A Better
World~Healthwise

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Introduction

Ireland is now part of 'The global village'. The world is on the move and Ireland has experienced an influx of non-nationals in recent years. In 2001, there were approximately twelve thousand applications for asylum in Ireland by refugees.

There are many legal, political and administrative implications associated with this phenomenon. Definitions of and distinctions between migrants, asylum seekers and refugees are of value in certain respects. However, they fall short of capturing the health aspects of population migration. Whatever the motivation for migration, these people seek a 'better world' with more opportunities.

There are acknowledged inherent health risks in moves from one country to another, especially when the countries are very different culturally. So, irrespective of their legal status this emerging population subgroup in Ireland has distinct health issues and needs.

Legislative and administrative measures are totally outside the remit of this review. This work details the health status and health needs of a large sample of asylum seekers in designated centres in Cork and Kerry in 2001. Its purpose is to minimise the potential for social, mental and physical ill health among this new population.

New public health concepts, as approved by the World Health Organisation, lay emphasis in the interrelationship of culture, health and illness. They recommend that migrant populations have a right to healthy working and living conditions and accessible health care. From a health perspective, restrictive models don't work. Health services must minimise language barriers and racism among health care workers and appreciate different concepts of ill health. Flexibility in health care provision, persuasion in modifying lifestyles linked to disease and social integration are the best approaches.

This review has been conducted because we recognize that how we care for the health of our migrant population matters. It matters to migrants. It matters to our health service, it matters to our international standing and it matters to the social health of our changing society.

Chapter Two

2.1 Introduction

The literature on the health aspects of migration is wide ranging. Sources extend from newspapers and the medical press to reviews carried out by voluntary groups, to well-resourced research studies published in peer-reviewed journals. Although each source has importance this review concentrates on published works.

In outline, this review attempts a critical appraisal in the following format:

1) Migration globally and nationally
2) Methodologies used to study health issues of migrants and
3) Major findings of health needs assessments of migrants

A glossary of terms is given separately

2.2 Migration Globally and Nationally

Worldwide, in 2001 an estimated one hundred and fifty million people were living outside their country of birth[1]. Every year one million people emigrate permanently and as many seek asylum. Today's world is highly mobile.

There has been a tightening of immigration controls in industrialised countries. There is an increasing tendency to confine asylum seekers in detention centres in countries of the west[2]. Over the last decade, facilities are being built and extended in places including the USA, Australia and the UK. Independent inquiries in several countries have raised serious concerns about health and human rights conditions in these centres[3].

The rationalisations for these detention policies are that they are an administrative and humanitarian necessity but also that they act as a deterrent to unauthorised immigrants who could be seen to challenge the material prosperity of the west[2].

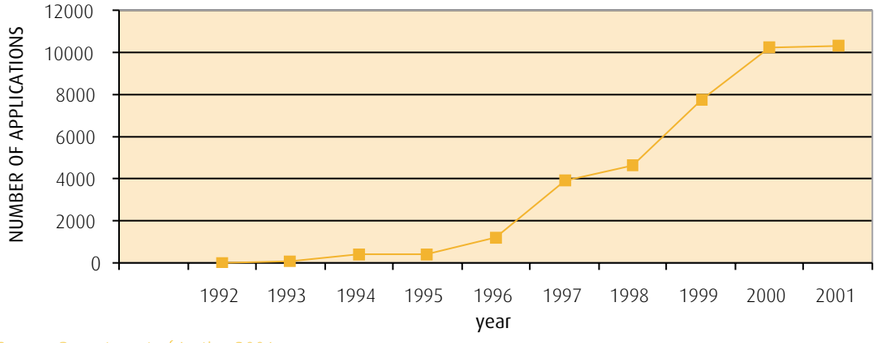
Ireland has a strong history of providing assistance to opposed groups (table 2.1) in response to appeals from bodies such as the United Nations. Throughout the 1980s and early 1990s Ireland received less than 100 applications annually for asylum.

Table 2.1

PROGRAMME REFUGEES IN IRELAND	
1956	Hungarian
1973	Chileans
1979	Vietnamese
1985	Iranian Bakai
1992	Bosnians
1999	Kosovans

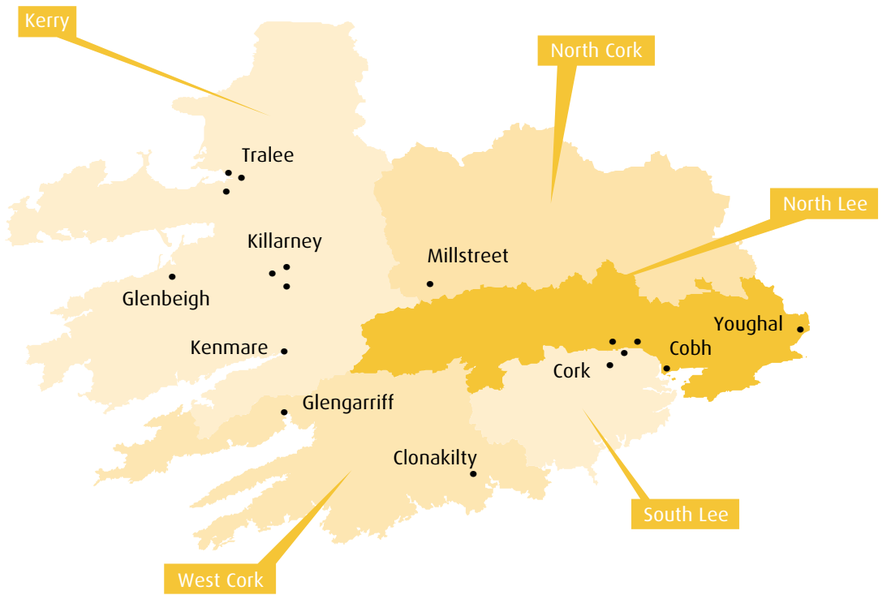
Since 1994, there has been a continuous increase in the number of individuals seeking refuge here (Fig 2.1). We had the third highest number of asylum applications per capita in Europe in 2000 (Irish Refugee Council 2001).

Fig 2.1 **Asylum Applications in Ireland 1992-2001**



Source: Department of Justice 2001

In April 2001 a system of 'Direct Provision' was introduced whereby bed and full board and a small weekly allowance was afforded to asylum seekers in designated centres throughout Ireland. At the end of August 2001, there were four thousand and seventy five accommodated in the Cork and Kerry region.



2.3 Methodologies used to Study Health Issues of Migrants

A number of difficulties have been identified in carrying out health needs assessments on refugees and asylum seekers[4]. These include:

1) A lack of routine data sources on ethnic health
2) Identifying an appropriate population for research
3) Engaging refugees in research
4) Ethical issues
5) Diagnosis of mental illness
6) Language

In routine health statistics collection, ethnicity is usually self-identified. Data on ethnic groups traditionally lacked information pertaining to health and official surveys relating to health rarely record race[5]. In the UK, country of birth rather than ethnic group is recorded on birth and death certificates. To address this issue the National Health Service, in 1995, introduced a mandatory coding of a patient's ethnic group in a contract minimum dataset providing information on hospital utilisation etc. by ethnic group[6]. Routinely collected information on morbidity and mortality in Ireland does not include ethnicity or country of birth.

The identification of a representative sample population is a major difficulty. Hughes et al[7] indicate that the use of random sampling is unrealistic in health services research of 'hard-to-reach' groups. Alternative strategies include: geographical selection, name spotting, affiliation listings and the 'snowball' sampling technique.

Understandably, suspicion has been identified as a 'survival skill' for asylum seekers. It has been suggested that negotiations with intermediaries and the use of key informants are valuable[8].

Little technical guidance is available from the usual international sources on the ethics of research in refugee populations[9]. In recognition of their vulnerability and their likely traumatised state the ethical standards for research must be higher than usual with the guiding principle of "do no harm".

Estimating the prevalence of specific mental health problems among refugees and asylum seekers is not an easy task. Many societies stigmatise mental illness and diagnosis of mental illness may be unreliable cross-culturally. Natural distress may be mistaken for mental pathology[4].

Finally, language, culture and educational background create difficulties in communication and obtaining informed consent. Qualitative research with asylum seekers poses particular issues as participation is dictated by the ability to communicate using a common language[10].

2.4 Major Findings of Health Needs Assessments of Migrants

There is a mounting volume of relevant research in this area. Some studies produce findings particular to specific living conditions, a geographical area or a distinct group and are not of general application. However, the literature allows us to broadly describe migrant populations whatever their legal situation, in terms of:

(a) The population

(b) Language and communication

(c) Living conditions and circumstances

(d) Cultural issues

(e) General physical and mental health and use of health services

(A) The Population

Migrants are a relatively young population. Similarly, minority ethnic communities typically contain a higher population of households with children than the general population[11-13].

Despite the perception that the typical migrant is male, the International Labour Organisation estimates that almost half are female globally. However, females are more likely to be in a parenting role e.g. an Irish study[10] of asylum seekers, in 1999, found that 84% of females were parents while 63% of males were non-parents.

The educational status of migrants is very variable. Downward social mobility and significant losses in financial terms often accompany forced immigration[14]. Indications from studies of asylum seekers in Ireland in the past five years are that educational attainments are high with 79% of the group having third level education[14].

In the UK, people from minority ethnic group have higher than average rates of unemployment[15]. Restriction on work permits make employment levels in Irish asylum seekers unhelpful and Irish workforce data does not specify country of birth or ethnicity. We know that 36,436 work permits were issued in 2001 to immigrants seeking work in Ireland (Table 2.3).

Anecdotally, it is understood that most of these immigrants are employed in jobs that native Irish people would not fill.

Table 2.3

Work Permits for Immigrants			
Top country of origin		Category of Employment	
Latvia	12%	Service Sector	38%
Lithuania	8%	Hotel & Catering	25%
Poland	7%	Agriculture & Fisheries	16%
Philippines	7%	Industrial	9%
South Africa	6%	Medical & Nursing	6%

Source: Department of Enterprise, Trade & Employment, 2001

(B) Language and Communication

The importance of English language skills as a means of communication has been emphasized by many workers[10,14,16-19]. In medical needs assessment studies, language has been cited as probably the greatest obstacle in accessing publicly funded health services[20]. Difficulties with communication are also a source of unnecessary difficulties, marginalisation and loneliness. The availability of accessible English language classes is proposed by many in addition to translation services.

(C) Living Conditions and Circumstances

Many researchers have commented negatively on the circumstances in which migrants live their lives, their rights and restrictions.

In the UK, housing quality is often quite poor for the minority ethnic groups. Also, there are reports of restricted choice of area of residence because of fear of crime and harassment[13].

Worldwide, asylum seeker detention facilities are particularly criticised as being overcrowded and isolated. Despite best efforts, they have the capacity for aggravating intergroup and intragroup tension[9].

Specific accommodation difficulties, that have been highlighted by recent Irish studies of asylum seekers, include overcrowding, boredom, welfare dependency, unemployment and lack of suitable accommodation specifically for children and for single men[10,12,16]. Shortage of rental accommodation, discrimination and finances make transition to the rented sector a struggle[10,12,16].

A strong wish to work in this country was expressed by most participants in a recent local study[12]. Lack of available education and training options add to demoralisation and result in deskilling.

Food complaints in terms of quality, variety and choice are common. Children's diet was a particular concern of parents[17]. Income poverty to supplement diet is a problem for those on the weekly allowance afforded by the 'direct provision' system in Ireland.

(D) Cultural Issues

Ireland is increasingly a multicultural society. There are now more visible populations of black Irish and other EU and non – EU citizens living here. A review in 2001, of studies on racism in Ireland, concluded that the degree of hostility has increased[21]. Levels of negativity are higher among rural, older people and those with lower levels of education and discrimination is an everyday feature of many immigrants' lives although it is sometimes expressed in a quasi-socially acceptable way.

Difficulties, related to ethnic distance experienced by immigrants and asylum seekers in Ireland, have been reported in a number of recent studies[10,12,16,17]. A poor understanding of life in Ireland prior to arrival and little training of service providers in refugee culture have been cited as causes. Negative perceptions of racial integration and peaceful co-existence were found in one study[10] with only a quarter of asylum seekers feeling 'good' or 'very good' about integration into Irish society.

(E) Physical and Mental Health and Use of Health Services

On arrival, health concerns seldom top the agenda for refugees and asylum seekers[22]. Avoiding deportation and getting a roof over their heads are priorities initially. However, diverse health needs surface with time.

Much of the focus on immigrant and minority ethnic group health needs has been on their mental health and on the risk of certain infectious diseases such as tuberculosis, measles and HIV, which have both personal and public health consequences[4].

In Ireland, the Department of Health and Children introduced an infectious diseases screening and vaccination programme for asylum seekers in 1999. Results from the Southern Health Board (SHB) database for the year 2000[22] indicate a high uptake rate for the service; only 2 non–infectious cases of TB were detected per 1,000 screened. Previous exposure to hepatitis B infection (anti HB_c

28%) has been noted in a substantial proportion, with a minority having markers of chronic carriage. There is a worryingly high level of susceptibility to rubella (18% of women of child bearing age being non–immune).

In a European context, there is much evidence to support infectious disease screening of asylum seekers. More than a quarter (27%) of all tuberculosis cases in Western Europe in 2000, occurred in patients of foreign origin[23], while 85% of HIV infected woman giving birth in London were born in sub–Saharan Africa[24]. The World Health Organisation (WHO) now stresses the importance of available testing and early knowledge of these infections. This enables patients to receive prompt treatment, be equipped to reduce the risk of transmitting the infection to others and limit long-term complications[25].

In the UK, the fourth National Survey of Ethnic Minorities[26] is a rich source of health data in that country. Mortality ratios for deaths, including perinatal mortality from all causes for nearly all migrant groups were higher than average. Specific disease and death rates may be country of birth related because of a variety of factors including social habits and genetic makeup.

Perception of health is also poor among minority ethnic groups in the UK. Overall, they are more likely to describe their health as 'fair' or 'poor' than the ethnic majority[27].

Health related social habits show marked variation across ethnic groups e.g. in UK, smoking rates range from 49% in Bangladeshi men to 19% in African men, to as little as 5% for all ethnic minority groups of women. Alcohol consumption tends to be lower in all minority ethnic groups for both men and woman compared to that in the white population[21].

While the amazing resilience of refugee groups has been recorded in several studies[20], fallout in terms of mental health has been reported in migrant groups including those researched in Ireland[10,12] . Depression and adjustment reactions are prevalent. In a review of studies, very high levels (25–50%) of Post Traumatic Distress Disorder (PTSD) were reported in asylum seekers. However, varying methodologies over different time periods and using different criteria (from self reporting to strict adherence to agreed criteria) make comparisons of studies problematic[4]. From a cultural perspective, it is not clear how the presence of psychiatric problems translates into the need for specific services.

Detention centres have a negative effect on psychological well-being. An Australian based study has allowed a broad comparison to be made between those held in detention and compatriots applying for refugee status while living in the community. The detained group manifested much higher levels of depression, post-traumatic stress symptoms, physical distress and suicidal ideation[28]. This distress has been reflected in suicide attempts, rioting and other acts of mass violence in centres internationally[2].

Certain infectious diseases are more common in refugee communities. In general, tuberculosis notifications for 'foreign born' citizens are higher than for national born Europeans[23]. The background rates of hepatitis B, hepatitis C, tuberculosis and HIV in the countries from which our migrants originate are considerably higher than comparable rates in Ireland[26].

Because of their relative youth, refugees and asylum seekers place considerable demands on paediatric, maternity and reproductive health services[19].

Although the use of primary care is generally greater amongst ethnic minority groups they experience difficulties in physically accessing their general practitioner and tend to be less satisfied with the outcome of the consultation[22]. They feel that the time spent with them is inadequate.

Cultural differences are evident in a number of instances, especially for mental health and reproductive health services. Asylum seekers attitudes to health are based on immediate needs rather than on prevention and the influence of lifestyle on health[29]. Solutions to some of these difficulties have been proposed. Healthcare should be widely available, non-stigmatising and not linked to asylum claims. A package including initial voluntary health screening should be offered as a gateway to mainstream health services[26].

Cultural competency training for health service workers has been mooted[12,13,16]. This involves acquiring the skills to understand cultural differences in presentation of illness and treatment and other dimensions of health. Link workers, translation services and community advocacy groups can also support the appropriate use of health services intended for their use[19].

Conflicting attitudes held by different arms of a government and a lack of uniformity with a basic coordinated European standard of healthcare for refugees result in a 'Healthcare Lottery' for migrants currently[26]. With a tightening of controls in industrialized countries the health needs of asylum seekers frequently fail to be addressed by public health systems worldwide[1].

Poverty has a profound effect on health and the damage lasts through generations. Insecurity and a low level of control cause chronic psychological stress, physiological change and ultimately physical disease. In the recently published UK 'Independent Inquiry into Inequalities in Health' there is a clear association within ethnic minority groups between poverty and poor health[13]. In consequence, the report recommends that specific consideration in health service planning be given to asylum seekers as a disadvantaged group wealthwise and healthwise.

Chapter Three

3.1 Introduction

A combination of research methods has been used to provide as complete and as objective a picture as possible of the distinct health issues and needs of immigrants and asylum seekers in Ireland at the beginning of the third millennium.

Quantitative methods (written questionnaire, nutritional assessment of diet and review of birth notification forms) were used to measure certain demographic and health status characteristics. While qualitative techniques (discussion focus groups and key informant interviews) provided personal experiences and insights.

A combination of research methods used to explore complex health issues is referred to as triangulation in health services research. It is borrowed from navigation whereby two visible points are used to plot a third. The use of quantitative and qualitative methods provided complementary information

Aim

The aim of this study was to establish the health needs of immigrants and asylum seekers and to identify those aspects of their lives in Ireland, that influence their mental health and well-being, in order to prevent the manifestation of social and physical ill health.

Objectives

The objectives of this study were to:

- Report on the health status and health needs of asylum seekers
- Identify those aspects of their daily lives that impact positively and negatively on their mental health and well-being
- Identify what they and their health service providers perceive as necessary to enhance their health and well-being
- Make recommendations to minimise the potential for social, mental and physical ill health among immigrants and asylum seekers

3.2 Research Method

Contact was made with the designated asylum seeker centres in the Southern Health Board (9 in Cork and 8 in Kerry). Initial meetings were held between the centre managers and the research team. The aims and objectives of the study were outlined to centre managers, and permission was given to proceed. The elements of the study design are described in the following sections:

3.3 Quantitative survey of asylum seekers

3.4 Nutritional review of food provided in centres

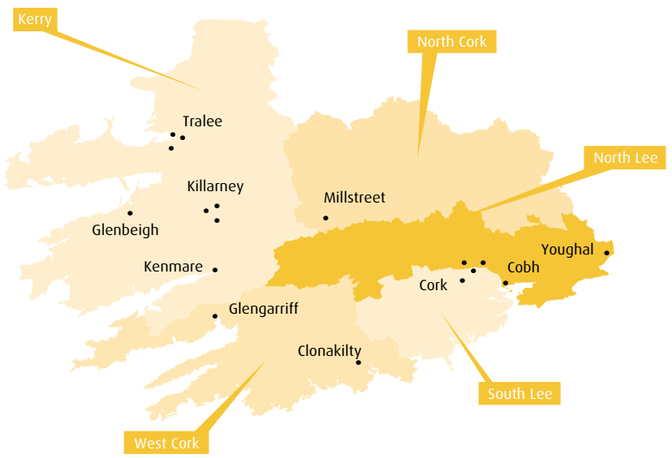
3.5 Outcome of pregnancy review

3.6 Qualitative study of asylum seekers, selected health service providers and key informants

3.3 Quantitative Survey of asylum seekers

3.3.1 Study population

There were 972 asylum seekers living in designated centres in Cork and Kerry in August 2001 (Fig 3.1). There are no recommended sample sizes for this type of study. It was agreed that the researcher would attempt to interview in the region of 200 asylum seekers over a given time scale.



3.3.2 Design of the Questionnaire

Questionnaires were developed to carry out a health needs assessment of asylum seekers living in designated asylum seeker accommodation in the Southern Health Board region. The following broad areas were included: demography, educational status, accommodation, health (general health status and mental health), health behaviour, use of health services (primary care and acute hospital) and use of infectious disease screening services (TB test which involves a screening questionnaire, chest x ray and possibly a skin test and blood tests for hepatitis B, rubella and HIV).

The questionnaire incorporated the General Health Questionnaire (GHQ)[30]. The GHQ is a mental state measure, outlining how subjects feel about their present state "over the past few weeks". It does not make clinical diagnoses and is not used to determine long-standing attributes. Questions related to physical health status and health related behaviours were used from the Irish lifestyles survey[31] as well as from a UK survey[20].

Questionnaires were translated into five other languages; Romanian, Czech, Russian, French and Portuguese, to assist those who had difficulty communicating in English. All asylum seekers surveyed spoke one of these languages. The researcher did not speak any of these languages and did not use an interpreter. However, the level of English was very good among the African population and those with poor English were requested to complete questionnaires translated into their language. The questionnaire was designed to be primarily self-administered by participants. A copy of the questionnaire is included in the Appendix.

3.3.3 Scoring of the Questionnaire

Questionnaire responses were coded numerically for analysis in Statistical Package for Social Services (SPSS)[32].

The GHQ responses were coded according to the four answer options; better than usual; same as usual; worse than usual; much worse than usual. Responses were coded using Likert scoring (0-1-2-3) and added to give a final GHQ score for each participant.

3.3.4 Selection of Participants

The field researcher established the times when the majority of residents would be in the centres. Adult asylum seekers were approached in each centre of residence. The aim of the research was outlined to all with no pressure placed on individuals to participate. Confidentiality was assured and the researcher provided assistance to participants in completing the questionnaires. Two hundred and ten residents completed questionnaires. They ranged in age from 18 to 58 years. The field work was carried out over a period of three months by a researcher.

3.3.5 Sources of bias

The questionnaire was usually self-administered although assistance was provided by the researcher when requested. Care was given to explain the questionnaire in a standardised format. *Non-response bias* was largely eliminated by asking residents on an individual basis to participate and there were very few refusals. *Selection bias* was addressed by using a presenting sample.

3.3.6 Pilot Study

The questionnaire was piloted on a small sample of asylum seekers to check phraseology and clarity of questions. It also checked for any problems with the presentation of questions and the methods of explanation used by the researcher.

3.3.7 Analysis

Completed questionnaires were inputted into SPSS for analysis. Data was inputted onto a spreadsheet in numeric form and labelled appropriately. The chi square analysis and Kruskall-Wallis tests were used.

3.4 Nutritional Review of Food Provided in the Centres

3.4.1 Study Population

Three groups were interviewed in each of 2 designated centres: asylum seekers; catering staff and proprietors or managers. Community nutritionists employed by the SHB conducted the interviews and assessments.

3.4.2 Design

The purpose of the input from community nutritionists was three fold (a) to gather information on the eating patterns and preferences of the asylum seekers when they lived in their own countries, (b) to assess the current provision of nutritious food in the centres and (c) to assist the centres in providing food choices that account for the preferences of the residents and are in line with current healthy eating guidelines and recognize the available catering budget.

Two asylum seeker centres in the Southern Health Board region were selected for illustrative purposes. Three visits were made to each.

A detailed written report was given to each centre detailing the information garnered at the meetings. A further meeting was held to offer advice on healthy cooking practices and healthy food choices appropriate to the residents.

3.5 Outcome of Pregnancy Review

Birth notification are recorded under the Notification of Births Acts 1907 & 1915. The form is completed by the maternity hospital on discharge of the baby and sent to the Director of Public Health Nursing. It contains information on the infant and parents. Information recorded include mother's name and address, date of birth, occupation, name of infant if available, birth weight, sex, outcome of previous pregnancies, antenatal care, method of delivery, type of infant feeding used, date of admission and discharge and any relevant information on the baby such as post natal problems or diagnosis of congenital anomaly. The forms are filed by date of birth but do not provide information on ethnicity. The majority of births in the Southern Health Board area take place in two maternity hospitals in Cork and the review was carried out on birth notification forms from these hospitals. All notifications for the period January 2000 to December 2001 were reviewed and asylum seeker births identified by mother's surname or address. Some forms recorded 'asylum seeker' under occupation.

The information from the forms was inputted into SPSS and analysed.

3.6 Qualitative Study of Asylum Seekers, Selected Health Service Providers and Key Informants

Focus groups were used to gather views and opinions in addition to consensual and conflicting beliefs on various topics under discussion.

3.6.1 Structure of focus groups

Four focus groups were held with asylum seekers; two with groups of all female participants and two groups of all male participants. The groups were divided into male and female groups in an effort to ensure that participants were comfortable with their group and the topics under discussion (Table 3.1).

Table 3. 1

Nationalities of Asylum Seeker Focus Group Participants			
Focus Group 1 5 female participants	Focus Group 2 7 male participants	Focus Group 3 8 female participants	Focus Group 4 7 male participants
Moldova	Nigeria x 2	Romania x 3	Croatia
Croatia	Congo	Czechoslovakia x2	Libya
Kenya	Gambia	Nigeria	Estonia
Kazakhstan	Ivory Coast	Congo	Czech Republic x2
Ukraine	Estonia	Angola	Sierra Leone
	Cameroon		Lithuania

Four focus groups were held with service providers, considered to be key informants on the health needs of asylum seekers (Table 3.2).

Table 3.2

Service Provider Focus Groups				
Focus Group 1 Midwives	Focus Group 2 6 Community Welfare Officers	Focus Group 3 3 Area Medical Officers & 3 Public Health Nurses	Focus Group 4 Voluntary Groups	Telephone Interviews With General Practitioners
2 x Special Care Unit	1 x West Cork	3 x Cork AMOs	3 x Volunteers from Kerry	5 from Cork from Kerry
2 x Post Natal	2 x Cork City	1 x Kerry PHN	2 x Volunteers from Cork	
2 x Out-Patient	2 x Kerry	2 x Cork PHN		
	1 x North Cork	1 x West Cork PHN		

3.6.2 Focus Group Topics

Discussion with asylum seekers revolved around 6 prompts: Tell me about your day to day activities; What did you expect before you came to Ireland?; Social life in Ireland (how do you socialise and with whom?; How do you feel about rearing children in Ireland?; In Ireland what makes you happy?; What do you worry about/makes you unhappy since you came to Ireland?; What can be done to stop this?).

Discussion with service providers involved the following issues: What services do asylum seekers request most often of you? Can you provide them?; In your day-to-day work, are there difficulties with the *approach*, needs and expectations of asylum seekers? Can you elaborate with examples?; What, in your experience, causes most frustration for asylum seekers in Ireland?; What changes need to be made to fulfil their health needs and avoid future difficulties?

3.6.3 Sources of bias

There is potential for bias in any qualitative study. *Selection bias* was addressed by inviting all individuals in the centres on the day of the focus groups to participate. *Interviewer* bias was minimized by keeping to the format of questions agreed at the outset, allowing participants to talk without prompting and assuring them that it was anonymous.

3.6.4 Pilot Study

An initial pilot qualitative study was carried out to determine the understandability of the questions that were posed to asylum seekers. The pilot study was carried out in a drop-in centre of a voluntary organisation in Cork City. Questions were adapted to facilitate communication.

3.6.5 Procedure for conducting the Focus Group Sessions

Asylum seeker focus groups were held in the asylum seeker centres at times deemed likely to maximise participation. Service provider focus groups were held in meeting venues. One researcher facilitated each focus group while another recorded the comments of participants. Each focus group lasted approximately one hour.

3.6.7 Content Analysis of the Focus Group Sessions

A general theme structure was adopted in reporting on the focus group discussions. Emerging issues are highlighted, outlining the context within which these themes developed. As the objectives of this study are centred on the health-consequences of asylum seekers' experiences in Ireland, the structure of the results section encompasses the issues individually, with the health consequences of these topics highlighted as mentioned by participants.

3.6.8 Limitations of the study

The main limitations of the study were language difficulties. The questionnaires were translated into a number of languages to deal with this. The researcher did not speak any of these languages and did not use an interpreter. However, the level of English was very good among the African population and those with poor English used questionnaires translated into their language.

4.1 Introduction

This study was carried out using both quantitative and qualitative methods. The quantitative study gathered information on demography, educational status, uptake of health screening and vaccination services, self-reported general health status, mental health status and use of health services. As there are increasing numbers of babies born in Ireland to asylum seeker mothers, the outcomes of pregnancies were documented through a review of the birth notification forms. The experiences of asylum seekers were explored since their arrival in Ireland, using qualitative methods. The views of key informants were also sought using focus group discussions, telephone interviews and one-to-one interviews. Key informants included GPs, Area Medical Officers and Public Health Nurses, Community Welfare Officers, managers of centres and members of voluntary organisations. The issue of food and diet has repeatedly been identified as problematic particularly for those living in centres. The community nutritionists visited centres to document the views of asylum seekers and meet with the managers and caterers to discuss how this might be addressed.

The results are presented under separate sections as follows:

4.2 Quantitative survey of asylum seekers

4.3 Nutritional review of food provided in centres

4.4 Outcome of pregnancy review

4.5 Qualitative study of asylum seekers

4.6 Qualitative study of health service providers and key informants

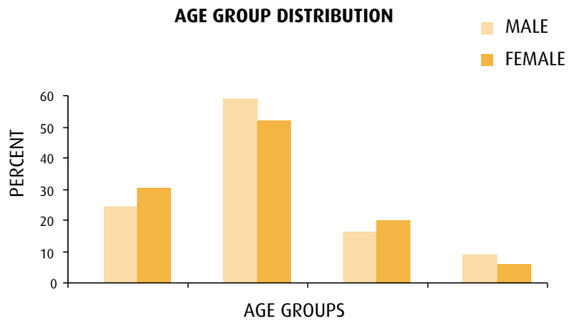
4.2 Section A – Quantitative Survey of Asylum Seekers

There were 972 asylum seekers in the Southern Health Board region at the time living the study was carried out. The majority were living in 'direct provision' with some moving into private rented accommodation as they became eligible. There were 210 questionnaires completed by adults living in 'direct provision' over a three-month period. The main findings are outlined below.

4.2.1 Age

There were 129 males and 81 females in the study group, ratio 1.6:1. All participants were adults, ranging in age from 18 to 58 years of age, with a mean age of 31 years. The majority of participants (51%) were in the 26 to 35 year age group (Fig 4.1). Five percent of participants chose not to answer this question.

Fig. 4.1



4.2.2 Country of origin

Respondents were from a range of countries as outlined in table 4.1 with the two largest groups being from Nigeria (22%) and the Czech republic (16%). For the purposes of analysis the respondents were grouped into Africans and those from Eastern Europe (including the former Soviet Union); 45% from the African continent and 55% from Eastern Europe.

Table 4.1

Country of Birth			
Country of Birth	Frequency	Country of Birth	Frequency
Albania	5	Latvia	2
Algeria	7	Lithuania	5
Angola	4	Moldova	8
Bulgaria	2	Nigeria	46
Cameroon	4	Poland	2
Croatia	8	Romania	16
Congo	4	Russia	6
Czech Republic	33	South Africa	4
Estonia	2	Somalia	1
Egypt	1	Sierra Leone	5
Gambia	6	Slovakia	2
Ghana	2	Turkey	3
Guinea	1	Uzbekistan	2
Iran	1	Ukraine	9
Ivory Coast	4	Yemen	1
Kosovo	5	Zaire	2
Kenya	2	Zimbabwe	2
Kazakhstan	3		

The majority of those interviewed (56%) had been living in designated centres on 'direct provision' for less than 6 months and 5% were still residing in the centres 16 months after arrival in this country (Table 4.2).

Table 4.2

Length of Time in Ireland		
Months	Number	Percentage
0-5	118	56%
6-10	57	27%
11-15	25	12%
16-20	10	5%
Total	210	100%

4.2.3 Family

The study did not record marital status of respondents. However, 62% of the women questioned had children living with them and half of all the women had children under 5 years of age. Twenty five percent of the men had children (19.4% had children under 5 years old). Of those who had children, 82% had one or two children (Table 4.3).

Table 4.3

Number of Children	
Respondents	Number of children
120	0
44	1
30	2
13	3
3	4

Almost half of the families had children under 5 years of age. Only 25% of children under the age of 5 years attended preschool. However, we do not have an age breakdown of this group but a quarter of these children were born since the mothers arrived in Ireland (under a year old).

The majority of women in the study who had children born in Ireland (86%) were resident here for less than 9 months at the time of the baby's birth suggesting that they were pregnant on arrival in this country. Of those women who had children born in Ireland, 68% had attended antenatal clinics and only 2 (12.5%) attended parentcraft or antenatal classes.

4.2.4 Education and Employment

Estimation of educational standard was based on reporting of school leaving age and level of schooling. The response rate was 87%. Of those who responded, 80.5% left school after the age of 15 years (Table 4.4).

Males were more likely to be older than females when finishing school ($t=3.33$ 1df $p < 0.01$). Average school leaving age of males was 19.4 years and of females was 17.2 years.

Table 4.4

Education Level of Respondents (n=197)	
	Percent
Primary education	12.2
Second level	50.8
Third level	37.1

The standard of education was quite high, half of the respondents attended secondary schools and 37% attended third level colleges. Africans were more likely to have completed third level education. In addition, those who had an incomplete second level education were more likely to speak English poorly.

Twenty five percent of Eastern Europeans stated that they were unemployed prior to coming to Ireland with only 10% of those from the African continent having been unemployed.

The type of work they carried out prior to coming to Ireland varied. Eight percent did not answer the question and 19% were unemployed (Table 4.5).

Table 4.5

Employment Status prior to Arrival in Ireland		
	Number	Percent
Unemployed	40	19
House duties	28	13.3
Other types of employment	125	59.5
Unanswered	17	8.1
	210	100

4.2.5 Language

Forty eight percent of respondents spoke English well or adequately and 8.6% of the group had no English. Older people were more likely to have better English. The ability to speak English was very good among the African population where 34% stated that they spoke English at home. Those who spoke English well/ adequately were four times more likely to have left school aged 15 years or more and to have completed second level education and ten times more likely to have been in employment prior to coming to Ireland.

Only half (52%) of those who had poor or no English were currently attending or had attended classes and two thirds of those who had not attended would like to do so. The main reason given for non-attendance was that classes were not provided (Table 4.6).

Table 4.6

Problems Preventing Attendance at English-Speaking Classes	
Reason	Number
Classes not available	14
Level of English taught is inappropriate	7
Can't afford the bus fare to the classes	6
No information is available about classes	6
No childminding facilities are available	4
Total	37

4.2.6 Accommodation

All the participants in the study lived in centres where 'direct provision' was provided. Two thirds of respondents stated that they shared a bedroom with three or four other people. Sixty four percent said that they shared the bedroom with others from the same country. It was not specified whether the other residents were family members or other adults. However, of the 36% who shared a bedroom with people from other countries, significantly more of them were males.

Two thirds of respondents stated that they had problems with their accommodation, with lack of space cited as the most common reason. The difficulties are outlined in Table 4.7.

Table 4.7

Problems with Accommodation		
Problem	Number	Percent
Lack of space	51	55
Food	13	14
Lack of privacy	12	13
People from different cultures and habit	7	8
Uncomfortable	3	3
Too noisy	3	2
Not clean	2	2
Language	2	2
Total	93	100

Significantly more Africans than Eastern Europeans perceived problems with their accommodation, X^2 =6.96 df =1 p=0.008. There was no significant association between problems with accommodation and duration of time spent in Ireland (X^2 =0.733 df =1 p=0.4).

4.2.7 Health Service Usage

4.2.7.1 General Practitioner Services

Eighty nine percent of respondents stated that they were registered with a GP since arrival. Those who had not registered said that they did not know why or that they were not here long enough. Seventy three percent had had a general check up by a GP since arrival with significantly more women than men having attended (X^2 =5.9 df=1 p=0.015). Sixty three percent had seen their doctor in the previous month, again with significantly more women attending (X^2 =17.7 df=1 p=0.000). However, 31% of those who had children (<16 years old) had not had a check up by their doctor.

Twenty nine percent of respondents stated that they had difficulties making appointments to see their GP. Of those having problems, 72% cited "language" and the remainder blamed the "system". Interestingly, 90% of those having difficulty spoke poor or no English.

Thirty seven percent of those who attended a GP stated that they needed an interpreter at the time. Table 4.8 outlines how this need was fulfilled. In 6% of cases a child relative was used.

Table 4.8

Provision of Interpretation at GP Surgery		
	Number	Percent
Adult relative	36	50
Other adult	21	29.3
Interpreting service	8	11
Practice staff	3	4.2
Child relative	4	5.5
Total	72	100

Significantly more Eastern Europeans required an interpreter when attending a doctor.

4.2.7.2 Vaccination Status of Children

Eighty nine percent of respondents stated that their children were vaccinated, with 5.6% not vaccinated. There was no information available on the remainder of the group. The location of where they received their vaccination is outlined in Table 4.9.

Table 4.9

Where was your child Vaccinated?		
	Number	Percent
Totally in Ireland	26	29
Partially in Ireland	17	19
Totally in Country of Origin	37	41
Not vaccinated	5	5.5
No information	5	5.5

4.2.7.3 TB Test

Seventy percent of respondents stated that they had been tested for TB in this country. A significantly greater number of those who have had a general check up by a family doctor also had a TB test (p<0.01). More Eastern Europeans had a TB test than Africans, this value not reaching statistical significance (Table 4.10).

Table 4.10

Respondents who had a TB Test		
	TB tested	Not TB tested
African	59	32
E European	82	29
Total	141	61

X^2 =1.94 df =1 p=0.16

4.2.7.4 Use of Services

The doctor was the most commonly attended health professional but the type of doctor attended was not stated. Counselling and psychiatric services were among the least used. Table 4.11 outlines the use of medical services.

Table 4.11

Use of Medical Services	
Service	Percent
Doctor	84%
Dentist	30%
HIV test	28%
Hospital Inpatient	17%
Hospital Outpatient	17%
Optician	16%
Chemist	13%
Family planning	3%
Counsellor	2%
Psychiatric Service	2%

The longer an asylum seeker was resident in this country the more likely they were to use services such as dental and optical; 44% of those in Ireland for more than six months visited a dentist and 26% attended an optician.

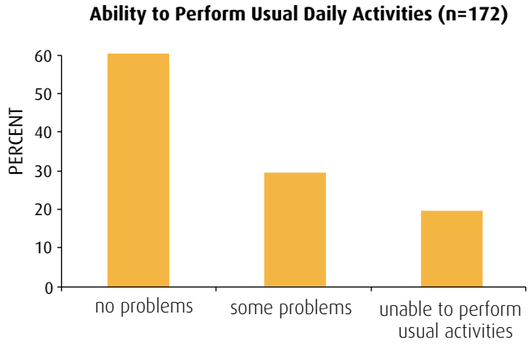
4.2.7.5 Accident and Emergency Services

Eighteen percent of respondents stated that they, or a family member, had used the Accident and Emergency (A&E) service since coming to Ireland, in 83% of cases it was an adult relative and in 17% a child relative. Of those who attended A&E all had done so within the previous three months.

4.2.8 General Health Status

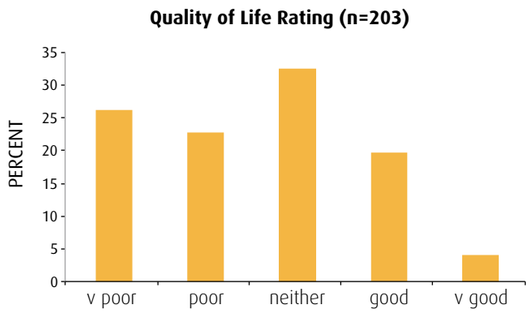
In response to a question on whether they had problems carrying out their usual daily activities the response rate was 82%. Fifty eight percent of those who responded stated that they had no problems (Fig 4.2).

Fig 4.2 Usual Daily Activities



Forty six percent stated that they experienced some or extreme pain and physical discomfort.

Only 22% of respondents rated their quality of life as good or very good (Fig 4.3).



However, despite the fact that a minority (22%) of respondents rated their quality of life as good or very good, 53% were satisfied or very satisfied with their health (Table 4.13). Those who stated that their quality of life was good or very good were significantly more likely to be satisfied or very satisfied with their health.

Table 4.13

Comparison of Quality of Life and Health Satisfaction			
Quality of Life	Number (%)	Health Satisfaction	Number (%)
Very Poor	51 (25%)	Very Dissatisfied	20 (10%)
Poor	44 (22%)	Dissatisfied	48 (24%)
Mediocre	64 (32%)	Indifferent	26 (13%)
Good	38 (19%)	Satisfied	86 (44%)
Very Good	6 (3%)	Very Satisfied	17 (9%)

4.2.9 Self-reported Medical Conditions

Respondents reported that they suffered from a number of medical conditions, the most frequently stated were allergies and bronchitis/respiratory illnesses (Table 4.14).

Table 4.14

Reported Medical Conditions	
Condition	Number
Allergies	23
Bronchitis/respiratory illnesses	20
Depression	15
Heart attack	14
High blood pressure	14
Anxiety	12
Asthma	11
Skin diseases	9
Angina	7
Diabetes	7
Stroke	3
Fits or epilepsy	3
High cholesterol	3

Twenty five percent of respondents indicated that they regularly take prescribed pills or medication.

4.2.10 Psychological Health

The General Health Questionnaire was used for this section of the study. The Likert scoring method was applied. The scores were then ranked from 0-36. A ranking of 12 is considered the threshold where a person scoring less than this is considered to have good psychological health and scores over 12 suggest increasing psychological difficulties. The response rate to this section was 70%.

Twenty two percent of respondents scored between 0 and 10 indicating good psychological health while 40.2% of the scores indicated some psychological difficulties (Table 4.15).

Table 4.15

Frequency of GHQ Ranked Scores		
Ranked Score	Number	Percent
0-10	33	22.4%
11-20	55	37.4%
21-30	47	32.0%
31-36	12	8.2%
Total	147	100.0%
Non-Response	63	
Total	210	

The majority of respondents (70%) scored above the recognised threshold of 12 (Table 4.16). There was no difference in the percentage of people who scored above the threshold value in those aged over or under 31years of age. Similarly, there was no difference between males and females.

Table 4.16

GHQ Threshold Levels of Respondents		
Threshold Level of 12	Number	Percent
Below Threshold	44	29.9
Above Threshold	103	70.1
Total	147	100.0

Table 4.17 profiles those who scored above the threshold of 12. Only 4% of those who scored above the GHQ threshold had used counselling services and only 2% had seen a psychiatrist. Forty two percent of those who scored above 12 said that they were satisfied or very satisfied with their health.

Table 4.17

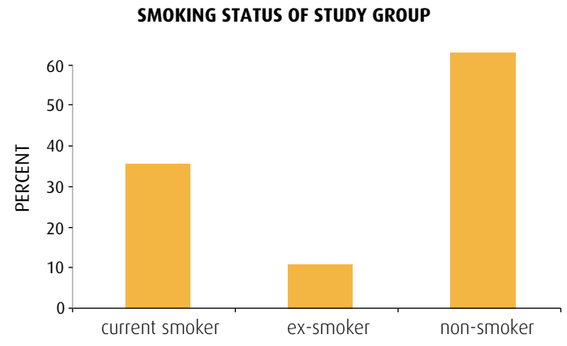
Profile of Respondents who Scored above GHQ Threshold Value (n=103)	
Sex	
- male	62%
- female	38%
Age	
- under median age of 31	54%
- over median age of 31	46%
Continent of origin	
- Africa	48%
- Eastern Europe	52%
Used counselling services in Ireland	
- yes	2%
- no	98%
Ability to carry out daily activities	
- no problems	46%
- some problems/unable	54%
Quality of life rating	
- poor/very poor	57%
- neither	30%
- good/very good	13%
Satisfaction with health	
- dissatisfied/very dissatisfied	41%
- neither	17%
- satisfied/very satisfied	42%

4.2.11 Health Behaviours

4.2.11.1 Smoking

Almost one third of respondents were current smokers (Fig 4.4).

Fig 4.4 Smoking status



Of those who smoked, 70% were male and 75% were from Eastern Europe. Thirty nine percent of smokers said that they smoked 10 or less cigarettes per day with 46% smoking 11-20 cigarettes a day.

4.2.11.2 Cannabis Use

The response rate to this question was 79%, and three quarters said that they had never used marijuana in their lifetime. Of those who had used it, all were male. One percent said that they had used it both in the previous twelve months and in the past month.

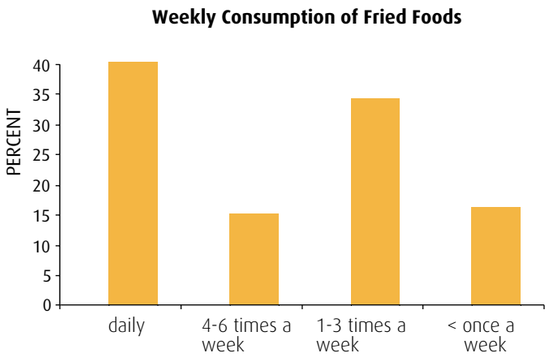
4.2.11.3 Alcohol Use

Twenty seven percent of respondents stated that they drank alcohol. Reported weekly intakes show that 49% of those who drank alcohol consumed 2 or less units per week. Of those who drank 91% were male and there was no difference between those living in Ireland for more or less than 6 months.

4.2.11.4 Nutrition

Forty percent of the group reportedly ate fried foods every day of the week while a further 14% did so 4-6 times a week (Fig 4.5).

Fig 4.5 Consumption of Fried Foods



Thirty five percent of respondents said that they always added salt to their food and only 7% never added salt.

Three quarters of respondents felt their diet could be healthier. Table 4.18 outlines how they thought it could be improved.

Table 4.18

In what way could your diet be healthier?		
How could your diet be healthier?	Frequency	Percent
More vegetables	85	40%
More fruit	84	40%
Less fried foods	46	22%
More meat/fish	45	21%
More flavourings/ different spices	27	13%
Other	33	16%

4.3 Section B – Nutritional Review of Food Provided in Centres

4.3.1 Typical Eating Patterns

Summary data has been gathered on the typical eating patterns (including food and drink choices) of a sample of asylum seekers (15 Africans and 12 Eastern Europeans) who were in the centres on the day of the visit. Results indicate that both Africans and Eastern Europeans have similar eating patterns to Irish people, eating at least three times a day (morning, afternoon and evening meals) with snacks in between as required. However, key informants in the centres told us that there is less routine in the timing of meals among residents interviewed. Main meals depend on work or school commitments.

Some differences were noted in the foods eaten at the main meals which were different to food eaten at these times among Irish people. A flavour of the African diet is given in Table 4.19. Given the size of the African continent and the geographic distribution of the asylum seekers currently in Ireland, it was noteworthy that typical foods differed somewhat in North Africa (NA) when compared with West Africa (WA).

Table 4.19

Typical Foods of Asylum Seekers from Africa	
Breakfast	Traditional cereal dish +/- soup (WA) Bread / sandwiches (meat and egg) (NA) Fruit or nuts
Mid-day	Stew, Rice, yams, macaroni (WA) Couscous, potatoes, rice (NA) Greens or bean-based side dishes
Evening meal	Carbohydrate based (WA) Protein based (NA) Rice, yams, cassava, semolina, Bean-based dishes, Fruit
Dislikes	Sugary sweets or confectionary, Chips, Sweet fruit juices

Meanwhile, Table 4.20 provides a picture of the usual Eastern European diet.

Table 4.20

Typical Foods of Asylum Seekers from Eastern Europe	
Breakfast	Brown bread, jam, Porridge made with milk, yoghurt, Cheese and ham
Mid-day	Soup, Meat and vegetables, Homemade desserts
Evening meal	Potatoes, pancakes, bread, Eggs and ham, Fruit
Dislikes	Biscuits, Fried food and chips, Large portions of protein

Comments from asylum seekers included:

- Diets were considered to be less healthy since coming to Ireland
- Men said that they felt the food served was contributing to ill health
- Residents in centres occupied by families were happier with the food provided than those in male-only accommodation
- Fruit juices were considered "too sweet" compared to those at home
- Deep fried potato chips were considered to be "children's food"
- Soup served was considered "too thin" – African 'soup' resembles an Irish stew type dish
- "...rice is badly cooked...parboiled at home..."
- Eastern Europeans were generally more satisfied with food than their African counterparts
- African women tend to use both breast milk and formula at home. Once they start weaning they tend to use okra soup and beans or small pieces of fish and chicken. They do not use cow's milk

4.3.2 Response to Dietary Needs of Asylum Seekers

Catering staff felt that trying to cater for different nationalities and religions provided a major challenge. Attempts had been made to cater for the likes and dislikes of different groups from time to time including:

- Vegetarian option on menu
- Muslims – sourcing of Halal meat (blessed meat)
- Roasted oxtail and shinbeef for Africans
- Fruit bags
- An evening meal container for those who returned to the centre late or missed the evening meal
- Sandwiches in the mornings for those who may leave the centre for the day
- An invitation to cook which was unsuccessful because of the numbers involved

Catering Assessment Reports were given by the Community Nutritionists to each centre and dealt with:

1. Variety of food on menu
2. Availability of healthy food choices at all meals
3. Use of healthy ingredients and healthy cooking practices
4. Advice on reducing total fat, saturated fat, salt and increasing fibre
5. The perspective of asylum seekers on foods currently served

4.4 Section C – Outcomes of Pregnancy Review

Data was collected for the two year period 1st January 2000 to 31st December 2001 on birth notifications from two maternity hospitals in Cork City. A total of 224 records were identified.

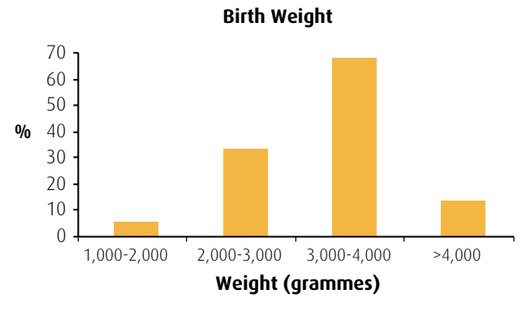
4.4.1 Sex

There was an equal male:female ratio (113:111) of recorded births. All babies were born in hospital, apart from one who was born en route to the hospital.

4.4.2 Birth Weight

The mean birth weight of babies was 3319g (range 1085-5190g). Eighty eight percent of babies had birth weights between 2500 and 4500g. The mean gestational age was 39 weeks (range 28-42 weeks) and 5% were born less than 37 weeks gestation (Fig 4.6).

Fig 4.6 Birth Weight



The marital status of a fifth of mothers (22%) was recorded as single. Less than half the babies (42%) were born to mothers residing in designated centres with 58% living in the community. Only three mothers had a previous history of stillbirth – one had two stillbirths. Nineteen percent had a past history of spontaneous abortion.

4.4.3 Antenatal care

This information was available on 83% of the births. Ninety-one percent of these had combined antenatal care (provided by both GP and hospital) (Table 4.21).

Table 4.21

Antenatal Care		
	Number	Percent
Hospital/Obstetrician	5	3
GP only	3	2
Combined	170	92
None	5	3

4.4.4 Rubella status

Information on rubella immune status was available on 82% of mothers, of which 10% were not immune.

4.4.5 Type of delivery

There was some form of obstetric intervention in 33% of deliveries as outlined in Table 4.22.

Table 4.22

Method of Delivery		
	Number	Percent
Spontaneous	131	67
Caesarean section	47	24
Vacuum extraction	13	7
Breech/ forceps	5	2

4.4.6 Infant Feeding

Almost two third (63%) were recorded as breast feeding their babies, while 27% bottle fed with the remainder using a combination.

4.4.7 Hospital Stay

The average length of stay for all mothers was 3.8 days (one mother spent 58 days in hospital, the reason for which was not stated). Only 2% of babies remained in hospital after their mothers were discharged.

4.5 Asylum Seeker Views on their Health

This section entails an overview of emerging themes. The health consequences of these topics highlighted where expressly mentioned by participants. The main themes that emerged related to control over their lives, issues in relation to socialization, and finally, the impact on their mental and physical health of living in 'direct provision' in Ireland.

4.5.1 Control

Lack of control created a great degree of frustration among participants. They dislike the fact that they have little choice over their day to day living. They place the responsibility largely on the 'system' that deals with their asylum process.

Unemployment: They felt that their life in Ireland had been largely unproductive.

"...Man is not born to be idle...we are not lazy man"

All were angry about their daily inactivity and irritated by the fact that their skills remain unrecognized.

"...cannot practice our skills..."

They fail to understand their enforced dependency when they are capable of working and paying taxes.

"...but there is no need to take taxes for asylum seekers, just leave us work ...", "... if we get work permit we can give something back..."

For many Ireland has failed to live up to their expectations in that they came looking for a better life. Females said that it is their culture to work, either within or outside the home.

"...we all work in our country, it is normal..."

Permission to work was an immediate priority.

Education: Many felt that there was a lack of recognition of their qualifications.

"...we have education, a doctor here who cannot work...plenty of skills..."

Many were satisfied with the educational system provided for their children.

"...good country to bring up my children...treated well in school...they are accepted there..."

One participant cited language and ethnic difficulties in the treatment of his daughter in school.

"...the only black...did not understand English..."

Food: This was a most contentious issue within all the focus groups and the one felt to be most in need of change. All said that their days centered around meals.

"...wake up as late as possible...have breakfast, sleep...eat...watch TV, sleep..."

The repetitiveness of food and the fact that it was not culturally appropriate to all residents created concern among respondents.

"...Muslim...I eat different food..." "...if you are Irish and go to another country the food may not suit your system...same for us..."

They acknowledge the difficulties that arise when trying to cater for different nationalities within a centre.

"...no way to satisfy everyone..."

Accommodation: Many are unhappy with the restriction placed on them while living in centres.

"...here we are like prisoners...we are grown ups...have to sign in and out..."

Adult males have difficulties sharing bedrooms with other men and particularly when they are of different nationalities.

"...4 in a room...may disturb others..."

Some women felt that the centres and their locations were ideal for children.

"...manager good...big garden.."

However, getting their own house was a priority of all the women.

Money: Many felt that the weekly allowance was inadequate.

"...children cannot get everything they want... too little when school begins...we pay rent for books too..."

Two said that lack of money prevented them keeping in contact with family back home.

"...calling Kenya is expensive...don't ring anymore...letters take 1-2 months..."

Lack of money impacts on the provision of health care.

"...if child is sick I must get a taxi to the doctor or hospital...social may or may not pay..."

All felt that they needed more money.

Lack of money was a major obstacle to socialising outside the centres.

"...no money and cannot go anywhere...all the days of the week the same...spend all my money on bus tickets..."

Asylum process: For many the process took a lot longer that they had expected when they arrived in the country.

"...not interested in you...have an attitude...feel like you have done something wrong...feel like an enemy...". "...listen but do not hear you...say ' yes, yes, yes'..."

The process is too long and difficult.

"...only 7% get residency...93% very long appeal..."

Independence: All were unhappy with having little to do and would like to be able to cater for themselves.

"...want to work...not handed money..."

The lack of choice and restrictions on freedom were mentioned by some.

"...it's live here, eat here...even if you have different tastes...we don't have choices..."

Others felt that life in Ireland would offer them freedom and an opportunity for a better life.

"...everything was going to be better...we came here because of our problems..."

4.5.2 Socialisation

Respondents outlined differences with Irish society and their difficulties assimilating into a new culture with no money, language barriers and without being allowed to work. There was a general sense of isolation from the Irish people.

Irish society: Most knew very little about Ireland before arrival.

"...know very little..."

However, they expected to be offered a better life than in their own country.

"...green country...good people...Catholics and missionaries went to Africa..." "...when you hear Ireland you think Christian country...see Christ in very few people..."

Participants' experiences of Irish people varied. Some had very positive experiences while others indicated negative treatment as a source of major disappointment with life in the country.

"...different treatment...angry that we are here...feels like we have committed the greatest sin on earth to seek asylum in Ireland...go to the pub and asked for ID card...don't get in...some are very caring..."

Language: Barrier to socialising, particularly for Eastern Europeans.

"...no English so nobody pays attention to me..."

Isolation: A sense of isolation from life outside the centre.

"...Irish people do not come in here..."

Most socialise with their own family or friends within the centres. Others outlined difficulties they have meeting others.

"...can't go to playgroup with my child...I am too shy..."

They felt that if they were allowed to work they would integrate better into Irish life.

"...no problems with Irish people if I had a work permit..."

Family: There was a great sense of family loss as many were separated from their families back home.

"...here with my daughter...left my two sons back home in Kenya...she cannot understand as one is her twin..." "...wife and child back home..."

Others outlined the practical difficulties of rearing children within centres.

"...house is a big problem...landlords will not rent...don't want refugee children..."

Voluntary Organisations: The work of these organisations was acknowledged by many.

"...meet people...can use computers and do courses..."

However, some have difficulty getting voluntary work.

"...to improve my English...went to ISPCA and Barnardo's but did not need volunteers..."

4.5.3 Health

Most participants focused on mental rather than physical health. They felt that inactivity impacted on their mental health but felt that their current lifestyle also had an effect on their physical well being. They were generally satisfied with the level of health service provision they had received since coming here.

Mental Health: They generally felt that their time was unproductive and they spend their days doing nothing.

"...losing time..."

Men tended to be angrier about their daily inactivity than women and were resentful that they were unable to utilise their skills.

"...an idle man is the devil's workshop...just sleep and eat...affects spiritual life, then emotional and then physical life..."

Males felt that Irish people compared their life here to a holiday.

"...not a holiday...just eat and sleep..."

They felt they had too much time to think about what they had lost and left behind.

"...not healthy when you think...have left two children behind...too much time to think of them..."

"...become silly...forget everything..."

"...feel like I don't know anything..."

"....could die soon...must work...like prisoners....thinking bad thoughts..."

Physical Health: Many outlined that current lifestyle had a negative impact on their health.

"...eat, sleep, smoke..."

One lady felt that she was getting "too fat" from all the inactivity.

"...don't eat fried food at home...have to eat it here...doctor says no more fries...would go hungry..."

Health services: generally positive views expressed

"...hospital very nice...they listen and try to explain...". "...everybody has a doctor...".

4.6 Qualitative Survey of Selected Service Providers and Key Informants

The views of a range of service providers were sought using a variety of methods including focus group interviews and telephone interviews with a number of GPs who provide primary care services. The areas covered included the services most frequently requested by asylum seekers; difficulties in providing that service; what were perceived as sources of frustration for the asylum seeker; their own frustrations and finally, the changes they felt were necessary to improve the service.

4.6.1 Services Requested and Provided

Table 4.23 outlines the range of services provided by service providers and voluntary organisations throughout the Cork and Kerry.

Table 4.23

Services Provided to Asylum Seekers				
Obstetric	Community Welfare Officers	Community Services	General Practitioners	Voluntary Organisations
Ante-natal	Direct provision payment	Infectious disease screening	Primary care services	Legal advice – legal clinic
Post-natal	Supplementary payments	Vaccinations	Referral to other services	Advice on welfare entitlements
Infertility services	Other payments (crèche, diet, travel)	Child welfare visits	Letters to recommend alternative accommodation	Assistance seeking accommodation
	Others (referrals, food intolerance certs, letter for transfer out of centres)			Workshops, English classes, computer classes and internet access
	Link with other services			Counselling service

A number of challenges were identified by all service providers in relation to providing a service for this population: physical and psychological ill health, language, time, resources, cultural differences, mobility of asylum seekers and a lack of understanding of the service provider's role.

4.6.2 Physical & Mental Health

The medical personnel considered most of the patients they encountered to be in very good physical health. Health services that they required pertaining to their illness were usually easily accessed (e.g. infectious disease services). Maternity consultations are often late in pregnancy and unsatisfactory in this respect.

GPs expressed solidarity with immigrant patients and appreciated that their situation could not be very satisfactory. They had diagnosed anxiety and frustration but little formal depression. Other respondents felt that the longer immigrants lived in designated centres the more likely they were to become depressed.

4.6.3 Communications

Inability to communicate effectively was considered by medical personnel in particular as the main barrier to the provision of a satisfactory service. It caused frustration for all concerned.

"...even booking an appointment can take ages..." "...the language barrier...particularly if giving vaccinations...the consultation takes longer..."

Much goodwill and willingness to address this difficulty was expressed.

Many reported that family members or other adults translated even though there is an official interpreter service available. This service is Dublin based and provided by telephone. It was considered not to be entirely satisfactory. Nursing staff were concerned because they were unable to ensure that asylum seekers understood prescriptions or were complying with medical advice.

"...those with certain illness...have lots of tablets to take...just hope they understand..." "...had a diabetic discharged on insulin...few days later he was found to be injecting water...he had good English"..."you can't take anything for granted..."

Information in different languages is needed.

"...communication is difficult whether it is a language difficulty or not...may have misinterpreted what is said...our people need training...structure..."

In contrast, Community Welfare Officers who provide financial support, experienced the least difficulty with language. They find that the children quickly become bilingual and are used to interpret in money matters.

4.6.4 Time and Waiting

The amount of time required to deal with an asylum seeker's problems is of particular concern. Health professionals said that a consultation can take up to an hour and this is not always due to language difficulties.

"...spend a lot of time sorting their forms and letters...need an interpreter and it takes time...not just language, they often appear not to want to understand what you are saying...will not listen..."

GPs find that it takes much longer than the average consultation time for Irish patients.

"...expect to be seen immediately which can be very annoying..."

All participants said that asylum seekers seem to be generally unhappy about waiting. This often leads to confrontation.

"...a lady interrupted when dealing with another person and when told to wait simply stood there and watched until I finished..."

"we create an expectation of instant gratification ...things are processed much faster for them and thus they demand to be seen first".

4.6.5 Cultural differences

Differences in culture between some immigrants and the Irish population has proved challenging for health care staff. These are wide ranging and vary from breast feeding practices, to religious beliefs and this can cause problems when prescribing medication or for certain consultations.

"leave it in God's hands" "...lady refused to see a male doctor...Muslim...a PHN had to monitor her regularly in the centre..."

African women come from different tribes and may have different birthing practices. In some rural area in Africa, babies are born at home and an old woman in the village delivers the baby. Many do not go to hospital to have their children. It is very important to some women who cuts the umbilical cord because they feel that if the wrong person does so *"the child will never be right".*

All male children of Muslim families are circumcised. Many service providers said that there had been some difficulties in identifying who would provide this service and where it should be provided. One doctor said that she had seen a baby where a member of a child's family had attempted to perform a circumcision but it was not successful and the child had to be admitted to hospital. It was agreed by all that our medical personnel are not fully aware of many of these cultural differences.

Many Muslims say that they want to move to be near a Mosque to practice their religion. One participant stated that African women have a different way of looking after their children. If a child is hospitalized she will stay with that child at all times and the others may be unsupervised back in the centres.

Overall, there was a call for realism, flexibility and compromise.

4.6.6 Mobility

Asylum seekers frequently move from centre to centre or out of the area and this creates difficulties for all service providers.

"...lady came from Galway...rang the hospital there and they were delighted to know where she was ...had been looking for her for ages..."

"...moving women in late pregnancy out of centres and into the community...cause for concern...not prepared and become very stressed..."

In general, participants said that asylum seekers prefer to be located centrally in city centres and towns rather than in rural areas. Movement creates difficulties when trying to get results of tests. Information transfer of medical records is an ongoing problem and in particular for pregnant women.

"...arrive and no record of tests...hours on the phone...pent up aggression causing problems..."

There is much time spent trying to follow up defaulters from clinic appointments.

"...a lot go 'underground'"..."may not reappear until they are called for asylum interview in Dublin...come looking for travel money and accommodation..."

4.6.7 Lack of Understanding of Role of Service Provider

Community Welfare Officers (CWO's) said that it is particularly difficult for them to carry out their duties effectively due to a lack of understanding on the part of asylum seekers of their role.

"...feel that the CWO is responsible for everything...hold the cheque book...expected to sort out their move out of direct provision..."

"...in contact with Dublin and therefore associated with the asylum process...will not confide in us...seen as part of Department of Justice..."

There is also a lack of understanding among the service providers as to what services are provided by each and this is often due to lack of communication.

"...hospitals have no idea what a CWO does... contacted to sort out all problems...often the only name the person has..."

4.6.8 'Direct Provision'

A number of health care providers expressed a belief that this system leads to frustration and tensions among asylum seekers.

"massive number are depressed living in centre... personal choice is taken away from them... ...adults spend much time watching TV with children playing in the corner..."

The mixture of different ethnic groups and cultures was seen as problematic.

The issue of food was highlighted by all participants.

"...the food is not what they are used to ...find it hard to eat...want to cook their own food...all complain about the food..." "...don't have to provide for every region but make some effort...common restaurant or kitchen where cooking by themselves is allowed..."

One participant said that while the quality of the food was good it was used as method of getting out of 'direct provision'. They felt that the centres could not possibly cater to suit all tastes.

"...a Nigerian woman made a meal for me and I could not eat it...how can we expect them to eat what we cook....African women in particular can't stand being fed...their whole reason is to cook..."

Many felt that food was the main talking point in all the centres.

"...it is all they talk to you about..."

4.6.9 Appropriate Health Services

There was a strong feeling that services need to be adapted to cater for a multiethnic society. There are many deficiencies in the current service provision.

"...do not want to go to A&E...only as a last resort...GPs are bogged down..."

"...should have psychological assessment when they arrive in our centres...definite deterioration in their psychological health...services need to be coordinated...idleness and boredom lead to problems..."

4.6.10 Asylum Process

Many felt that the current system had a negative impact on the psychological health of asylum seekers.

"...only feasible in the short term...need to be sorted out before six months..."

They also felt that large centres are problematic.

"...sharing is a recipe for disaster...shown already that there is trouble when large numbers together..."

There were suggestions that the Department of Justice should address the current asylum process, perhaps by decentralisation of the service.

"...must travel to Dublin for interview...train and two nights accommodation...train times are a problem when late interviews ..."

Services for immigrants, provided by the Departments of Health, Education, Justice Equality and Law Reform need to be coordinated and it is considered that this is not happening at present.

"...all work in isolation...the victims are the asylum seekers and their children..."

5.1 Introduction

There has been an exponential increase in the numbers of people entering Ireland as immigrants including those with work permits and those seeking asylum since the early 1990's. The Government, in attempting to deal with the increasing accommodation difficulties, established a number of centres throughout the country for asylum seekers - 'direct provision' in April 2001. The Southern Health Board area, comprising counties Cork and Kerry, had 18 centres located throughout the region which accommodated approximately 1000 persons, by August 2001.

There has been much concern expressed relating to the health of migrants in general and in particular, in relation to the group who are living in designated centres. The discussion section will centre on the scope and limitations of the methodology used in this study, the study population, language and communication issues, living conditions and circumstances, cultural issues, physical and mental health and the use of health services.

5.2 Methodology

The study employed a combination of quantitative and qualitative methods to explore the complex health issues of this population. It has been found that the use of random sampling is unrealistic in health service research of 'hard to reach' groups[7]. The use of key informants has been shown to be invaluable to inform this type of research[8]. There are no recommended sample sizes available for this type of research and therefore, the decision was taken to interview as many as possible on an opportunistic basis. In addition, this facilitated the qualitative aspect of the study where a level of familiarity and trust was established between the research team and those living in the centres. There was no attempt made to select particular age groups or ethnic groups. The main limitations of the study proved to be the language barrier. However, the questionnaires were translated into a number of languages and then self-administered with some practical assistance from a researcher and without major difficulties.

5.3 The Population

The findings of this study show that this is predominantly a young population and this feature is in keeping with international findings. Half of the participants were aged 26-35 years old and the male female ratio of 1.6:1 is similar to that found in other studies[11,12,13]. The majority of the women had children (62%) and the majority of these children were of preschool age. Women were more likely to be in a parenting role with only a quarter of the men having children living with them.

The participants came from a range of countries but the top three countries represented were Nigeria, Czech republic and Romania. For comparative purposes the respondents were grouped into African or Eastern European. While it is accepted that this is an oversimplification, as there are many cultural differences even within those who originate from the same country let alone the same continent, there are also many similarities.

The educational status of migrants was very variable and levels of education cannot necessarily be directly compared to that of this country. However, age of leaving school can be accepted as implying a certain level of education. Four fifths of the study population left school after the age of 15 with males spending longer in school than females. Thirty seven percent of our study group attended third level colleges and Africans, who are asylum seekers here, were more likely to have completed their education than Eastern Europeans. The standard of English among African asylum seekers was also much higher. This may reflect a different profile of persons who are likely to seek asylum from Africa compared with those from Eastern Europe. African asylum seekers may come from wealthier backgrounds as travel by air or sea to reach Ireland is costly.

The majority of asylum seekers in the study were in employment prior to coming to Ireland, 90% of those from Africa and 75% of the Eastern Europeans. Therefore, these people were coming from gainful employment to now having all their

practical needs catered for and thus losing "*control over their lives*". Many find it difficult to suddenly go from leading an active productive life to one of waiting and inactivity. They all felt that there would be less problems if they were officially allowed to work in Ireland. Restriction on work permits to asylum seekers is unhelpful particularly where the asylum process is lengthy. In the UK, minority ethnic groups have been found to have higher levels of unemployment than the ethnic majority[15]. Many commented on the lack of recognition of their qualifications and experience. It has been shown that downward social mobility and significant losses in financial terms often accompany forced immigration[14].

5.4 Language and Communication

The importance of English language skills as a means of communication for foreign nationals has been widely documented in studies[10,14,16]. Almost half of all the study respondents spoke English well or adequately, with only 9% unable to speak English. Despite this, only half of those who could not speak the language had attended English language classes. Unavailability of classes was cited as the main reason for non-attendance. Ability to speak English well correlated with higher educational status as might have been expected, but English language skills were also associated with having been born in the African continent as distinct from Eastern Europe and elsewhere. This feature has practical relevance for those providing health services to certain subgroups of immigrants and asylum seekers in Ireland.

While many of the study participants spoke English well and had little difficulty communicating, studies have cited language as a major barrier to accessing publicly funded health services[20]. Many of the service providers consulted in this research stated that communication difficulties created problems in terms of lengthening consultations and understanding of advice and instructions.

"you can't take anything for granted".

They also felt that there was often a lack of appreciation of the role of the service provider and the use of appointment systems in clinics. They suggested that there needs to be orientation and training provided to both the asylum seeker and the service provider towards mutual understanding and appreciation. The importance of availability of basic information on services has been widely highlighted in the literature and both service providers and users echoed this need.

5.5 Living Conditions and Circumstances

This study dealt with asylum seekers living in designated centres under the 'direct provision' system. This process involves all asylum seekers reporting to the Department of Justice in Dublin on arrival in the country and applying for asylum. They are referred to 'reception centres' in Dublin where they have access to immediate medical services including GP, infectious disease screening and counselling services if required. After a few days, they are sent to one of the designated centres scattered throughout the country. Therefore, people arrive in these centres at different times and the groups arriving may consist of several nationalities and ethnic groups. There are also a mixture of family groups and single persons in some centres while some centres cater predominantly for families with others primarily for singles. This creates a challenge in providing suitable accommodation within centres. The study found that two thirds of respondents shared bedrooms with three to four other people, the majority with people from their own country. However, the majority of those who shared with people from other countries were male. Service providers and asylum seekers themselves expressed dissatisfaction with this situation and it was seen to be a source of frustration. This finding has been confirmed by studies elsewhere where detention facilities have been found to have the capacity to aggravate tensions[9].

In many countries, asylum seekers have criticised detention centres for leading to isolation[9]. Irish studies have highlighted boredom, unemployment, overcrowding, welfare dependency and a general lack of suitable accommodation particularly for children of asylum seekers living in this country[10,12,16]. In this study, the main problems for those living in centres were similar: lack of space, dissatisfaction with food, a lack of privacy and the mixing of different ethnic groupings. Many also had difficulties regarding the rural location of the centres which led to feelings of isolation and discrimination. They felt that living in designated centres prevented them getting out to socialise because of the costs of travel and the limits imposed by their small weekly allowance. Women felt that while there were some positive aspects to the centres in terms of space and gardens for their children they would fare better living in the community in their own house.

"children cannot have their friends back to birthday parties... rules of the centre"

Food was central to all discussion and focus groups. Food complaints in terms of quality and choice are common and other studies have found that children's diet was a particular concern to parents[17]. The study found that while the eating patterns in their native countries are similar to those in Ireland the food eaten at meals differs. Many of the asylum seekers said that their days revolved around meal times. It must be acknowledged that it is difficult to cater for all dietary requirements at all times. The centres attempt to provide a varied menu and allocate days where traditional African food is prepared and other days with food suited to Eastern European tastes. However, the lack of control over what one was eating appeared to be the main area of contention. African women in particular, felt that cooking and preparing food for their family was what they always did and should do. In general, they all considered that their diet had become less healthy since coming to Ireland with an increase in the amount of fat (chips, fries) and a reduction in the amount of fresh fruit and vegetables (5 or more portions each day at home). Also, they felt that fruit juices were too sweet and biscuits are not eaten at home. Even in those centres where some cooking was permitted the aromas created tensions between the different groups and this did not really solve the problem.

Many service providers said that asylum seekers discussed and complained about food at every meeting. They felt that it tended to be used as a means of getting out of the centres. Letters regarding food intolerances and need for special diets were regularly requested from GPs and Area Medical Officers. These added strength to requests for alternative accommodation from the clients perspective but were a source of annoyance and seen as very time consuming by some of the health professionals.

Families, who had children born in Ireland, or women in late stages of pregnancy, are usually granted permission to leave 'direct provision' and source accommodation in the community. However, many stated that there are huge difficulties finding any type of accommodation and often the housing that is available is unsuitable in terms of location or living standards. Similar difficulties have been identified in other studies in the UK[13] and in Ireland[10,12,16]. Families are often unprepared to move out of the centres because of feelings of isolation and inability to cope. The need for a transition period was suggested where support would be provided in managing a budget and coping with day to day issues in a new country. A 'step down' facility has been set up recently in Tralee, Co Kerry which serves the entire country. Women with new-born babies tend to be sent here and after a time go to a house in the community. This model may prove useful and could be replicated in other regions of Ireland.

5.6 Cultural Issues

Studies on racism in Ireland have concluded that there has been a marked increase in the phenomenon[21]. This study did not specifically address issues regarding racism. However, both asylum seekers themselves and service providers referred to it. Asylum seekers had both positive and negative experiences of Irish people.

"..it feels like we have committed the greatest sin on earth to seek asylum in Ireland..."

It was felt that education and training was needed for all to help us to understand why people seek asylum.

"... these people choose to come here...must have left something far worse behind..." (voluntary worker).

Recent Irish studies have reported difficulties relating to ethnic distance experienced by asylum seekers in Ireland[10,12,16,17]. Contributing factors include a poor understanding of life in Ireland on the part of the asylum seekers prior to arrival, and little training in refugee culture for those charged with providing services for these groups.

Language was not the only difficulty in attempting to provide health care for this population. Different cultural backgrounds and religious beliefs lead to practices that are not always easy for service providers to understand. Some who are diagnosed with serious health conditions such as HIV infection choose not to take medications but will "*leave it in God's hands*". There are differing birthing practices among some ethnic minorities which have implications for the maternity services. Muslim women will not attend male doctors. There is a need for asylum seekers to be understood by Irish people but there is also a need for those providing services to understand the subtleties of the backgrounds and traditions of individual patients and groupings.

Male circumcision provides a new challenge for our health services. It has not been a routine procedure in many of our hospitals to date. However, service providers are now receiving requests for the service. To date, it has been dealt with on an individual basis but a more co-ordinated approach is needed.

5.7 Physical and Mental Health

It is acknowledged that, on arrival, health concerns rarely are the main priority for asylum seekers[22]. Getting a roof over their heads and avoiding deportation is crucial. It is only as time goes on that health needs become important.

5.7.1 Physical health

The GP is frequently the first point of contact with health services. Given the young age profile and the opinion of experienced GPs that they are, in overall, good physical health, it is surprising that a quarter take regular medication and a half reported experiencing pain or discomfort and 42% experience difficulties in daily tasks. These findings may reflect general unhappiness and emotional rather than physical difficulties.

5.7.2 Mental health

Questions relating to quality of life often give a clear picture of a person's mental health. Studies carried out in the UK found that perception of health is poor among minority ethnic groups[21]. In general terms, the asylum seekers in this study were much less satisfied with life and to a lesser extent with their health. In this instance, only 22% of this study group rated their quality of life as good or very good. This compares to 80% of the general Irish population in the Irish Lifestyles Survey (SLAN) 1998[31]. Fifty three percent of this study group were satisfied or very satisfied with their health compared to 69% in the SLAN survey [31].

The General Health Questionnaire (GHQ) is a mental state measure, indicating how subjects feel about their present state "over the past few weeks". It does not make clinical diagnoses, nor is it used to determine long-standing attributes. A ranked scoring system is used and a score of 12 is accepted as the threshold under which mental health is considered to be good. A score greater that 21 is considered significant in terms of poor mental health. Forty percent of respondents scored above 21 indicating a significant problem among this population. There was an internal consistency in these findings. Those who scored above the GHQ threshold value of 12 were more likely to have rated their quality of life as poor or very poor which is similar to the findings from the SLAN survey[31]. Only 4% of those who scored poorly in the GHQ attended counselling and 2% attended a psychiatrist. This may have been due to unavailability or considered inappropriateness of these services. Many of the service provider participants felt that the longer asylum seekers remained in centres the more likely they were to become disheartened. Also, they felt that they did not trust people to confide in.

"...they will talk about their life since coming to Ireland ...never hear about their life before..."

A likely explanation is that there may be different ways that people from different cultural backgrounds deal with stress or bereavement.

A recent Irish study, which reviewed the files of asylum seekers attending psychiatrists, concluded that asylum seekers may have been exposed to significant levels of pre-migratory trauma, they often have poor language skills and drop out of treatment quickly which may indicate dissatisfaction with existing treatment approaches[32]. This poses a challenge for mental health professionals who are concerned with the diagnostic and treatment implications of illnesses occurring in people from cultures and traditions with which our mental health services are unfamiliar.

5.7.3 Infectious diseases

There is much evidence to support infectious disease screening in the European context. A quarter of all TB cases diagnosed in Western Europe in 2000 occurred in patients of foreign origin and very high levels of HIV (30%) were found in pregnant women from the sub-Saharan continent[23,24]. It is estimated that 1 million people in Eastern Europe are living with HIV[24].

Since 1999, in Ireland, a programme of infectious disease screening has been provided by Community Medical Teams. However, there is no similar scheme for other immigrants who may be at risk. The programme is voluntary and screens for TB and hepatitis B for all and HIV for those who, by reason of high prevalence rates in their country of origin, are at increased risk.

The Southern Health Board database indicates that 93% of registered asylum seekers attended clinics at least once to avail of this service[22]. Two cases of non-infectious TB were detected in 2000 and no case of infectious TB and 87% of those who attended for screening availed of this element of the service. Records indicate that 78% of attenders availed of a hepatitis B test while 70% had a HIV test. Over a third of those tested (28%) showed evidence of past infection with hepatitis B but most had fully recovered. Overall, 7% of those screened were found to be carriers of the hepatitis B virus. One per cent were carriers of hepatitis B e antigen and are at most risk of liver damage and of transmitting the infection to others. Currently, collated HIV test results are not available for this population subgroup. A common mode of transmission of hepatitis B and HIV is from pregnant mother to child and all expectant mothers are routinely tested for bloodborne viruses (hepatitis B and HIV) in Ireland.

Early testing and Specialist Infectious Disease Services provide those with HIV or chronic hepatitis B with the opportunity of a very good medical outcome and support towards preventing further infections. The present Department of Health & Children policy of encouraging screening is well substantiated as would be an outreach policy for those who fail to attend initially.

Both GPs and Area Medical Officers provide vaccination services. The majority of respondents (89%) said that their children had been vaccinated. This is similar to the results of the SHB database[22]. However, on reviewing the pregnancy outcome data, 10% of mothers were non-immune for rubella and the SHB database reported 18% of women of child bearing age as non-immune. This indicates a need for targeted immunisation programmes among this group to reduce the risk of transmission of rubella and increase the vaccination of non-immune to prevent congenital rubella.

5.7.4 Health behaviours

Health related lifestyle factors were considered: one third of respondents are current smokers and this is in line with the Irish population[31]. Three quarters of smokers are from Eastern Europe and 70% are male. Unlike the Irish population, alcohol consumption is low with a quarter of respondents reporting alcohol consumption, the amounts of which are generally low (< 2 units per week). Service providers felt that the longer they remained in this country the more likely they were to adopt our habits. A quarter of respondents stated that they had ever used marijuana. At present, there are differences in patterns to the Irish population and health promotion messages must be delivered to encourage females and the African group not to smoke and to maintain the low alcohol intake.

5.7.5 Obstetric Services

Asylum seekers, because of their relative youth, place considerable demands on maternity, paediatric and reproductive health services[19]. There are increasing numbers of babies born to asylum seekers in this country. Concern has been expressed about the health of these babies as many of these women arrive in the country in late pregnancy[17].

Birth weight is a good indicator of health and low birth weight is associated with poverty, smoking and lower socio-economic groups. However, this study, which included a large sample (224) and looked at a selection of objective pregnancy outcome measures, found that 88% of babies weighed between 2500 and 4500g. This is similar to the birth weight range reported by the National Maternity Hospital Dublin (where 91% of their total births were in this range) in the year 2000[33] and is reassuring. The majority of babies (88%) were born with ample maturity, between 37 and 42 weeks gestation, which is similar to the findings in Irish hospitals[33] and is also encouraging. The marital status of a fifth of the mothers was recorded as unmarried. This is less than the Irish situation but care is needed when interpreting this information as many of these women arrive in Ireland pregnant and may not wish to disclose their marital status. Their marital status may not reflect how supported or otherwise they are.

Concern has been expressed about the provision of antenatal care[33]. This study recorded that 91% had at least some form of combined antenatal care. However, this needs further investigation as the number of visits was not recorded or the timing of the first visit. Late arrival in Ireland of pregnant immigrants results in their not having access to adequate antenatal monitoring. Early and adequate antenatal care is accepted good practice worldwide. A third of all deliveries required some form of obstetrical intervention, with 24% having caesarean sections. This level is considerably higher than that reported at the National Maternity Hospital, Dublin in 2000 at 14.2%[33].

Our review of 224 birth notification records, did not identify any perinatal deaths. However, a Dublin Hospital's, clinical report for the year 2000 states that its perinatal mortality has increased from 6.7/1000 in 1999 to 9.0/1000 in 2000. It attributes some of this increase in perinatal mortality to pathologies such as intra uterine syphilis and intrauterine malaria, conditions likely to be more prevalent in immigrants from certain areas of the world.

Many recent newspaper articles report that maternity services, which are already stretched, have to face further challenges when trying to provide healthcare to this new population. They report increasing numbers of non-national women arriving in late pregnancy, without adequate antenatal care, delivering babies who are at increased risk of developing complications. Claims have been made that these women and babies are in poorer health and have relatively high levels of infections such as HIV and hepatitis B.

Certainly, these reports are a cause for concern and resources must be put in place to deal with the increasing demands. However, there is also a need for epidemiological research in this area to monitor trends over time and identify how the health status of this population can be improved.

As the non-national population continues to grow, healthcare providers are experiencing difficulties dealing with the additional burden of language and cultural communication deficits. Comments made by the maternity nurses, on the need for language and cultural sensitivity, indicate the potential value of training and, perhaps, the use of liaison nurses and a consultation forum for this group of non-national maternity service users.

5.8 Use of Health Services

All asylum seekers are entitled to free primary and hospital care in Ireland. They are allocated a medical card on arrival in the country. The majority of study respondents stated that they had a medical card. This is better than that reported in the UK where 30% hadn't signed up with a GP and 35% were registered but not using GP services[18]. Three quarters of respondents said that they had attended their GP for a check up since arrival, the majority having done so in the previous month, indicating a high level of consultation. Women were more likely to have attended than men, which may be due to their being pregnant or having small children, and reflects the well recognised pattern of usage by all women. Studies in the UK have found that the use of primary care is generally greater among ethnic minority groups, that they experience difficulties in physically accessing their GP and tend to be less satisfied with the outcome[22]. This study found that 29% had difficulty making appointments to see their GP and it is clear that language is a major barrier.

Interpretation services were seen as being problematic for both patients and health care professionals in the provision of healthcare to asylum seekers. Other adults provide this service in most instances although official interpreter services are available and can be accessed by phone. This is perceived as being time consuming and interferes with the dynamic of the consultation. Service providers generally preferred when a relative or friend who spoke English provided this function.

When patients attend hospital outpatient departments it is possible to pre-empt and arrange the translation service. Maternity services have particular difficulties in this area as women may arrive in labour and there is often an immediate need for intervention. Cultural competency training for health service workers had been mooted in many previous studies[12,13,16].

The longer an asylum seeker remains in this country the more likely he/she to use such services as dental and ophthalmic. Forty four percent of respondents who had been in Ireland for longer than six months had attended a dentist and a quarter had attended an optician.

The much beleaguered A&E services are also used by asylum seekers. Those who attended were more likely to reside in centres within the city rather than rural centres and this may be related to the proximity of the A&E department. It is not clear as to the relative appropriateness of these visits.

Overall, health care providers expressed much goodwill towards the new population groups for which they are trying to cater. Calls for resources, realism, flexibility and compromise based on mutual appreciation were made.

Cultural differences are evident in providing care for this population[29]. In particular, all health care providers cited longer consultation times. Many felt that asylum seekers have a different expectation of the services timewise "*they expect to be seen immediately*". While language has been cited as a reason for some of the difficulties, many also felt that there was a huge lack of understanding on both sides. Link workers, translation services and community advocacy groups can support the appropriate use of health services intended for their use[19].

Chapter Six

This study aimed to establish the health needs of immigrants including asylum seekers living in Ireland. It sought to identify those aspects of their lives in Ireland that influence their mental health and well-being. It also sought to identify what asylum seekers and their service providers perceived as necessary to maintain and enhance their health and well-being. The study population consisted of those asylum seekers who were living in designated centres throughout Cork and Kerry and receiving 'direct provision'. In addition, the views of service providers and other key informants were documented to provide a more complete picture. The following conclusions were drawn from the findings of the study:

Asylum seekers are predominantly a young population with more males than females in the group. More of the males are single and the majority of women are accompanied by young children or are pregnant.

Currently, asylum seekers in Ireland are a heterogeneous group coming from 35 countries. Thus they come from a multitude of backgrounds and this poses considerable challenges in the provision of healthcare.

The majority of asylum seekers have been employed prior to coming to Ireland. They are prohibited from working until they are granted asylum and this leads to considerable dissatisfaction and stress.

They are generally well educated by their and our standards, with those from the African continent attaining higher educational standards than their Eastern European counterparts. Africans, also, have a better understanding of the English language.

Communication difficulties create problems when accessing medical services. The importance of basic information on services for the asylum seeker is crucial. There is a lack of understanding of the roles of service providers and thus, a need for orientation and training for both service provider and asylum seeker to enable mutual understanding and appreciation.

Problems with accommodation include overcrowding, lack of space, sharing with different ethnic groups, feelings of isolation and boredom and the food. This leads to inter and intra group tensions which is not helped when people are unable to socialise outside the centres because of travel costs and living on a small weekly allowance. This is compounded by the inability to obtain work permits and thus enforced idleness.

The provision of a diet suited to a variety of different cultural background and ethnic origins poses a major challenge for the managers of designated centres. The food, while nutritionally of high quality, causes much frustration and concern. This is often due to a lack of control over one's daily living. Attempts to satisfy all tastes have proven almost impossible but the input from Community Nutritionists should improve the situation. Also, the duration of time spent living in the centres needs to be addressed, as moving to private rented accommodation would allow the asylum seeker to regain this control.

There is a need for a transition period when people are moving out of centres into the community which must be supported to help in practical skill development such as budget management. 'Step down' facilities are needed similar to that currently provided in Tralee, Co Kerry.

Cultural differences must be addressed by those providing healthcare service to asylum seekers. Training and education is needed, in particular, when dealing with those who are diagnosed with serious health conditions, such as HIV, and in the provision of maternity services. An understanding of the subtleties and background of individuals and groups is essential.

The physical health of asylum seekers is reported to be generally good but their long-term health status has not been studied. Despite apparent good health, as reported by GPs, many asylum seekers take medication and their self reported ability to undertake daily tasks is poor. This may be a reflection of general unhappiness or poor emotional health.

This group reported low satisfaction with their lives and to a lesser extent their health. Their quality of life is much poorer than that reported for the general Irish population in the SLAN survey[31]. They also have significant problems with their mental health as identified by the GHQ. Despite this, very few attend psychological or psychiatric services and this may be due to unavailability or inappropriateness of the Irish mental health services.

Asylum seekers, generally, come from countries where there is a higher prevalence of certain infectious diseases than in this country. Uptake of screening and vaccination services for some infectious diseases is high but defaulters and non-attenders need to be targeted. A more proactive approach needs to be taken regarding the issue of access of healthcare for those individuals who have been diagnosed with long-term diseases such as TB and HIV. Infectious disease prevention and treatment services will need to be resourced, accordingly.

The prevalence of current smokers is similar to that of the Irish population but the majority of smokers are from Eastern Europe and are male. Females and Africans should be encouraged not to smoke.

There are early indications that the worst aspects of the western diet (high fat and high refined sugar intake) are being adopted by immigrants. Practical support for healthy eating choices are an immediate concern.

Alcohol consumption is generally low but there is a need to deliver health promotion messages to encourage this population to maintain low alcohol intake.

There are increasing numbers of babies born to asylum seeker mothers and this is placing considerable strain on our obstetric services. Despite concern regarding the health of these babies, perinatal mortality and morbidity was found, in this study, to be similar to the Irish population. The caesarean section rate is higher than that reported in many of our maternity hospitals and warrants further study. Furthermore, our service providers require support and training to deal with cultural differences and traditions. Service developments to cope with these needs and demands are required.

GP service usage is very high among asylum seekers but some difficulties are encountered when trying to access the service. Language is the main barrier but there are also cultural difficulties, in expectations and these often necessitate longer consultation times. Additional resources, training and supports are needed by Irish GPs to cater for this group. Clarification of the role of GPs, particularly in the early months in Ireland when demands are high, is also apparent.

Chapter Seven

The recommendations from this study are based on conclusions reached using a number of different qualitative and quantitative research methods. These recommendations relate to three distinct areas: the development of the health services, health related information and thirdly the role of Government departments concerning immigrants and asylum seekers.

The focus of the research is towards health and recommendations that include agencies and departments that are not primarily charged with a health remit are made in the context of those agencies' influence on health directly and indirectly.

Health Services

- An Ethnic Minority Health Unit (modelled on the existing Travellers Health Unit) should be developed to act as a forum for service users and providers (primary and secondary care). Voluntary groups should be key players in the unit. Advocacy, support and co-ordination and community development would be within the remit.
- Existing Infectious Disease Screening services should be developed to ensure maximum uptake of testing and vaccination services. Targeting of groups with low uptake is required.
- Consideration should be given to a dedicated Primary Care service available to sort out initial health issues for those arriving into the country for the first time as a gateway to mainstream GP and health services.
- GP services and Primary Care Teams must be adequately equipped (training, resources, payment etc) to meet the needs of an emerging multiethnic population.
- Health Promotion service plans should include immigrants as a specific target group and actively support healthy lifestyle choices for them.
- Infectious Disease Specialist services must be adequately equipped (training, resources etc) to meet this emerging need.
- Maternity services must be financed and equipped to cater for ethnic minorities in reproductive health matters.

Other Government Departments & Agencies

- Local Authorities, Government Departments and Voluntary Agencies and Health Boards should consider the health implications for immigrants of new and existing policies and services. They should work together in joint projects e.g. provision of cultural awareness programmes to service providers and immigrants including asylum seekers towards mutual understanding, community development projects, multicultural festivals etc.
- English language, communication and cultural orientation classes for immigrants and asylum seekers should be freely available and appropriate.
- The duration of the asylum process and the present system of 'direct provision' should be considered in the light of potential negative impacts on health. Options to be considered may be limiting time in the centres, expanding self-catering options and the provision of sheltered housing and 'step down' facilities.
- Nutritionally sound and culturally acceptable diets should be provided in the centres. Nutritional advice from Health Board Community Nutritionists can be sought locally.

Health related information

- The Central Statistics Office should consider including ethnicity/racial origin in routine statistics including identification of children born in Ireland of non-national parents.
- All lifestyle and health behaviour surveys such as SLAN should include a sub-sample of non-nationals.
- All health information collection systems that routinely collect information e.g. Hospital Inpatient Enquiry (HIPE) system, maternity hospital outcome databases, vaccination databases, National In-patient Psychiatric Report System (NIPRS) and any new primary care information system should consider inclusion of ethnicity on a mandatory basis with a view to providing service utilisation data and serving this population.
- A follow-up health study of 'new Irish' children should be undertaken which would incorporate social, emotional and physical well-being.
- Surveillance of social class, poverty, and ethnicity data should be linked to monitor potential inequalities in health related to ethnicity and social deprivation in Ireland.

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Glossarey

Refugee

A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality or, owing to such a fear, is unwilling to avail himself or herself of the persecution of that country.

Programme Refugee

A person who has been invited to Ireland on foot of a Government Decision, in response to humanitarian requests from bodies such as UNHCR.

Asylum Seeker

A person who seeks to be recognised as a refugee in accordance with the terms of the 1951 Geneva Convention relating to the Status of Refugees.

Leave to Remain

Permission to remain in the State granted at the discretion of the Minister for Justice. This permission may be given to a person who does not fully meet the requirements of the definition of a refugee under the 1951 Geneva Convention ,but who the minister decided should be allowed to remain in the States for humanitarian reasons.

Social Welfare

Prior to November 1999, asylum seekers received the same social welfare payments as that of an Irish national and also had the right to financial support in order to rent private accommodation.

Asylum seekers who arrived into the State after April 2000 receive £15 (€19) per adult per week and £7.50 (€9.52) per child per week. All asylum seekers are entitled to apply for social welfare payments including disability allowance, and single parent allowance.

Direct Provision Accommodation

Introduced by the Irish government in November 1999 and applied to all asylum seekers since April 2000, on a pilot basis, this system provides full board to asylum seekers in a specified address. Exceptions to this rule include asylum seekers who are pregnant for more than 32 weeks, as well as their partners and family under 18 years of age and those for whom direct provision is deemed unsuitable.

Community Nutritionist

Specialist in food and nutrition who is based in the community as opposed to a hospital setting.

Health Promotion

"The process of enabling people to increase control over and to improve their health" (WHO).

Inequity

Unequal access to healthcare. Equity is determined by actual need for service rather than ability to pay or geographical location.

Primary Care

The care a patient receives at first contact with the health care system, usually involving co-ordination of care and continuity over time.

Primary Prevention

Aims top reduce the incidence of the disease through community-based activities to modify behaviour and/or lifestyle of high risk individuals or society as a whole.

Qualitative

Qualitative research uses analytical categories to describe and explain social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all the participants. It is particularly useful in health services research.

Thank you for participating in our study. The following questionnaire covers a number of topics requesting information on issues related to your health. The purpose of this questionnaire is to get an insight into your health since you have arrived in Ireland, with the purpose of identifying what needs to be done to ensure your continued good health and make any improvements necessary to the health care we provide. We would like to re-assure you that the responses you provide will be dealt with in the strictest of confidence. Under no circumstances will any of the responses be attributed directly to yourself or your family.

If you require assistance with the completion of this questionnaire please do not hesitate in asking our researcher for help.

Office Use Only:

Date of Interview: _____

Interviewer's Name: _____

Questionnaire Number: ☐☐☐·☐

QUESTIONNAIRE STARTS HERE

Sex of Respondent: Male ☐ Female ☐

Age on last birthday: _____ (Years)

Area of Residence: Cork City ☐ Cork County ☐ Kerry ☐

Your Country of Birth: _____

How long have you been in Ireland: Years: _____ Months: _____

Section 1

1.1 How many people live in the household/room/apartment with you?

State the number _____

1.2 Are ALL the household from the same country?

Yes ☐ No ☐

If NO state all Countries

_____

_____

_____

_____

1.3 How many children aged under 5 live in the household?

State the number _____

1.3a Do they attend pre-school?

Yes ☐ No ☐

1.4 How many children aged between 5 and under 16 live in the household?
State the number _____

1.4a Are they attending school?
Yes ☐ No ☐

1.5 Is your Accommodation:
Rented ☐
Bed & Breakfast ☐
Special Centre .....(Please name) _____

1.6 How many bedrooms are there for your household group?
1 bedroom ☐ 2 bedrooms ☐ 3 bedrooms ☐ 4 or more bedrooms ☐

1.7 Are there any problems with your accommodation?
Yes ☐ No ☐
If Yes, Please state these problems:
_____
_____
_____

Section 2

2.1 What age are the OTHER adults in your family unit in Ireland? (Age in years)
Adult 1 ☐☐ Adult 2 ☐☐ Adult 3 ☐☐ Adult 4 ☐☐ Adult 5 ☐☐

2.2 From which country did you come to Ireland?
☐ Nigeria ☐ Sierra Leone
☐ Romania ☐ Ukraine
☐ Poland ☐ Bulgaria
☐ Congo ☐ Iraq
☐ Zaire ☐ Czechoslovakia
☐ Algerian Other please specify _____

2.3 What language do YOU mainly speak at home?
(State one only) _____

2.4 Do YOU speak English? *Tick one Box Only*
Well ☐ Adequately ☐ A little bit ☐ Not at all ☐

2.5 How many people in your household speak English Well or Adequately?
State the number _____

2.6 Have YOU attended or are YOU attending classes for speaking English?
Yes ☐ No ☐

2.7 Would you like to attend classes to help you with speaking English?
Yes ☐ No ☐
If Yes, are there any problems that prevent you from doing so? Please specify.
_____
_____
_____
_____

Section 3

3.1a Have YOU had a general health check-up by a family doctor since you came to Ireland?
Yes ☐ No ☐

3.1b If there are children in the household under 16 have they had a general health check-up by a family doctor in Ireland?
All the children ☐ Some of the children ☐ None of the children ☐

3.1c Have you been tested for TB since you came to Ireland?
Yes ☐ No ☐

3.2a Are you or any of your household registered with a family doctor?
Yes ☐ No ☐
If no, why not?
_____
_____
_____
_____

3.3 In the last month, did you attend a family doctor?
Yes ☐ No ☐

3.4 Have any of the children in your household been vaccinated?
Yes ☐ No ☐

3.4a If yes, where?
Totally in Ireland ☐ Partially in Ireland ☐ Totally in country of origin ☐ Not at All ☐

Section 4

4.1a Do you have any problems, language or otherwise, making an appointment to see your family doctor?
Yes ☐ No ☐
If YES, what are the problems?
_____
_____
_____
_____

4.2 **Have you or your household ever needed an interpreter when seeing a family doctor in Ireland?**

Yes ☐ No ☐

4.3 **If Yes, how was this interpreting need met?** *Tick One Box Only*

☐ An Adult Relative ☐ Interpreting Service

☐ A Child Relative ☐ Practice Staff

Other... Please specify _____

Section 5

5.1 **Have you used any of the following health services since you have been in Ireland?**

Doctor/GP Practice _____ ☐
Optician _____ ☐
A chemist for advice _____ ☐
HIV test _____ ☐
Dentist _____ ☐
Counsellor _____ ☐
Psychiatric Service _____ ☐
Family planning services _____ ☐
Hospital Inpatient _____ ☐
Hospital Out Patient _____ ☐

5.2 **Has any member of your family used the Accident & Emergency Department at a hospital in Ireland?**

Yes ☐ No ☐

5.2a **If Yes, was that person**

An Adult ☐ A Child ☐

5.2 **If YES, how many times;** *State number of visits*

In the last 3 months ☐

In the last year ☐

5.4 **Have you had a baby born in Ireland?**

Yes ☐ No ☐

5.5 **Where was the baby born?**

In hospital ☐

In your own home ☐

Other please specify _____

5.6 **Did you use;**

	Yes	No	Not applicable
Hospital Ante Natal Clinics	☐	☐	☐
Ante Natal Classes	☐	☐	☐

Section 6

By placing a tick in one box in each group below, please indicate which statement best describes your own health state today.

6.1a **Usual activities** (e.g. work, study, housework, family or leisure activities)

Tick One Box Only

I have no problems with performing my usual activities ☐
I have some problems with performing my usual activities ☐
I am unable to perform my usual activities ☐

6.1b **Pain/discomfort** *Tick One Box Only*

I have no pain/discomfort ☐
I have moderate pain/discomfort ☐
I have extreme pain/discomfort ☐

6.2 **How would you rate your quality of life?**

Very poor ☐ Poor ☐ Mediocre ☐ Good ☐ Very Good ☐

6.3 **How satisfied are you with your health?** *Tick One Box Only*

Very dissatisfied ☐ Dissatisfied ☐ Indifferent ☐ Satisfied ☐ Very Satisfied ☐

6.4 **Have you ever been diagnosed by a doctor with any of the following?**

Angina ☐ Asthma ☐
Heart attack (coronary thrombosis, myocardial infarction) ☐
Bronchitis or other respiratory illnesses ☐
High blood pressure ☐ Diabetes ☐
Stroke ☐ High cholesterol ☐
Anxiety ☐ Depression ☐
Fits or epilepsy ☐ Allergies ☐
Skin diseases ☐ Other, please specify _____

6.5 **Do you regularly take any prescribed pills or medication?**

Yes ☐ No ☐

Section 7

We would like to know if you have had any medical complaints and how your health has been in general over the LAST FEW WEEKS. (The General Health Questionnaire)

Have you recently; *Tick One Box Only*

		Better Than Usual	Same As Usual	Less Than Usual	Much Less Than Usual
7.6	been able to concentrate on what ever you're doing	☐	☐	☐	☐

		Not at all	No More Than Usual	Rather More Than Usual	Much More Than Usual
7.7	lost much sleep over worry?	☐	☐	☐	☐

		More So Than Usual	Same As Usual	Less Useful Than Usual	Much Less Useful
7.8	felt that you are playing a useful part in things?	☐	☐	☐	☐

		More So Than Usual	Same As Usual	Less So Than Usual	Much Less Capable
7.9	felt capable of making decisions about things?	☐	☐	☐	☐

		Not at all	No More Than Usual	Rather More Than Usual	Much More Than Usual
7.10	felt constantly under strain?	☐	☐	☐	☐

		Not at all	No More Than Usual	Rather More Than Usual	Much More Than Usual
7.11	felt you could not overcome your difficulties?	☐	☐	☐	☐

		More So Than Usual	Same As Usual	Less So Than Usual	Much Less Than Usual
7.12	been able to enjoy your normal day to day activities?	☐	☐	☐	☐

		More So Than Usual	Same As Usual	Less So Than Usual	Much Less Able
7.13	been able to face up to your problems?	☐	☐	☐	☐

		Not at all Than Usual	No More Than Usual	Rather More Than Usual	Much More
7.14	been feeling unhappy & depressed?	☐	☐	☐	☐

		Not at all	No More Than Usual	Rather More Than Usual	Much More Than Usual
7.15	been losing confidence in yourself?	☐	☐	☐	☐

		Not at all	No More Than Usual	Rather More Than Usual	Much More Than Usual
7.16	been thinking of yourself as a worthless person?	☐	☐	☐	☐

		More So Than Usual	About Same As Usual	Less So Than Usual	Much Less Than Usual
7.17	been feeling reasonably happy, all things considered?	☐	☐	☐	☐

8.1 How would you describe your smoking status?

Current Smoker ☐ Ex-Smoker ☐ Non-Smoker ☐

8.2 If you are a current smoker, how long have you been smoking?_____(Years)

8.3 If you are a current smoker how many of the following do you usually smoke?

Branded cigarettes _____

Hand rolled cigarettes _____

8.4 Do you drink alcohol?

Yes ☐ No ☐

8.5a If YES, how many units a week?

Show flashcard

State number _____ *units*

8.5b On how many occasions (if any) have you used marijuana (grass, pot, cannabis, hash, hash oil)?
(Please tick one answer for each line)

	Number of Occasions				
	Never	1-2	3-5	6-9	10+
In your lifetime	☐	☐	☐	☐	☐
During the last 12 months	☐	☐	☐	☐	☐
During the last 30 days	☐	☐	☐	☐	☐

8.6 How often do you eat fried foods?

Daily ☐ 4-6 times a week ☐ 1-3 times a week ☐ Less than once a week ☐

8.7 How often do you add salt to your food at the table?

Always ☐ Rarely ☐ Usually ☐ Never ☐ Sometimes ☐

8.8 Do you think that your diet could be healthier?

Yes ☐ No ☐

8.9 **If Yes, How?**

More vegetables ☐ More meat/fish ☐

Flavourings/ Different Spices ☐ More fruit ☐

Less fried foods ☐ Other please specify _____

Section 9

Education/Employment

9.1 **At what age did you leave school?** _____ (Years)

9.2 **What did your education consist of?** *Tick One Box Only*

No schooling ☐

Primary school education only ☐

Some secondary education ☐

Complete secondary education ☐

Some third level education at university, technological institute ☐

Complete third level education at university, technological institute ☐

9.3 What did you work at before you arrived in Ireland?

Unemployed ☐

House Duties only ☐

Other (please state) _____

9.4 **What did your spouse (your father if you are unmarried) work at before you arrived in Ireland?**

Unemployed ☐

House Duties only ☐

Other (please state) _____

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We wish to dedicate this piece of work to immigrants to our shores and trust that it will contribute to their positive health.