity to attend clinics for routine ante-natal care.
- They may have suffered from poor nutrition in early pregnancy as they may have sacrificed their own needs to provide food for their existing children. This may give rise to intra-uterine growth retardation and/or low birth weight.
- Spina bifida is associated with inadequate folate intake ante-natally during the first trimester of pregnancy.
- If they have newly arrived in the country and are at the end of their pregnancy, they may have other young children who need to be looked after whilst they are in hospital during delivery (this can be arranged through the local Social Work Department).
- As a result of dispersion, they may have been separated from potential support networks and may feel isolated.

Pregnant asylum seekers and refugees may be unfamiliar with the types of care available in Scotland. If possible, they should be offered a choice of female health worker and interpreter, with an interpreter also arranged for ante-natal classes. As with other pregnant women, a hand-held ante-natal record will be provided and is particularly useful if a woman moves into new accommodation during the pregnancy.

As with the indigenous population, sensitivity is required for HIV testing and some women may be at risk of other infections, such as hepatitis B and C. In addition, women from certain areas of the world may have been subjected to female genital mutilation; therefore, sensitivity has to be considered in their care.

Counselling for haemoglobinopathies and ante-natal screening for malformations should be offered. Although, in many cultures, termination of a pregnancy is unacceptable, do not make assumptions about what the woman or couple might wish to do in the event of a malformation being discovered – they need access to information so they can make an informed choice.

A woman who is pregnant as a result of rape will need especially sensitive support. She may face particular difficulties relating to her baby, although this is not universal.

When giving birth, women in many cultures are used to being supported by female family members and will feel their absence when they go into labour. In these cultures, husbands and male partners are rarely the major sources of support and this may be an unfamiliar role to both the woman and her partner.

Refugee children, asylum-seeking children and children of asylum seekers may have come from countries where they do not have a policy on neonatal screening for conditions such as phenylketonuria, hypothyroidism, cataracts, congenital heart disease or congenital dislocation of the hip.

Additional payments for mothers and children

To assist with the cost of milk or milk formula for infants, the Asylum Support Regulations have been amended to allow additional payments to be made to pregnant women and children under the age of three who are currently being supported by NASS.

This means that babies under the age of one year are entitled to an additional £5 per week, while pregnant women and children between the age of one and three years receive an additional £3 per week. Mothers who are advised not to breastfeed by health professionals can apply for additional funding through their project workers, and their eligibility will be considered on receipt of written medical evidence.

Maternity payment

To help with the costs arising from the birth of a new baby, a single, one-off maternity payment of £300 may be provided to those asylum seekers who are supported by NASS.

Criteria

The application for a maternity payment has to be lodged in writing by the father or mother of the child, which is arranged in collaboration with the midwives and project teams at GASSP. Tel: 0141 222 7300.

However, the time frame for this payment is tight. Applications must be lodged either four weeks before the birth of the baby, along with formal medical evidence of the estimated date of delivery (EDD) from a health professional, or two weeks after the birth of the baby, when a birth certificate should be submitted to NASS to verify the birth.

New baby pack

The GASSP Team supplies a baby pack when a mother has a new baby. The following items are included:

- baby bath
- pail and potty
- high chair
- sterilising unit with bottles
- a cot.

Some community groups and drop-in centres may provide local information to asylum seekers about where to access baby equipment such as prams as these are not included in the pack.

Whilst breastfeeding is encouraged for all new mothers, those women who are HIV positive are advised not to breastfeed their babies to prevent transmission of the HIV virus to their newborn babies. Health professionals have queried the practice of providing sterilising units to mothers, as this may be interpreted as promoting formula feeding, and therefore a discouragement to promote and continue breastfeeding. However, in order not to discriminate against some mothers, sterilising units are provided to all mothers.

Experience has shown that this piece of equipment is not always automatically used in other countries of the world, and often needs to be demonstrated on its use and value.

Registration of newborns

Any birth, which occurs in Scotland, must be registered within 21 days by the Registrar of Births, Deaths and Marriages. The law requires the birth to be registered either in the registration district where the birth took place or in the registration district where the mother of the child lived.

The baby takes its citizenship from the mother's status; therefore babies born in Scotland to mothers who are seeking asylum are also classed as asylum seekers. They are not given automatic citizenship of the UK.

Working with asylum seekers and refugees

When working with asylum seekers and refugees, frontline staff when planning their care should consider some useful points.

- Avoid repetition in clinical notes.
- Take time to find out the correct family name rather than misusing several different names.
- Do not assume that all asylum seekers or refugees will require counselling for mental health issues.
- If using an interpreter check that, as well as using the correct dialect and language, they are culturally acceptable to the family or patient.
- Do not assume that all people from ethnic minority groups do not speak English.
- Do not be surprised if a child's birth date does not match his or her development.

How health visitors can help asylum seekers and refugees?

- Build up a trusting relationship.
- Address common health problems.
- Provide education about the NHS and how it works.
- Help adapt to a foreign culture.
- Help with social adjustment.
- Encourage to learn English.
- Encourage to get involved in the local community.
- Provide advice on using services appropriately.
- Foster independence.
- Act as a link for other agencies.
- Provide a link between community development and local agencies.
- Organise health clinics providing health education, preventative and screening measures.
- Offer support by working in drop-in centres.

Health visiting services

Before a visit

- Check the family's name and address.
- Arrange for an interpreter to be present – allow for culture and language.
- When arranging to meet the interpreter, brief them on any medical terminology that may be required.
- Ensure you have an ID card when introducing yourself as families may be unfamiliar with health visiting services.
- Be aware of the day and time of visit – refer to the religious festival calendar and note times of fasting, worship, etc.
- Speak English and use a language card.
- Find out about the family's culture and belief systems.

During a visit

- It may be appropriate to remove your shoes when entering the house, although this may not be necessary as many people have a room close to the door, which can be used for visits.
- Keep the visit simple: find out their belief system, ascertain their knowledge about the services and then work towards promoting health.
- Take the opportunity to start the visit.
- Arrange the time and date of next visit.
- Debrief interpreter.

Asylum seekers and refugees can be resilient and many appear to cope with dramatic life changes in spite of refugee status being imposed on them. Others bear the marks of severe depression, which is often manifested as a non-specific physical complaint, such as abdominal pains or generalised aches and pains.

Also, it is worth remembering that different groups of people have different needs, e.g. Somali refugees often have particular language difficulties and have come from a war-torn, anarchical country where there is no organised health care; whilst people coming from Iran may have been exposed to an organised health care system with different referral patterns.

In some cultural groups, the elderly women are perceived as the wise focus of the family to whom succeeding generations turn to for advice. It is through these elderly women that cultural norms and values are passed on through the generations but this flow of advice and information is often curbed as refugees may be living in an alien culture with little or no family support.

Background knowledge of other cultures and religions

Being a stranger in a strange land is a daunting prospect but being a member of staff and not having basic background information can be equally disempowering. One of the key requirements when working with people is to have an interest in other people's customs and religions. Finding out what is important to a family will make them feel welcome.

Questions that should be asked include:

- Where do you come from?
- What are the food laws you wish to observe?
- What else would it be useful for me to know?

Child protection

Child protection guidelines are available for all staff members to advise and inform them on possible actions to consider when faced with child protection scenarios. 'Home alone' is a situation in which a child or young person is left without the care or supervision of a responsible adult.

These situations are never absolute; however, they require sensitivity and judgement from health care professionals.

In some cultures it is acceptable to leave young children alone. In particular families from war-torn countries often feel it is safer to leave children at home rather than take them out in the streets or walk them over areas where there have been landmines.

Children's safety is paramount; health care professionals together with other agencies are working to ensure that families have enough information, and understand that it is not acceptable or safe practice to leave children unattended home alone in United Kingdom.

Sharing good practice

Immunisation sessions

As every health visitor or practise nurse knows, organising a smooth-running immunisation session involves a substantial amount of planning.

When working with asylum seekers or refugees, many other factors need to be considered so a safe and efficient session can take place.

In order to reduce staff anxiety, reduce patients' frustration and deliver a culturally competent service to all, some of the practical issues have to be thought through.

Points to consider

- Speak to the Child Health Department in order to check list of appointments.
- Check religious festival calendar.
- Check names are spelt correctly.
- Check times are convenient.
- Arrange for patients to attend according to their language.
- Arrange for appropriate interpreters to be present.

Organising the room

- Remember to provide a seat for the interpreter.
- In addition to all necessary equipment and vaccines, have translated material and posters available for use during the session.
- Make use of the WHO immunisation sheet and How to take your medicines leaflets.

At the end of the session

- Debrief the interpreters and sign their sheets.

Childcare – glimpses into other cultures

Childcare practices vary around the world and what seems common practice for professionals in the West can be alien for parents from other cultures and countries.

Traditional practices vary amongst many geographical areas and are heavily based on concepts, for example hot and cold conditions. Although younger women may no longer follow traditional practices, the family (and, in particular, mother or mother-in-law) may insist on following these traditions. It is important to understand how an individual woman and her family can come to a compromise.

Pregnancy

According to Chinese categories, cold foods are needed for the 'hot' condition of pregnancy.

There is a wide range of foods, which are felt to be either beneficial or harmful, although this varies between cultures and regions. For example, bean sprouts/green peas are avoided while home-made rice wine, herbal medicines and coconut juice are taken to help give the baby good quality skin. In Cambodia, beer is thought to make the delivery easier.

The cold ice water offered post-delivery in a hospital in the United Kingdom may be considered unhealthy as, once the baby is born, the mother's condition changes from 'hot' to 'cold', hence a need for hot foods to restore the body's balance.

Post-partum

The post-partum period is considered a 'cold' period and is very critical. The woman is felt to be weak and vulnerable to infection and disease. Women who have just given birth are kept warm and confined to bed for 30 days post-partum. Air conditioning and draughts from open windows are avoided and, if women do go outside during this period, they wear coats and head coverings, even if the weather is warm. The frequent post-partum doctor appointments for the infant and mother encouraged in the UK clash directly with the strong cultural belief among South Asians in the need for rest and quiet during this period.

To prevent 'wind' from entering the body's system, for one month after giving birth, a woman will not be immersed in water – bathing, showers and hair washing are forbidden.

The maternal diet at this time is balanced between hot (alcohol, ginger, black pepper and some high protein) and cold (fruits, vegetables, some seafood), while pork is felt to be very nutritious. Raw foods and sour foods (cause incontinence) are avoided.

The inability to follow traditional post-partum practices (d'sai kchey) is thought to cause health problems later, especially abdominal pain (even if it occurs months or even years later). Once a woman becomes sick from symptoms which are thought to be due to violation of d'sai kchey, she is sick for the rest of her life.

Infant care

During the post-partum period, all care of the infant, except feeding, is carried out by female relatives from the woman's extended family, especially her mother or mother-in-law.

Breastfeeding/bottle feeding

- Excessive hot foods are thought to deplete breast milk supply.
- Colostrum is believed to be 'dirty' and 'stale' and is discarded. In the first few days, infants are fed by other lactating women.

Weaning and solid food

Infants are traditionally breastfed until two to three years of age. Early weaning to cup is not a cultural norm and solid foods are introduced late, often after the child is a year old.

Other issues

- Male infants are not circumcised (except for the Cham nationality, who are Muslim).
- Infants are traditionally placed on their backs as the flat head, which this creates, is felt desirable.
- Maternal depression may be related to the mother's sense of bad outcomes/future because of her inability to follow traditional post-partum rest and dietary practices in this country.

East Africa

Refugee families in the UK are often separated from their extended family and are living spread out from each other in different areas of the country.

Pregnancy

- During pregnancy, women try to have good nutrition and, in particular, may increase the amount of meat in their diet.
- Drinking a mix of flax seed flour and warm water during the late stages of pregnancy is a traditional practice which is believed to help ensure an easy delivery.
- The husband must be involved in any decisions for surgical interventions, although he may defer a decision to his wife or female relatives.
- Multiparous women do not like surgical interventions and may wait until late in labour to come to hospital.

Post-partum

Traditionally, Somalian women rest in bed for 40 days post-partum, when they are attended by other women, who prepare nutritious food and do housework.

This period is known as 'afantanbah' in Somali culture and, during this time, the mother wears earrings made from string placed through a clove of garlic and the baby wears a bracelet made from string and 'malmal' (a herb which is available in Asian markets) in order to ward away the evil eye (in some Ethiopian cultural groups, a woman carries a metal object – often a knife – with her at all times to prevent evil eye). In addition, incense (myrrh) is burned twice a day in order to protect the baby from the ordinary smells of the world, which it is thought can make him/her sick.

At the end of 40 days, there is a celebration at the home of a relative or friend to mark the first time the baby and mother have left their home since the delivery. This celebration may be combined with a naming ceremony for the baby.

Infant care

Newborn care may include warm water baths, sesame oil massages and passive stretching of the baby's limbs (Somali). A herb called malmal may be applied to the umbilicus for the first seven days of life (Somali).

Breastfeeding

In all East African cultures, breastfeeding is equated with motherhood. Almost all mothers, at least initially, breastfeed and this often continues for two to three years.

Breast milk is not offered in the first 24 hours, when infants may be given sugar water (Ethiopia/Eritrea) or fresh cow, goat or camel milk (Oromo/Somali) as colostrum is thought to have little value, or to be unhealthy, and may be discarded. In some cultures, fresh butter is given to the infant in the first few days to help clean the meconium out of the bowels (Oromo).

Mothers are unfamiliar with pumping and storing breast milk and need education about how to do this.

Weaning and solids

Soft foods are first offered at a few months of age and drinking from a cup is offered at 6–8 months.

Toilet training

Toilet training is started at a few months of age by closely watching the infant's behaviour and gradually training it to go in a small bowl or potty. Using this method, bowel training may be achieved by 6–7 months and bladder training after a year. Nappies are rarely used in their native countries (especially Somali) so nappy rashes are unknown and are distressing when experienced here.

Other issues

- Male circumcision is done between the newborn period and five years of age and varies greatly in timing in different cultures.
- Practice of female ritual genital surgery varies from region to region, even within cultures. Most families understand that these procedures would not be considered legal in UK but may ask about them.
- Orthodox Christian infants are baptised at 40 days for boys and 80 days for girls.
- At birth, infants are given an informal family name and, after a few months, as the personality of the child becomes apparent, they are given a formal name.

Sickle cell anaemia

Sickle cell anaemia is an inherited blood disorder caused by abnormal haemoglobin in red blood cells, which carry oxygen to the tissues and organs of the body.

Unlike normal red cells, which are usually smooth and doughnut-shaped, the 'sickle' red cells are shaped like a crescent moon or a farmer's sickle and cannot squeeze through the small narrow blood vessels. Instead, they pile up and cause a blockage that deprives the organs and tissues of oxygen-carrying blood. This then produces periodic episodes of pain, which are characteristic of the condition. Ultimately this can damage tissues and vital organs and may lead to other serious medical problems.

The condition mainly affects individuals who are descended from families where one or more members originated from parts of the world where falciparum malaria was and still is endemic. Studies have shown that in areas where malaria is widespread (tropical regions of the world – parts of Africa, Mediterranean basin, Middle East and India), children who are carriers of the sickle cell gene, known as sickle cell trait, have a survival advantage over those who do not carry the gene.

For more information

Website of the Sickle Cell Society
www.sicklecellsociety.org

Thalassaemia

Thalassaemia is also an inherited disorder that is a result of either partial or no production of the alpha or beta chains, which form part of the structure of haemoglobin, a vital component of red blood cells. The latter are responsible for transporting oxygen to the tissues and organs of the body via the bloodstream. Thalassaemia can also result from an increased breakdown of red cells, which can lead to anaemia. The two major conditions are a-thalassaemia major and b-thalassaemia major.

There are two types of a-thalassaemia: alpha-thalassaemia major (also called a-thalassaemia hydrops fetalis or haemoglobin Barts hydrops fetalis), in which the foetus develops severe anaemia early in pregnancy, leading to heart failure and death before or immediately after birth; and haemoglobin H disease, a milder form of a-thalassaemia which is usually associated with chronic anaemia with relatively few complications.

Beta-thalassaemia major is characterised by deficient or absent β -globin chain production and the subsequent overproduction of defective red blood cells. Death occurs during early childhood unless the severe anaemia is reversed by regular blood transfusions.

Thalassaemia is more widespread in the countries of Asia, the Middle East and Mediterranean, but is also occasionally found in the white British population with prevalence being almost twice as high in parts of the UK (Scotland and Ireland) than others. There is no known survival advantage of those who are carriers of thalassaemia trait.

It is estimated that there are about 12,500 people in the UK with sickle cell disease and about 820 affected with beta-thalassaemia.

The actual gene mutations, or a raised haemoglobin F, sometimes modify the disease.

A multi-authored report *Screening for Sickle Cell Disorder and Thalassaemia in Scotland* (2004) is available from The National Resource Centre for Ethnic Minority Health, Health Scotland, Clifton House, Clifton Place, Glasgow G3 7LS; Tel: 0141 300 1054.

For more information

Website of the Thalassaemia Society
www.ukts.org

Female genital mutilation

Female genital mutilation (FGM) is a deliberate procedure that causes grave damage to girls and women and which, in many cases, results in serious health consequences.

Often referred to as female circumcision, FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the genital organs whether for cultural, religious or other non-therapeutic reasons. Different types of FGM are known to be practised today.

The mortality as a result of FGM is probably high but few records are kept. Deaths due to FGM are rarely reported. The practice may be performed during infancy, childhood, at the time of marriage or during a first pregnancy although the most common age appears to be between 4 and 10 years of age. The reasons given to justify FGM are numerous and reflect the ideological and historical situation of the societies in which it has developed. Many women believe that FGM is necessary to ensure acceptance by their community and are unaware that it is not practised in most parts of the world.

The World Health Organization (WHO) classification of female genital mutilation is in four stages:

- Type I
Excision of the prepuce, with or without excision of part/all of the clitoris.
- Type II
Excision of the clitoris with partial/total excision of the labia minora.
- Type III
Excision of part/all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
- Type IV
Pricking/piercing or incision of the clitoris and/or labia; stretching the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue.
Scraping of tissue around the vaginal orifice (Angurya cuts) or cutting of the vagina (Gishiri cuts).
Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening/narrowing it.
Any other procedure that falls within the definition of FGM types I, II or III.
The immediate and long-term health consequences of FGM vary according to the type and severity of the procedure performed. More recently, concern has arisen about possible transmission of the human immunodeficiency virus (HIV).

Immediate complications: haemorrhage, shock, infection (septicaemia, tetanus, gangrene), urinary retention and injury to adjacent tissues.

Long-term complications: bleeding, anaemia, difficulty in micturition, recurrent urinary tract infections, incontinence, infertility, vulval abscesses, keloid formations, dermoid cysts, neurinoma, calculus formation, fistulae, sexual dysfunction, dysmenorrhoea, haematocolpos, difficulties in pregnancy and labour.

The WHO, together with other United Nations (UN) agencies, has encouraged governments, in all countries concerned, to support national efforts towards the elimination of FGM.

Female genital mutilation has been unlawful in Scotland since 1985 (Prohibition of Female Circumcision Act 1985) although this was limited by geography to deeds performed within Scotland. Following the passing of the Female Genital Mutilation Act 2003, which repealed and re-enacted the provisions of the Act and gave them extra-territorial effect, England, Wales and Northern Ireland gained protection for women when it became illegal for anyone to be taken/sent abroad for the purpose of FGM.

The Prohibition of Female genital mutilation (Scotland) Bill was introduced to the Scottish Parliament in October 2004 with the policy objective to strengthen existing legal protection against FGM in Scotland and extend the protection offered to include the activities of permanent Scottish (UK) nationals in any part of the world.

The Bill also increases the penalty on conviction or indictment from 5 to 14 years' imprisonment to strengthen the protection available to people in communities in which FGM is practised.

The Bill makes FGM procedures unlawful, regardless of age and whether consent was given. (There are a number of reasons for this.)

For more information

www.who.int/docstore/frh-whd/FGM/infopack/English/fgm_infopack.htm
www.afro.who.int/press/2004/pr20040205.html
www.who.int/mediacentre/factsheets/fs241/en/print.html
www.who.int/reproductive_health/gender/sexual_health.html

Supporting families when a death occurs

Death is not easy for anyone to deal with and, as they strive to cope with their loss, this is often a time of great personal distress.

For asylum seekers who have recently left their home, trying to make funeral arrangements can be a daunting task when there is little understanding of the culture or English language.

People from different cultures may have various religious practices to observe. When a death occurs, health professionals are advised to consult with religious or community leaders to avoid confusion arising from different practices in relation to death and dying.

NASS-supported asylum seekers are, by definition, destitute and will not be able to pay for their relative's or friend's funeral costs, while single asylum seekers who have died may not have family or friends nearby to carry out their funeral arrangements.

NASS Policy 59 – Funerals

This document gives further guidance on this matter for health boards and local authorities.

<http://www.asylumsupport.info>

Role and responsibilities of official funeralor (Registrar for Births, Marriages and Deaths)

The Glasgow City Council Registrar's Service is responsible for the registration of all deaths. The responsibility of the Registrar's Service is founded on the need to provide 'A dignified funeral for the deceased person that is in deference to public health and decency'. Registration is required within eight days.

The address of the Glasgow Registration District Office is:

1 Martha Street
Glasgow G1 1JJ
Tel: 0141 287 7652

National funded funeral formerly known as a common funeral

Currently, the legislation for providing what would previously have been termed a common funeral, but is now referred to as a national funded funeral, enables the local authority to provide for the dignified disposal of a body in circumstances where no family, finances or the ability to make private funeral arrangements exists. The service makes no distinction based on religious grounds and is common to/socially inclusive of all.

Cremation is the preferred mode of funeral in that it is the most popular method chosen by today's society. Given that land resources are dwindling, it is also seen as being more environmentally astute.

Interment/burial will be considered only if a private grave already exists and some personal finances can be realised, e.g. from a limited estate.

The point of contact with the Registrar's Office is usually through the social services, police or representatives of the home or hostel accommodation, in which the deceased has resided. Where the person making the approach (the applicant) is in receipt of benefits, there is a redirection to the Department for Social Security (DSS) who can/should contribute financially to a privately arranged funeral at this time. Where there is no means of payment, responsibility for the funeral is likely to be transferred to the Registrar's Office, with the family relinquishing any control or say in the funeral arrangements. This includes the disbursement of cremated remains. This responsibility lies with the needs of the deceased – for a dignified funeral and in deference to public health and decency. The Registrar's Office has the right to endeavour to recoup such funeral expenses as have been incurred, for example by the reclamation of outstanding pension money or benefit, etc.

NB. Asylum seekers are not affected. The financial support received by asylum seekers is NOT a DSS benefit. It is part of the NASS support package and therefore a payment from the Home Office.

In the event of a death within the asylum seeking community, there will NOT be any interference with this payment. The Registrar's Office will NOT seek reclamation from this source.

Within Glasgow, to date, the only problem experienced by the Registrar's Office relate to the specific funeral needs on the occasion of death of an asylum seeker of Muslim persuasion. This situation appears not to have been fully considered by central government. Existing legislation and financial constraints do not meet the particular requirements and incumbent additional financial outlay of these occasions.

So far the Central Mosque has attended to, and funded, these particular funeral rites. The Central Mosque is in the process of designing/preparing the way to open a dedicated Muslim burial ground, within the Greater Glasgow area.

For more information:

Glasgow City Council,
Land Services Bereavement Services
20 Trongate
Glasgow G1 5ES
Tel: 0141 287 3961-4
Email: land@glasgow.gov.uk

Thanks and appreciation to Lucille Fury, Registrar of the Registrar's Service Glasgow City Council (16 November 2004).

What is the Compass team?

The Compass team is the Greater Glasgow Asylum Seeker and Refugee Mental Health Liaison Service.

The service consists of a small multidisciplinary mental health team lead by Dr Anne Douglas, Consultant Clinical Psychologist. It has been set up to provide advice and consultation to primary and secondary care services, including partner organisations, who are working with asylum seekers and refugees of all ages.

In addition, the Compass team provide some direct therapeutic interventions.

Compass is dedicated to building the capacity of mental health services to provide culturally sensitive health care for this client group.

Role of the Compass team

- To provide advice, consultation and information to health care professionals and partner agencies.
- To discuss therapy options and care pathways.
- To provide education and training.
- To contribute to strategic planning for culturally sensitive services.
- To support mental health services through:
 - group therapy programmes
 - assessment and individual therapy for people with complex problems (e.g. following torture, culturally sensitive issues)
 - joint assessment (where appropriate)
 - regular consultation to local psychology teams
 - inpatient liaison service
 - teaching and training
 - a monthly journal club
 - collecting (and disseminating) information on community resources (new legislation, research and literature)
 - monitoring and reviewing the use of mental health services.

Referral criteria

Individual therapy

Inclusion criteria

- Moderate to severe problems (e.g. depression or complex post-traumatic stress disorder (PTSD) following torture or rape).
- Culturally complicated presentation.

- More than one family member in need of individual therapy (i.e. family benefiting from a team approach).
- Clients of all ages.

Exclusion criteria

- Mild mental health problems.
- Significant alcohol or drug problems.
- Client in need of emergency psychiatric response.
- Client requiring social support only.

Group therapy for men and women

Inclusion criteria

- Moderate mental health problems.
- Social isolation.
- Limited structure in their life.
- History of trauma.

Exclusion criteria

- Acute mental illness.
- Significant risk of violence.
- Current substance abuse.
- Inability to travel independently.

Mental health therapy groups for male and female asylum seekers

The aims of the group

- To reduce feelings of isolation.
- To lessen symptoms of anxiety and depression.
- To improve self-esteem and trust.
- To improve awareness of local community resources.

Referral criteria

- Asylum seekers or refugees with moderate mental health problems (e.g. PTSD, anxiety/panic attacks, social phobia, moderate depression, history of sexual abuse/assault, stable psychotic illness).
- Socially isolated.

- Loss of confidence.
- Limited structure in their life.
- Inability to speak English is not a problem, as the group is activity based.
- Must be able to travel to the centre of Glasgow. This may not be suitable for women with very small babies, or serious agoraphobic, depressive or psychotic symptoms.
- No active issues of violence or poor impulse control.

Numbers are limited to 15 per group.

A crèche will be provided for the women's group only.

GPs, health visitors, community mental health teams, psychiatrists and psychologists can refer.

The groups are held in a city centre location, as referrals are citywide.

All referrals will be screened for suitability.

Compass

Units 34/35 Hyde Park Business Centre

60 Mollinsburn Street

Springburn G21 4SF

Tel: 0141 630 4985/0141 630 4989

Identifying psychological trauma in children

Not all children who experience traumatic events have a trauma-related disorder. Of those who do, only some will have PTSD. Others may have depression, phobias and deterioration of pre-existing conditions.

Common symptoms after trauma

- Repetitive and intrusive thoughts (flashbacks are rare).
- Sleep disturbances, including fear of the dark, nightmares and night waking.
- Separation difficulties.
- Irritability and anger.
- Pressure to talk and reluctance to talk to parents and peers.
- Difficulty in concentrating, memory problems.
- Alert to danger.
- Sense of foreshortened future.
- Survivor guilt.
- Depression.

Children under 48 months of age

- Recurrent recollections, not necessarily distressing:
 - increased nightmares
 - psychological distress from reminders
 - physiological reactivity to reminders.
- Avoidance of any type of reminder:
 - construction of play
 - social withdrawal
 - restricted affect.
- Sleep disturbance:
 - irritability, temper tantrums
 - decreased concentration
 - hypervigilance
 - exaggerated startle response.
- Loss of acquired skills.
- Bedwetting.
- Separation anxiety.
- Clinginess.

When to refer a child

- If health professionals are concerned about the behaviour of a child, impairing the child's ability to get on with life and development.
- If the symptoms persist for more than a month.

Referrals to psychological services can be made through the GP or by health visitors or contact to discuss with:

Ms Christine Puckering
 Psychological Medicine
 Division of Community Based Sciences
 Caledonia House
 Royal Hospital for Sick Children
 Yorkhill Hospital
 Glasgow G3 8SJ
 Tel: 0141 201 9261

Education

Glasgow City Council Education Services is the largest educational authority in Scotland and is responsible for the education of around 80,000 young people in primary and secondary schools and pre-five and special educational needs (SEN) establishments.

In April 2000, Glasgow City Council signed a five year contract with the National Asylum Support Service (NASS) to provide accommodation and support for asylum seekers and their families and Glasgow City Council Education Services has developed existing services for bilingual pupils to meet the needs of this new group.

Nine per cent of all the young people in education in Glasgow are bilingual. Bilingual bases, consisting of one or more classrooms staffed by English as an Additional Language (EAL) teachers, have been established in 26 primary schools and seven secondary schools in the city. These bilingual bases provide support for asylum seekers entering Glasgow's education system.

There are presently around 2,000 young asylum seekers and refugees in Glasgow – 1,300 of them in primary schools and 700 in secondary schools.

When a young asylum seeker arrives in a school they initially attend the bilingual base, where the EAL teachers will build up a profile of the pupil's linguistic and educational needs, provide specific support with English language development and prepare the pupil for transfer to mainstream classes. Pupils join mainstream peers for intervals and lunchtimes from the very beginning and then participate in less language-intensive areas such as PE and art before gradually moving into areas that require greater competence in English language.

The transfer into mainstream takes place at a pace appropriate to the individual pupil's needs, with EAL teachers providing support at all stages. Some pupils transfer to mainstream very quickly, others take much longer and many spend some time in a combination of the two settings.

Glasgow Asylum Seeker Support Project
 Education Team
 Tel: 0141 222 7367
 Fax: 0141 222 7376

MARIM Multi-agency Racial Monitoring Groups

Strathclyde Police has established the Third Party Reporting Scheme to allow victims of racial crimes to report incidents in a confidential and supportive way. Liaison with agencies such as housing, education, social work and the health services has resulted in joint solutions being formed to resolve some of the difficulties experienced by asylum seekers, refugees and members of black ethnic communities.

Working in partnership with other agencies has established a positive method of tackling many issues. Effective multi-agency working is vital for a holistic response to racism.

Third Party Reporting Scheme

The Third Party Reporting Scheme encourages all practitioners, particularly those in the community, to report racial and homophobic crimes.

All incidents of racial harassment are treated extremely seriously. The following procedures ensure that a full investigation is carried out and the police take appropriate action.

If a member of staff visiting a family is told that the family is being racially harassed, then information is given to the family by the practitioners, to ensure that steps can be taken to report this incident to the police through the Third Party Reporting Scheme.

Incident details are recorded including date, time, location and brief details.

Special requirements are documented, i.e. whether an interpreter is required, the preferred language, whether a female officer or plain clothes officer would be preferred. The declaration section must be read by/to the victim/reporter before signing the document.

Only with the victim's consent will the police then undertake investigation of the matter.

A number of locations have been identified where individuals can go to report crimes in confidence.

Racist incidents	
Scottish Refugee Council 5 Cadogan Square 170 Blythswood Court Glasgow 0141 248 9799	West of Scotland Racial Equality Council Napiershall Centre 39 Napiershall Street Glasgow 0141 337 6626
Glasgow Campaign to Welcome Asylum Seekers 52 St Enoch Square Glasgow 0141 286 6320	Glasgow Asylum Seeker Support Project 145 Kelvinhaugh Street Glasgow 0141 222 7343
Social Work Department Merryland Street Glasgow 0141 445 3178	Ibrox Library 1 Midlock Street Glasgow 0141 427 5831
Glasgow City Council Access Centre 0800 027 6544 (Arabic) 0800 027 6545 (Karmanjia) (Turkish Kurdish) 0800 027 6546 (Albanian) 0800 027 6547 (French)	

STRATHCLYDE POLICE

RACIST INCIDENT REFERRAL FORM (3rd PARTY REPORTING SCHEME)

1. Organisation _____ Referral No. _____
Date/Time Referral _____ Method of Receipt _____

2. Victim / Reporter Details (PLEASE REFER TO DECLARATION OVERLEAF)
Anonymity Preferred - Yes (Tick if applicable)
Name _____ Ethnic Group _____
Date of Birth _____ Occupation _____
Address _____ Contact Tel. No. (Day) _____
_____ Contact Tel. No. (Evening) _____

Please Tick
Witness Victim Reporter

3. Incident Details
Date _____ Time of Incident _____
Location _____
Brief Details of Incident _____

4. Special Requirements (If requested by Reporter/Victim)
Interpreter Required - *Yes / No Preferred Language _____
Female Officer Required - *Yes / No Police Contact: Phone only - *Yes / No
Plain Clothes Preferred - *Yes / No
Other Requirements _____

5. Report Taken By _____ Signature _____

* Delete as appropriate

DECLARATION

This section must be read bt / to the victim / reporter before a signature is requested.

The information contained in this form will be held confidentially, and may be held on computer for the purposes of identifying repeat victims and offenders.

This form may be used by the Police and other statutory Agencies, i.e. Housing, Education, Social Work Services and Health Authorities, who work in partnership to tackle race issues.

I _____ (Victim / Reporter)

I _____ (on behalf of) _____ (Victim etc)

Consent / Do not consent to the following agencies being informed viz.

POLICE HOUSING EDUCATION SOCIAL WORK

HEALTH OTHER (specify) _____

Signature : _____

FOR POLICE USE ONLY

6. Sub Divisional Office

Enquiry allocated to: _____ Date: _____

7. Outcome

5:41:1 Submitted - Crime Ref. No. (if applicable)

5:41:1 Not Submitted - Sub Divisional Officers Comments _____

THIS FORM MUST BE ATTACHED TO COMPLETED YELLOW COPY OF 5:41:1 PRIOR TO FORWARDING TO THE FORCE RACE RELATIONS OFFICER, CHIEF SUPERINTENDENT, COMMUNITY SAFETY (COMMUNITY SUPPORT) FORCE HEADQUARTERS.

COSLA Refugee & Asylum Seekers Consortium

The COSLA Refugees & Asylum Seekers Consortium was set up in December 1999 to manage and monitor the commissioning and provision of accommodation and other services for asylum seekers. Management of the Consortium transferred from Glasgow City Council to COSLA in January 2004.

The Consortium's objectives are:

- to promote the national service which the Consortium provides to local authorities, government, statutory agencies and the voluntary sector
- to better co-ordinate the activities of local authorities and protect their interests
- to provide a strong collective voice for local government and the Consortium in negotiations with the Home Office
- to secure support from the Scottish Executive for the role of local government and the Consortium in ensuring that refugees can help Scotland to balance its skills gap and declining ageing population
- to ensure that local authorities, government, statutory agencies, the voluntary sector and the Consortium are able to work together in common purpose
- to facilitate the provision of services to asylum seekers and the integration of refugees into communities
- to develop and implement an effective communications and media strategy for asylum and refugee issues.

COSLA Refugee & Asylum Seekers Consortium

Room 107
 Baltic Chambers
 50 Wellington Street
 Glasgow G2 6HJ
 Tel: 0141 248 2396
 Fax: 0141 847 0086
 Email: jackie@cosla.gov.uk
 www.asylumscotland.com

Glasgow Overseas Professionals into Practice (Gopip) project

Aim of the project

To adapt the skills of overseas-educated nurses, seeking asylum in Scotland, into the NHS.

Nurses educated overseas often only need a short period of supervised practice and an English language qualification, prior to gaining full Level One registration with the Nursing and Midwifery Council NMC (<<http://www.nmc-uk.org/nmc/main/home/>>).

Background

Glasgow Overseas Professionals into Practice (www.gcal.ac.uk/gopip) was set up by Glasgow Caledonian University in October 2002 in the School of Nursing, Midwifery and Community Health (NMCH). The project developed in response to:

- the shortage of nurses in the NHS in Scotland
- a recognition of the skills and nursing expertise of refugees in Scotland
- a need for clinical and academic supervision in order to successfully adapt these nurses skills.

Gopip has a Scotland-wide remit and is jointly funded by NHS Education Scotland (NES) and Queens Nursing Institute Scotland (QNIS). Current funding is for 50 nurses. 41 nurses are engaged with the project.

Summary

Gopip has unique experience in the successful adaptation of refugee nurses to NHS practice in Scotland. Gopip recognises the diverse knowledge and skills, which overseas educated nurses, bring to the NHS. Gopip recognises that all overseas nurses require support in order to competently adapt to NHS practice. Gopip aims to develop a programme, which will support the clinical area and the individual nurses in order to access the potential of this overseas-educated professional work force living in Scotland.

Please contact Ima Jackson, project coordinator if you would like any further information.

Email: Gopip@gcal.ac.uk

Tel: 0141 331 8352.

Additional services

The experience of working with asylum seekers and refugees has highlighted the need to work collaboratively with other agencies in order to provide an inclusive service, which will recognise health in its broadest sense, encompassing a holistic approach to providing. The following partner agencies have a wealth of information and a wide experience of serving these communities.

Scottish Refugee Council

The Scottish Refugee Council is a charity providing advice and support to asylum seekers and refugees in Scotland. Their services include:

- general advice
- education
- health
- housing and
- community development.

5 Cadogan Square
(170 Blythswood Court)
Glasgow G2 7PH
Tel: 0141 333 1850
Free advice helpline: 0800 085 6087
(Mon–Fri 9.30am–4.00pm)
www.scottishrefugeecouncil.org.uk

British Red Cross

The Red Cross provide an international tracing and messaging service. This service can help contact family members of asylum seekers or refugees, who may have been separated because of war or natural disaster.

West Central and South West Scotland
British Red Cross
2 Swan Street
Glasgow G4 0AX
Tel: 0141 332 1607
www.redcross.org.uk

Glasgow Asylum Seekers Support Project

The Glasgow asylum seeker project provides support and advice to asylum seekers and refugees who are housed by Glasgow City Council/Glasgow Housing Association.

145 Kelvinhaugh Street
Glasgow
G3 8PX
Tel: 0141 222 7300

NHS 24 Round the Clock Support and Advice Service

People who do not speak English as a first language can use NHS 24. Through LanguageLine, 120 languages are available.

Tel: 08454 242424.

Further advice and information

Scottish Refugee Council Headquarters and One Stop Service

5 Cadogan Square
170 Blythswood Court
Glasgow G2 7PH
Tel: 0141 248 9799
Fax: 0141 243 2499

Opening hours:

Monday
9.30am to 1.00pm, 2.00pm to 4.00pm

Tuesday
9.30am to 1.00pm, 2.00pm to 4.00pm

Wednesday
Housing surgery 9.30am to 12.30pm
Education surgery 10.00am to 4.00pm

Thursday
9.30am to 1.00pm, 2.00pm to 4.00pm

Friday
9.30am to 1.00pm, 2.00pm to 4.00pm

National Resource Centre for Ethnic Minority Health

Clifton House
Clifton Place
Glasgow G3 7LS
Tel: 0141 300 1037

Ethnic Minority Law Centre

41 St Vincent Street
Glasgow G1 4PV
Tel: 0141 204 2888

Confidential counselling and testing for HIV and hepatitis

The CAST team offer a comprehensive client-centred service for people living with HIV or hepatitis infection.

Brownlee Centre
1053 Great Western Road
Glasgow G12 0YS
Appointments and enquiries: 0141 211 1075
Helpline: 0141 211 1089

GUM Clinic

Testing and Advice
The Sandyford Initiative
6 Sandyford Place
Sauchiehall Street
Glasgow G3 7NB
Tel: 0141 211 8601/8602

Medical Foundation Scotland for the Care of Victims of Torture

A medical legal report writing service is available via their lawyers.

Suite 5, Second Floor
73 Robertson Street
Glasgow G2 8QD
Tel: 0141 847 0012

Woman's Support Project

This project is working against violence against women and children. This service offers advice to health professionals as well as direct services to women.

Granite House
31 Stockwell Street
Glasgow G1 4RZ
Tel: 0141 552 2221

CancerBACUP Scotland

3rd Floor, Cranston House
104–114 Argyle Street
Glasgow G2 8BH
Admin: 0141 223 7676
Helpline: 0808 800 1234

Web addresses

All websites were active and correct at 12 January 2005.

Name	Site address
Ambulance Service Association	www.asa.uk.net
Amnesty International	www.amnesty.org
Asylum Aid	www.asylumaid.org.uk
Asylum Policy Information	www.asylumpolicy.info
Asylum Rights in the 21 st Century	www.asylumrights.net
Asylum statistics	www.homeoffice.gov.uk
Asylum Support Information	www.asylumsupport.info
British Medical Association	www.bma.org
British Red Cross	www.redcross.org.uk
CancerBACUP	www.cancerbacup.org.uk
Centre for Research in Ethnic Relations, University of Warwick	www.warwick.ac.uk/fac/soc/crer_rc
Charter 88	www.charter88.org.uk
Civil Rights.Org – a collaboration of the Leadership Conference on Civil Rights and the Leadership Conference on Civil Rights Education Fund	www.civilrights.org
Commission for Racial Equality	www.cre.gov.uk
Convention of Scottish Local Authorities	www.cosla.gov.uk
Council for Assisting Refugee Academics	www.academic-refugees.org
Crosspoint NGO Directory	www.magenta.nl/crosspoint/uk.html
Department of Health – Caring for dispersed asylum seekers	www.dh.gov.uk
Diversity Directory	www.diversityuk.co.uk
Electronic Immigration Network	www.ein.org.uk
Ethnic Minority Foundation	www.ethnicminorityfund.org.uk
European Commission against Racism & Intolerance	www.coe.int/ecri
European Council on Refugees and Exiles	www.ecre.org
European Monitoring Centre on Racism and Xenophobia	www.eumc.at
Every Child Matters	www.everychildmatters.info
Exile Images	www.exileimages.co.uk
Glasgow City Council	www.glasgow.gov.uk
Greater Glasgow NHS Board	www.show.scot.nhs.uk/ggnhsb/

Greater Glasgow Primary Care NHS Trust	www.show.scot.nhs.uk/ggpct
HARP's Mental Health & Well Being	www.mentalhealth.harpweb.org.uk
HARPWEB	www.harpweb.org.uk
HIV/AIDS Carers & Family Support Group	www.hiv-aids-carers.org.uk
Home Office – Racial Equality Unit	www.homeoffice.gov.uk
Home Office Immigration & Nationality Directorate	www.ind.homeoffice.gov.uk
Immigration Advisory Service	www.iasuk.org
Immunisations advice available in 32 languages	www.immunize.org
Institute of Race Relations	www.irr.org.uk
Jesuit Refugee Service	www.jesref.org
Joint Council for the Welfare of Immigrants	www.jcwi.org.uk
Justice	www.justice.org.uk
MEDACT	www.medact.org
Medical Foundation for the Care of Victims of Torture	www.torturecare.org.uk
Multicultural Matters	www.multicultural-matters.com
NHS Health Scotland	www.hebs.com
NHS Scotland e-library	www.elib.scot.nhs.uk
Nisus Scotland	www.nisusscotland.co.uk
Office of the Immigration Services Commissioner	www.oisc.org.uk
One Scotland Many Cultures	www.onescotland.com
Oxfam	www.oxfam.org.uk
Parliament of the United Kingdom	www.parliament.uk
PhotoInsight	www.photoinsight.org.uk
Positive Action in Housing	www.paih.org
Race for Racial Justice	www.r4rj.org.uk www.racialjustice.org.uk
Racial Harassment Organisation	www.racialharassment.org.uk
Refugee Access	www.refugeeaccess.info
Refugee Action	www.refugee-action.org
Refugee Council (UK)	www.refugeecouncil.org.uk
Refugee Legal Centre	www.refugee-legal-centre.org.uk
Runnymede Trust	www.runnymedetrust.org
Scottish Asylum Seekers Consortium	www.asylumscotland.org.uk
Scottish Council for Voluntary Organisations	www.scvo.org.uk
Scottish Executive	www.scotland.gov.uk

Scottish Parliament	www.scottish.parliament.uk
Scottish Refugee Council	www.scottishrefugeecouncil.org.uk
Scottish Refugee Integration Forum	www.scotland.gov.uk/about/DD/EqualityUnit/00014325/SRIFintro.aspx
Shap Calendar of Religious Festivals	www.support4learning.org.uk
Shelter	www.shelter.org.uk
Sickle Cell Society	www.sicklecellsociety.org
Skilltech	www.nisusscotland.co.uk/skilltech
Student Action for Refugees	www.star-network.org.uk
Thalassaemia Society	www.ukts.org
Transcultural Nursing & Healthcare Association	www.fons.org/networks
UN Refugee Agency	www.unhcr.ch
University of Oxford Refugee Studies	www.rsc.ox.ac.uk
World Health Organization	www.who.int

