NOT TO BE CIRCULATED, PUBLISHED OR QUOTED WITHOUT PERMISSION FROM AUTHOR

Paper to be presented at The Social Policy Conference 2009 Edinburgh

Anne Harris – Sociology Department   Warwick University

Food experiences of Asylum Seekers Facing Destitution

This paper draws on the findings from a study I conducted for my PhD thesis, which explored asylum seekers to the UK, who have exhausted all claims for asylum, and face destitution as well as many problems, amongst which is meeting food and dietary challenges. Recent research sought to document food choices, behaviours and experiences of food security and the food voucher system as provided in Section 4 of the Immigration and Asylum Act 1999 ('hard case support'). Many asylum seekers have become destitute as a consequence of a negative response to their claim for refugee status and by people whose claim for asylum is still being processed. This study was propelled by the apparent lack of research on food behaviour and food security, of the increasing numbers of diverse cultures asylum seekers represent.

In 2002, the government reversed its policy of supporting asylum seekers with food vouchers and re-introduced cash benefits, in recognition of the multiple failures of the voucher system. Nevertheless, vouchers have continued to be used as a means of support for asylum seekers at the end of the process for refugee status and receiving Section 4 support. Many asylum seekers experience the limitations of current asylum support policies and procedures and it is extremely difficult to find fast and simple solutions to destitution and food security, even when the individual is entitled to support from the UKBA (UK Border Agency).

Analysis of ethnographic qualitative in-depth interviews were used to understand and assess the realities and lives of asylum seekers by listening to their voices and responding to their food and related health needs, as they experience and perceive them in the UK. Experience as a Public Health Nutritionist led me to observe food behaviours of asylum seekers. Interviews with 32 participants included; married couples, single men, single women, single parents and married men's food experiences, before arrival of their families to the UK.

Social capital was found to be critical for renewing provision, particularly in terms of reciprocity among friends and neighbours, many of whom had limited food resources. In particular, numerous small organisations provide practical assistance such as food, clothing and companionship. Lack of integration, destitution and social isolation for many in the study, who lived temporarily with friends while awaiting or receiving Section 4 'hard case' support. Asylum seekers are most at risk of destitution when they move from one stage of the asylum process to the next (Hamilton and Harris, 2009). This results in a lack of autonomy over food choices and food procurement, and is associated with food insecurity, depression and ill-health.

Who is an asylum seeker?

Throughout human history people have migrated from their place of birth for different reasons, often to seek new ways of surviving because they fear for their lives in their country of origin. Large movements of asylum seekers around the world, as in the late 20th century are often linked to wider regional or global struggles, mainly because of war, repression and human right abuses, rather than poverty (Crawley and Loughna, 2003). In recent years war, violence and persecution in many countries have left large groups, often families with children with no option but to abandon their homes and flee, resulting in a growing number of asylum seekers and refugees coming to Britain seeking a better life.

For the purposes of this paper a definition of asylum seekers is;

> " a population of people who have arrived in the country without the required entry documentation and who, at the time of entry, apply for asylum". The Geneva Convention of 1951.

Kneebone and Allotey (2003) state that 'asylum seekers are not a heterogeneous population, and should not be treated as a single amorphous group of non-citizens, these people are from a diverse number of countries globally.

Definition of destitution

A legal definition of destitution is provided by section 95 (3) of the Immigration and Asylum Act 1999, which says:

> "a person is destitute if – (a) he does not have adequate accommodation or any means of obtaining it (whether or not his essential living needs are met);
> or (b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs".

A more stringent definition of destitution has been described by Smart (2009) as:

> "…currently with no access to benefits, United Kingdom boarder Agency (UKBA) support or income, and either street homeless or staying with friends only temporarily."

The rationale of this paper will use the latter definition in order to discuss the association between destitution, food security and food behaviour of asylum seekers receiving food vouchers or with no recourse to public funds.

Destitution is not a short-term condition and Smart (2009) states that nearly half of the visits to asylum seekers in the research had been destitute for more than six months, and a third had been destitute for more than two years with the majority coming from the most war torn countries. This strongly indicates that refused asylum seekers are prepared to face destitution and all its associated hardships, relating to food and health in the UK, for long periods without returning to their country of origin.

Reasons for destitution

Asylum seekers cannot claim mainstream benefits or access homelessness services and do not have permission to work. They can apply for limited Home Office asylum

support and are provided with accommodation in a 'dispersal area' on a no choice basis. This is overseen by the United Kingdom Border Agency (UKBA).

Hamilton and Harris (2009) found that asylum claimants are most at risk of destitution when they move from one stage of the asylum process to the next. This is often caused by difficulties experienced by the UKBA in administering support, and a lack of difficulty of understanding of the asylum process amongst asylum claimants. For example asylum seekers are particularly vulnerable before they are able to submit their claim for asylum, when they are first dispersed and their asylum support is being set up, appealing a negative decision on their asylum claim, when transferring onto mainstream benefits and when moving onto Section 4 support (Hamilton and Harris, 2009)

Policy Background and Welfare for Asylum Seekers

The Immigration and Asylum Act 1996 removed asylum seekers rights to the same welfare benefits as British citizens, leaving local authorities to determine the level of support they could provide for this population of people. In 1998, the government argued that there was a need to change the nature of asylum support, to "remove access to mainstream social security benefits, minimise cash payments and reduce the burden on local authorities" (The Stationary Office, 1998). In 1999, responsibility for providing adequate resources was returned to central government, and the food voucher system for those seeking political asylum was introduced and co-ordinated by a new government body, the National Asylum Support Service (NASS) through which asylum seekers were removed entirely from mainstream welfare services. A single asylum seeker over the age of 25years was entitled to £36.53 a week, £10 of which was redeemable for cash. This is 70 per cent of the level of Income Support (considered to be the minimum to prevent destitution) given to British citizens. Children of asylum seekers get the same benefits as British children. Those supported by NASS received vouchers so that they could buy food and essential everyday items. Emergency vouchers were issued on arrival to the UK and it was expected that people collect them each week from a Crown (main) post office near to their accommodation. The vouchers could only be used at selected shops and it was suggested that the landlord would inform the names and addresses of the shops where the vouchers could be redeemed or shops displayed the Sodexho BUY-PASS symbol in the window. Shops did not give change from a voucher so it was advised that they got enough low value vouchers (available in amounts down to 50 pence) (Darnbrough *et al* 2001). The total value of the vouchers was set at 70% of income support and vouchers unlike other social security benefits or services did not entitle people to other benefits or services such as reduced admission charges

The 'voucher system' introduced in April 2000 created such difficulties that the government announced a Home Office review of it in September 2000. Token Gestures (Doyle, 2008) was a report published in October 2000 by various groups including Oxfam and was highly critical of the system. Vouchers could only be exchanged for food and other essentials at designated shops that have signed up to the scheme; these were mainly supermarkets and expensive local shops. Cheaper and culturally appropriate sources of food, such as market stalls and small local shops selling familiar foods fell mainly outside the scheme (Doyle, 2008).

When the voucher System was operating in 2000 further problems included excessive expensive bureaucracy which often meant families were left without any income for food for days or even weeks (Doyle, 2008). Retailers often did not understand the system and sometimes denied asylum seekers items they required mainly due to ignorance or intolerance to the latter. Further, many asylum seekers did not get any change from vouchers in cash, which meant either buying another item (often not required) to make up the shortfall or not spending the full value of the food voucher (personal communication – Penny Walker). Refugee organisations stated that they were 'extremely concerned with the physical health impact of vouchers' and that 'the ability to maintain good health on vouchers is questionable'. The policy was criticised by all organisations involved with asylum seekers such as Trade Unions, and the British Medical Association and was in an audit commission report 2000 for being inhumane and stigmatising as well as bureaucratic and inefficient (Doyle, 2008).

In October 2001 the government agreed to phase out the scheme and that there would be a review of the voucher policy, stating that the voucher system was "too slow, vulnerable to fraud and felt to be unfair by asylum seekers and local communities" (Hansard, 2001). In recognition of the many problems that had been identified with using vouchers to support asylum seekers, the government abolished the system and replaced it with a return to cash benefits for asylum seekers. However provision remained for some asylum seekers at the end of the process (Section 4) to be supported with vouchers (Doyle, 2008).

Refused asylum seekers who have exhausted their appeal rights and do not have dependent children lose their right to accommodation and asylum support 21 days after losing their asylum appeal (Section 95, Asylum and Immigration Act 1999). Many asylum seekers are destitute at the point when their asylum support is terminated. 'Section 4' support in the form of accommodation and vouchers, may be provided in very limited circumstances to individuals who are destitute and temporarily unable to leave the UK. People on Section 4 support are entitled to receive accommodation and £35 a week in vouchers, card gift vouchers (where credit is loaded onto a plastic card and deducted as it is spent), and paper vouchers. Unlike the previous voucher scheme, people on 'Section 4' support are not able to receive any of their support allowance in cash. It is intended by the government to be a short-term measure to support people until they are able to return to their sending country. At the end of March 2008, 9,365 applicants (including dependents), were receiving 'Section 4' support (Home Office asylum Statistics, 2008).

This research attempts to explores the experience of refused asylum seekers living on food voucher support under Section 4 of the above Act and those who experience destitution who move from one stage of the asylum process to the next. The aim of this paper is to see what effect social policy and the reduction of mainstream benefits is having on food experiences and food security of asylum seekers.

Food Security

In order to ascertain whether asylum seekers who find themselves destitute are food insecure it is necessary to give a definition of household food security and when it occurs:

> 'whenever the availability of nutritionally adequate and safe foods, or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain', and is manifest as 'a managed process with a general sequence as the problem worsens'
>
> (Anderson, 1990).

Household hunger is characterised by decreases in the quantity and quality of food eaten, and the last stage indicating severe household food inefficiency. As refugees become assimilated into the economy and culture, and are resident for an increasing length of time, many will shift their cultural practices in ways that can have negative effects on health. Lifestyle, domestic organisation, activity patterns and gender relations will undergo changes with effects on activity, diet, exposure to disease injury and health-seeking behaviour (Sellen, 2001). For example, dietary and lifestyle change is often implicated as the major factor behind the increase in chronic diseases among immigrants and minorities adjusting to a 'Western' diet (Sellen, 2005). There are concerns that the extent of destitution is largely hidden and many of those who are destitute seek support elsewhere to provide practical assistance such as food, basic necessities, which in turn have a negative impact on food security and health, including mental health (Smart, 2009). Refugee organisations in the research, indicated the increase in numbers of destitute asylum seekers and decreases in quantity and quality of food these people received. Many had noticed that this had impacted on their client health in a deleterious way, particularly mental health:

> "With the present economic crisis people cannot find informal work and cannot contribute to the shared household fund to buy food. They are sleeping on the floor of an emergency shelter we provide, but now there is hardly any more room. You can see how their health is deteriorating, especially mental health."
>
> Penny Walker (Coventry Peace House"

An outcome of food insecurity can be measured by nutrition status, and is the extent to which an individual is experiencing under-nutrition or over-nutrition, or is in a state of nutrition balance. This is a major determinant of current health status, and future health outcomes, for individuals and households for asylum seekers, especially those who find themselves experiencing long term destitution (Smart, 2009). Sellen (2001) measured food security among refugee families in East London and found that all households sampled were food-insecure and 60 per cent of children were experiencing hunger and was significantly associated with recent arrival. Further, Gibson (1990) states for pregnant women, nutritional status is important determinant of health for the foetus and the newborn. An individual's nutritional status is determined by a combination of factors, including genetics, predisposition to certain conditions, patterns set down during foetal growth and development, degree of physical activity and food intake. James *et al*.(1997) and Roos *et al*.(2001) illustrate that diets progressively become more unbalanced and less in line with nutritional requirements (for healthy growth, physical and mental development, pregnancy and breast-feeding) with decreasing socio-economic status. Social inequalities are as important as income in understanding food poverty and its relationship with nutritional status and health (Dowler and Calvert, 1995, Dowler and Dobson, 1997, Dowler, 1998). Manandhar *et. al* (2006) explored food and nutritional status amongst

asylum seekers in North West Ireland where the results indicated issues for concern for nutritional status, health and well-being. It was found that poor quality food containing a high calorie intake from protein and fats was combined with limited food choice and social exclusion

Acculturation for forced migrants moving to the UK means that groups of individuals from diverse cultural backgrounds come into continuous first-hand contact with changes in the original cultural patterns. Deleterious health outcomes caused by social and cultural stresses of being an asylum seeker include living alone, missing meals and snacking. They are less likely to go out in search of sociability, care, food and health care, which may reduce their appetite for food coupled with stress and anxiety (Coveney, 2000).

A major finding in the study illustrated that many single men experiencing destitution who had found temporary work in the informal sector accessed cheap fast food outlets containing high a calorific content. Reasons for this food behaviour was due to either lack of cooking skills or unsociable hours shift work entailed when convenience food would be more desirable. A consequence of this high sugar, fatty energy-dense diet exposes individuals to the risk of heart disease, diabetes and some cancers. Refusal by the Home Office of not allowing asylum seekers to work who arrived in the UK after 2001 has resulted in many people losing the basic right to earn money for food and resort to erratic food provision that destitution brings on.

> " I don not have time to prepare food when I work shifts at the chicken factory"
>
> Iraqi asylum seeker man

Some women in the study spoke about altruistic behaviour in relation to food in order to feed their children.

> "…sometimes I go without in order to feed my children"
>
> Angolan asylum seeker woman

Asylum seekers with dependent children are not ordinarily supported under Section 4 as they are entitled to mainstream asylum support until the youngest child reaches 18 years of age, or the family leaves the UK. Families whose children are born after their asylum claim has been refused will be supported under Section 4. Young children are particularly vulnerable to the effects of poor nutrition, which can have lifelong consequences. Under-nutrition in pre-school children has profound effects on mental and physical development and may never catch up, even if the iron deficiency is treated. Children of asylum seekers are at a high risk of inadequate food intake (Sellen, 2001). Refugee organisations spoke about the increase in numbers of children belonging to destitute asylum seekers who were hungry:

> "We have seen more children coming into voluntary feeding centres for a meal and often these children were born in the UK, and experience hunger"
>
> Penny Walker – Coventry Peace House

Smart (2009) states that the asylum system is not succeeding in protecting the welfare of children. The agencies that took part in the survey, received visits by destitute

people with children, including people of all types of immigration status and people affected by delays in processing asylum support, Section 4 support and mainstream benefits the most common country of origin of destitute people with children was Zimbabwe – destitution has not led them to take steps towards voluntary return, which would entitle them to Section 4 support.

Social Capital and Availability of Nutritious Food

A major finding in the research revealed that social capital was critical for renewing food provision, particularly in terms of reciprocity among friends and neighbours, who were also destitute and had limited food resources.

The importance of social capital in this research was very significant in relation to food security and was a strategy for asylum seekers who were either receiving Section 4 support or had no recourse to public funds and were destitute. Food is a significant focus for inclusion or otherwise, for asylum seekers and refugees, impacting on health, social determinants of food choice, nutrition status and household food security. Once in the UK migrant food behaviours were found to alter through contact with other migrants and was vital for mainly single female migrants where social capital was critical for food provision, including procurement, preparation and consumption. New groups, based on cultural and social identity, consisted of mainly young single women, many with children who used food and drink in replacing kin and friends, left behind from their sending country. New syncretic behaviours were constructed, which reflected new social, economic and cultural configurations. Fischler (1998) confirms that food can be a signifier of belonging, or of demarcation and difference 'the way any given human group eats, helps assert its diversity, hierarchy and organization, and at the same time, both its oneness and otherness of whoever eats differently'. The sharing of food is a vital part of kinship and friendship networks in all societies and the extent to which an individual is invited to share food with another individual is a sign of how close a friend that person is thought to be (Lupton, 1996). Migrant women shared food with each other either by consuming a meal together, giving of foodstuffs to support the family when money or food vouchers were unavailable for food procurement on a regular basis. The frequency of this food giving illustrated strong components of affective ties and was directly related to the construction and reproduction of emotional relationships.

This newly constructed food behaviour via social capital proved to be invaluable for these young women who were experiencing loneliness and isolation by sharing of food, which helped provide some food security in terms of reciprocity among neighbours, community groups and friends. Such activities involved information sharing as to where culturally acceptable and familiar foods could be found in local shops, combining food vouchers in order to buy in bulk, as well as advising on contents and cooking methods (mainly British foods) of unfamiliar food, advise about breast-feeding and weaning practices.

> 'Difficulties at first with British shopping, we don't understand the food. We ask our friends where we can buy our food with the vouchers. They tell us and sometimes take us there. We couldn't find the halal meat because we didn't know where to go, because not sold in

> supermarkets for vouchers. They told us where we can sell vouchers so we can buy the halal. It is important to have friends, stops being lonely and they give food when have none, especially those who have none.'
>
> Sudanese asylum seeker

Many women spoke about how they had replaced extended family members with new social networks that provided practical help in the form of: looking after friend's children to allow the mother to go shopping alone, prepare meals, loan money for food, give food to those who had none in the form of raw ingredients or cooked food. It is in the context of the family that the social dimensions of eating and those of emotion are particularly tied together (Lupton, 1996). It is clear that new behaviours had developed for these young female migrants, in order to replace family members, through the use of food and drink to develop food pathways that are emotionally and practically supportive, especially when they experience the difficulties of acquiring nutritionally adequate and safe foods.

Asylum seekers in the research who were experiencing destitution and living alone receiving Section 4 support, in the form of a food voucher valued at £35.00 stated that this was not enough to buy all food requirements and other necessities:

> "I do not have enough money to buy food and other things I need on only £35.00 a week. The cost of food and especially meat and fish is very expensive, this is a luxury. The supermarket vouchers makes me have less money for food because I do not have any change"
>
> Somalian asylum seeker

This amount is less than that received by asylum seekers while their claim is being decided. For example a single person aged 25 or over receives £42.16 a week, and those on Section 4 vouchers receive just under 60 per cent. Recent increases in the price of foodstuffs exacerbate and lower the power over food procurement and choice.

> "£35 is not enough for me to buy food, so I sometimes put my money together with my friend and we can buy rice or vegetables in bulk, helps make things cheaper, but not all supermarkets have our foods"
>
> Iraqi male asylum seeker

Refugee organisations stated that they had seen Section 4 clients experiencing hunger and tried to provide free food parcels and help with those who were destitute and did not know where their next meal was coming from:

"Sometimes people have not eaten for days because they have used the vouchers once they have received them, indicating £35 is not enough to live on. Some sell their vouchers for £25 cash so that they can buy cultural and religious foods in shops practically next door to where they live, and do not have to travel to supermarkets, which incur travel expenses."

Jane Longville Coventry Refugee Centre

Doyle (2008) stated that nearly three quarters of refugee organisations (73 per cent) reported having seen Section 4 clients experiencing hunger in the last six months. This clearly indicated that the 'safety net' Section 4 should provide for food security and shelter is not currently working.

Acquiring Acceptable Foods in Socially Acceptable Ways – Food Behaviour

Isolation, financial poverty, loneliness and mental health

He who eats alone, dies alone - African proverb

The ability to acquire acceptable foods in socially acceptable ways was a major cause of concern for many refugee agencies and asylum seekers experiencing destitution. An outcome of this problem manifested in increased mental health problems and was a growing problem for statutory and non-statutory organisations working with asylum seekers who were destitute:

"I was so desperate that I did something that I'm ashamed of. I was so hungry that I went into a police station and asked them if I could spend a night in a cell. They said no, as I had not done anything wrong. They were polite to me. On the way out I deliberately smashed a police car headlight so that they would have to arrest me. I spent a week in jail. The judge at the trial was very sympathetic. I know it was wrong to do this but I was so desperate. The food was actually quite good."

Zimbabwe asylum seeker

Some destitute asylum seekers who find themselves homeless with no food or shelter have resorted to extreme measures in order to survive life on the streets:

"I've been living as a (male) prostitute for the last year. I charge £5 a time and some clients

argue about even paying me that because they know how desperate I am."

Zimbabwe asylum seeker

Living away from their families, friends and communities of asylum seekers live in a limited environment, which can negatively affect their access to food as well as their pleasure of the social context that food normally brings. The social exclusion of forced migrants and their lack of opportunities to integrate with the host community, and to feel part of social life impacted on how food behaviours had changed since arriving in the UK. The details of encountering a different society were associated with violent uprooting, disruption of social and cultural connections with the home country, post traumatic stress, not feeling secure in every day life, conflict of values, loneliness, poor self-esteem and alienation. Fischler (1988) states that, 'food and cuisine are a central component of the sense of collective belonging and the symbolic value of food is central to our sense of identity, at both individual and group level.' Evidence from a review of migrant mental health reported more feelings of changed energy levels, changes to appetite and to dietary choice among immigrants compared to native groups (McKay *et al* 2003). A migrant individual, or group, adapting to food habits and norms of the new host culture is an indicator of cultural distance, which has been associated with psychological distress and ill-health (Williams, 1993).Various studies have shown that the homeless who experience hunger are the most adversely affected by mental health problems (Patel and Kerrigan, 2004). Asylum seekers are already vulnerable to mental health problems due to the trauma and upheaval they may be suffering. Many of those made destitute are forced to live in conditions that make it very difficult to gain access to psychiatric and social services. Comments from staff at Coventry Refugee Centre included:

'The main problem that we are seeing is increased mental health problems, for example, anxiety and depression, because of destitution, lack of food and shelter.'

Jane Longeville, Coventry Refugee Centre

Many asylum seekers took desperate measures in order to ensure some form of food supply, but is clearly not acquiring food in " socially acceptable ways", which further exacerbates food insecurity this population for people who are already in a fragile condition of mental health.

Food and Identity

For many migrants, culture plays a key role as a source of identity, especially in relation to food, and acts as a focus for resistance to exclusion and discrimination (Gofton, 1986). Regardless of income, people make food purchases according to their financial resources, but it is important to remember that they do so in a social and cultural context. Feelings of alienation and isolation in relation to food, experienced by some asylum seekers living a life of destitution impacted on their physical and mental health in a deleterious way. Loss of identity in relation to being unable to access food let alone familiar foods caused anxieties for many in the study. Food is much more than nutrition, and food choice is more than just an important health-related behaviour (Fine *et al* 1996, Murcott, 1998). Eating is a universal and necessary

feature of human existence and survival but is infinitely variable in actual practice, varying within and between societies (Gofton, 1986). Evidence in anthropological and sociological literature on nutrition, diet and food indicates that many of the qualities and attributes we link with particular foods are largely symbolic and embedded in our cultural and societal norms (Douglas, 1975, Messer, 1984, Murcott, 1988, Martens and Warde, 1998, Coveney, 2000).Worldwide, migrants are usually slower to discard their food habits than many other aspects of their cultural life (Shiels, 2004). The central place of food in cultural identity does not mean that a change in residence results in an automatic change in dietary preference and choice (Storey and Harriss, 1988, Harbottle, 1997, Luke *et al* 2001). Food operates as a source of group, as well as national identity. Some people spoke about the difficulties they encountered sourcing culturally appropriate foods such as halal meat, familiar foods

> "It is important for us to buy the halal meat because this is our religion, but
>
> we find this very expensive"
>
> Iraqui asylum seeker

Sharing food is our central social ritual, and usually starts within our own family groups. Douglas (1975) points out that food sharing is a 'metonym for the family' and marks family roles and relationships in a material form. Food made in the home for the family is charged with symbolism (Charles and Kerr, 1988, Petridou, 2001, Bugge, 2003), and promotes intergenerational care-giving, altruism and love as model characteristics (Moisi *et al* 2004). Some asylum seekers in the study spoke about how they missed their families and how they felt lonely:

> "… cooking is so lonely now…I miss my mother and sisters in my kitchen
>
> back home, we would discuss all we had done that day….now so lonely"
>
> Iranian asylum seeker woman

The social environment in which food is prepared, distributed and consumed, the cooking together, eating out, eating together and food sharing, reinforce social relations and cultural norms, and acts as social 'glue' (Quandt *et al.* 2001). Traditional meal patterns and traditional food changes for destitute migrants, living in temporary accommodation may find their dietary intake affected by any changes. Dislocation from food and personal identity impacts on mental health in a negative way by manifesting emotions of loneliness, distance, alienation and anxiety through a sense of not belonging.

Impact on health

This paper has attempted to give a brief snapshot of the food behaviours and food insecurities destitute asylum seekers experience in the UK. Many asylum seekers already have diet related health problems that they either bring with them, or develop through inadequate food provision and anxieties destitution brings. (Zwi and Alvarez-Castillo, 2003) state that:

> Although human mobility is an integral part of the biological and cultural evolution of human settlement asylum seekers and refugees constitute a population group that arguably presents one of the most significant current public health challenges

Refugees are a population of economically deprived and socially excluded population segments in the UK (Acheson, 1998), and suffer poor nutritional and health outcomes linked to poverty and social exclusion compared to experience before arrival (Wilkinson, 1998). These findings illustrate the health and diet related problems this population experienced over ten years ago. The increase in numbers of destitute asylum seekers over the last 4-5 years can only have exacerbated the health and diet problems destitution and social exclusion bring about. Statutory and voluntary providers voiced concerns that, limited access to cash and transport, irregular lifestyles, temporary accommodation with inadequate cooking facilities adversely affect the nutritional well-being of refugee families (Coventry Refugee Centre, 2008). To date, only two assessments in the UK (London and Northern Ireland) have been carried out to evaluate these concerns or develop nutrition interventions among Britain's diverse, sizeable and growing refugee communities, indicating a gap in the research area of food security and nutritional status of destitute asylum seekers.

Access to welfare, which includes food and basic necessities for destitute asylum seekers must recognise that people who flee from their country of origin are likely to require assistance and support for the whole of their duration in the country, until they are returned to their sending countries (Smart,2009). Lewis (2003) states that successive pieces of legislation have attempted to make it increasingly hard for people to enter the country, forcing them in many cases to try to get in and stay illegally. Their access to welfare benefits and services have also been systematically restricted, on the grounds that welfare acts as an incentive to stay.

The successive removal of welfare services and benefits has had an enormous impact on the lives of people who have usually fled terrible circumstances in their country of origin with a dangerous and frightening journey to get to the UK, which was perceived as a place of safety. Such policies and practices affect the most basic necessities as to whether or not they are able to get enough to eat and sleep. Further the uncertainty of waiting for a decision adds to the level of psychological distress experienced to a population of people who already have fragile mental health problems.

In 1999 (Sellen, 1999) a study by the East London and City Health Authority suggested that asylum seekers constituted the most 'economically deprived and socially excluded segment of the UK population' and that the latter find access to services difficult. Further the UK government in its Department of Health Report 2005, has voiced its commitment to tackling and reducing health inequalities among women and young children and specifically to asylum seekers in relation to needs assessment, healthcare, planning and provision. Clinicians, nutritionists and policy

makers have identified immigrant populations in Britain as increasingly at risk for chronic lifestyle-related diseases and poor diet (Karni, 1996).

In order to avoid deteriorating health it is important to take steps to avoid destitution amongst those with health needs. This means ensuring that both the UKBA and other agencies have procedures for assessing health needs and finding ways of enabling those with health needs to access support without delay. Smart (2009) argues that not only were people dealing with destitution but were also suffering from ill health. This was slightly more prevalent in cases of refused asylum seekers who had been destitute for a long time and there is a need to investigate further to understand better the extent of the health needs of destitute people.

There has been widespread criticism of the current use of vouchers. In March 2007, the Joint committee on Human rights stated:

> "We consider the section 4 voucher scheme to be inhumane and inefficient. It stigmatises refused asylum seekers and does not adequately provide for basic living needs. There is no evidence that the voucher system encourages refused asylum seekers to leave the UK." (2007).

Survey results to voluntary sector services suggest that Section 4 support is not providing a safety net to prevent destitution among refused asylum seekers (Smart, 2009). Destitution is not a short-term condition, with many people experiencing destitution for more than 6 months and with a third of destitute refused asylum seekers being destitute for more than 2 years (Smart, 2009). This strongly indicates that refused asylum seekers are prepared to face destitution in the UK for long periods without returning to their country of origin. The most striking feature of the survey results is that the majority of destitute people came from one of a very small number of countries where there are well documented human rights abuses and persecution impunity for human rights abuses and/or conflict.

Further Smart (2009) states that the asylum system is not succeeding in protecting the welfare of children. Children of destitute asylum seekers are also at risk of ill health and suffer more acutely from physical problems associated with their social deprivation before entering the UK including malnutrition and disease which they may not be immunised against (Sellen, 2001). The adequacy of the diet during pre-school years is a crucial determinant of long term health. Ensuring that young asylum seeker children obtain a healthy diet is an efficient strategy for reducing long-term costs to the state of health care provision for asylum seeker families (Sellen, 2005).

Finally identifying the experience and impact of nutrition and health of hungry and destitute asylum seekers is a growing problem requiring further research. Welfare restrictions coupled with the criminalized nature of claiming asylum under the current system forces these migrants to live their lives secretly, with increased homelessness, destitution and hunger with serious consequences for health including mental health.

Bibliography

Anderson, A.S., Bush, H. Lean, M. Bradby, H. Williams, R. and Lea, E. 2005. 'Evolution of atherogenic diets in South Asian and Italian women after migration to a higher risk region', *Journal of Human Nutrition and Dietetics,* 18, 1, 33-43

Charles N and Kerr M, 1988. Women, food and families. Manchester University Press, Manchester

Coveney J, 2000. Food, morals and meaning. Routledge: London

Castles S Crawley H and Laughna S 2003 States of Conflict, Causes and Patterns Forced Migration to the EU and Policy response

Douglas M, 1975. 'Deciphering a meal', in Implicit meanings, London: Routledge and Kegan Paul.

Darnborough et al 2001 Who Counts as a Refugee Open University

Dowler E and Calvert C, 1995. Nutrition and diet in lone-parent families in London. Family Policy Studies centre, London

Doyle,L 2008 More Token Gestures A Report into the use of Vouchers for asylum Seekers claiming Section 4 support. The Refugee Council

Fine B, Heasman M and Wright J, 1996. Consumption in the age of affluence: the World of Food. Routledge, London

Gibson R, 1990. Principles of nutritional assessment. Oxford University Press, New York

Gofton L, 1986. The rules of the table: sociological factors influencing food choice. In: Ritson C, Gofton L, and McKenzie J. (eds). *The Food Consumer.* John Wiley and Sons Ltd, Chichester

Fischler C 1998 'Food, Self and Identity' Social Science Information 27, 2

Hamilton K and Harris J 2009 Twenty One Days Later. A report by the Refugee Survival Trust and The British Red Cross

Karmi, G. 1996 Refugee health requires a comprehensive health strategy. *British Medical Journal 1996,* 305: 205-206

Kneebone, S. and Allotey, O. 2003. Refugee health, humanitarianism and human rights. In: Allotey O (ed). *The health of refugees; public health perspectives from crisis to settlement.* Oxford University Press, Victoria, Australia; pp 1-13

Lupton, D. 1996 *Food, the Body and Self.* London: Sage Publications.

Manadhar *et al* 2006 Food, Nutrition and Poverty among Asylum seekers in North West Ireland.

Murcott, A. (ed), 1998. The nation's diet; the social science of food choice. Longman, London.

Moisi, R. Arnould, E. and Price, L. 2004. Between mothers and markets: constructing family identity through homemade foods. *Journal of Consumer Culture:* 4 (3); 361-384

Patel and Kerrigan 2004 Mental healthcare of asylum seekers and refugees. Save the Children

Roos *et al* 2001 disparaties Group (tasks 4 and 5) Disparities in food habits. *Review of research in 15 European Countries*. Helsinki, National Public Health Institute Finland.

Sellen, D., Tedstone, A. and Frize, J. 2000. Research Development: young refugee children's diets and family coping strategies in East London. London School of Hygiene and Tropical Medicine, Public Health Nutrition Unit, Final Report. For the Children's Society, East London Project (King's Fund Development Grants Programme)
needs of children being met? *Journal of the Royal Society of Health, 2000,*93: 1-5.

Sellen, D.W., Tedstone, A. Assessing food security and nutritional well-being of pre-school refugee children in the United Kingdom. In Kershen AJ, Penn, A. eds.*Food in the Migrant Experience* .London: Routledge, 2002: 214-28

Smart K. 2009 The Second destitution Tally: an indication of the extent and causes of asylum seeker people at the end of the asylum process. Refugee Council

Wilkinson, R. G. 1996. *Unhealthy Societies: the Afflictions of Inequality,* London, Routledge.

Williams, R. 1993. Health and length of residency among south Asians in Glasgow: a study controlling for age. *Journal of Public Health Medicine:* 15 (1); 152-60

Zwi, A. and Alvarez-Castillo, F. 2003. Forced migration, globalisation and public health: getting the big picture into focus. In Allotey O (ed). *The health of refugees: public health perspectives from crisis to settlement.* Oxford University Press, Victoria, Australia; pp 14-34