

102935



REFERENCE  
ONLY

**EASTERN HEALTH BOARD/PAVEE POINT**

**PRIMARY HEALTH CARE PROJECT  
FOR  
TRAVELLERS**

**Preliminary report on Results of Baseline Survey**

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INFORMATION SERVICE**

**8th June 1995**

## **Results of Primary Health Care Baseline Survey**

**Study carried out December 1994 - March 1995**

***Five Sites Surveyed:***

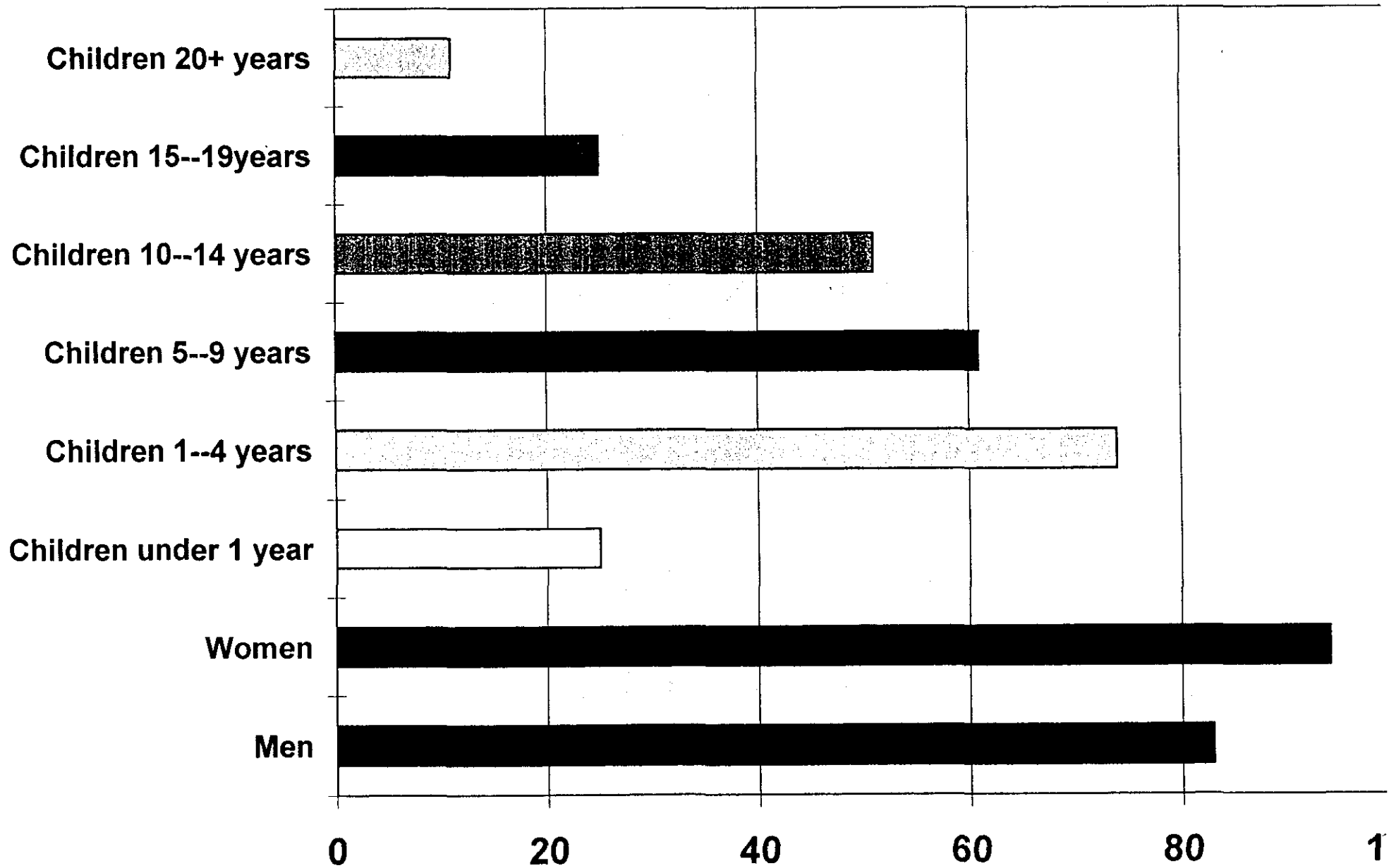
- **Avila Park**
- **Cappagh Field**
- **St Marys Park**
- **Dunsink Lane Halting Site**
- **Roadside Dunsink**

***Total Number of Families surveyed: 88***

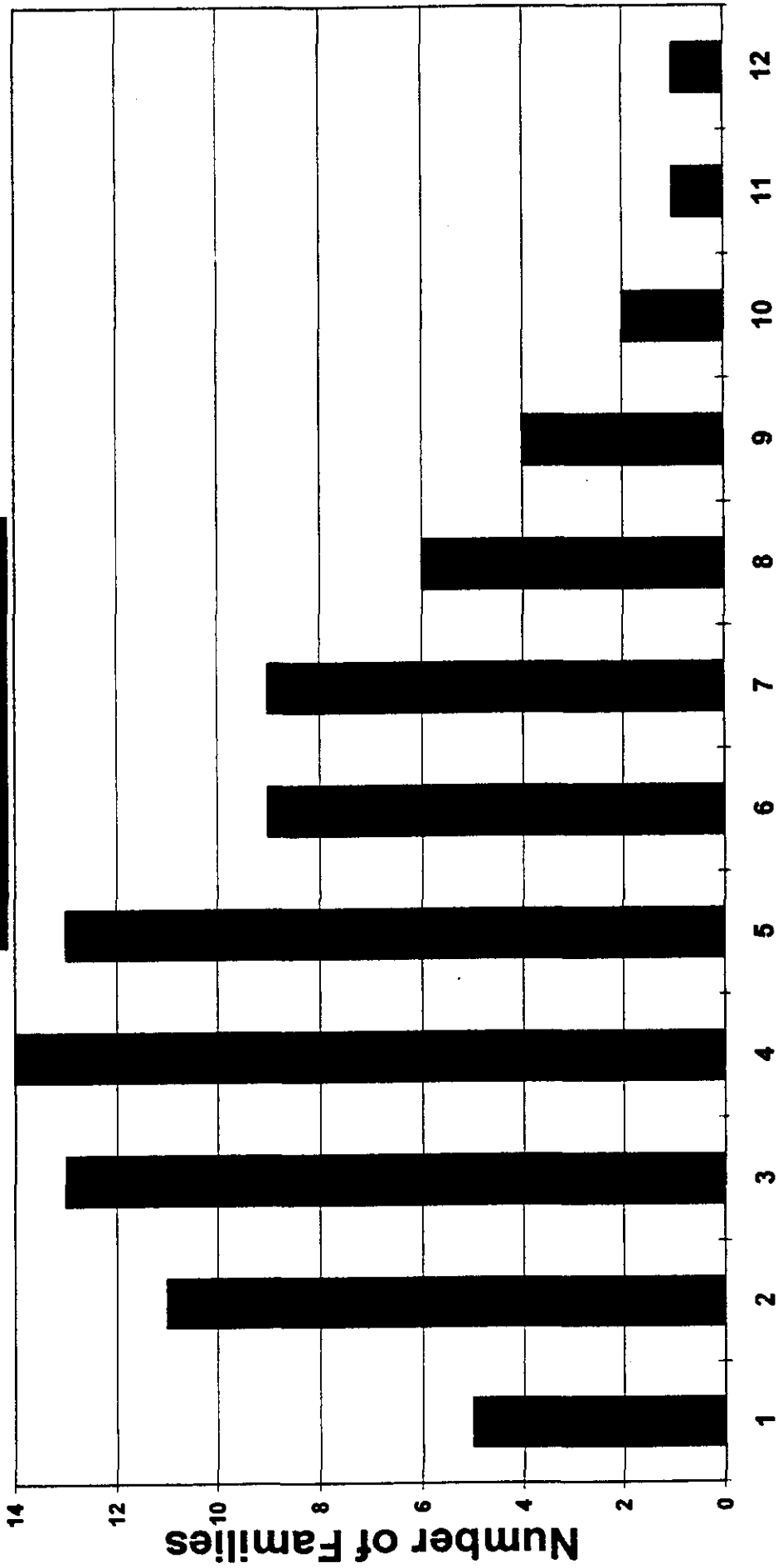
*Number of Families on Each Site*

• Avila Park:	23
• Cappagh Field:	14
• St Mary's Park:	10
• Dunsink Lane Halting Site:	25
• Roadside Dunsink:	<u>16</u>
<i>Total:</i>	<i>88 families</i>

# FAMILY DETAILS

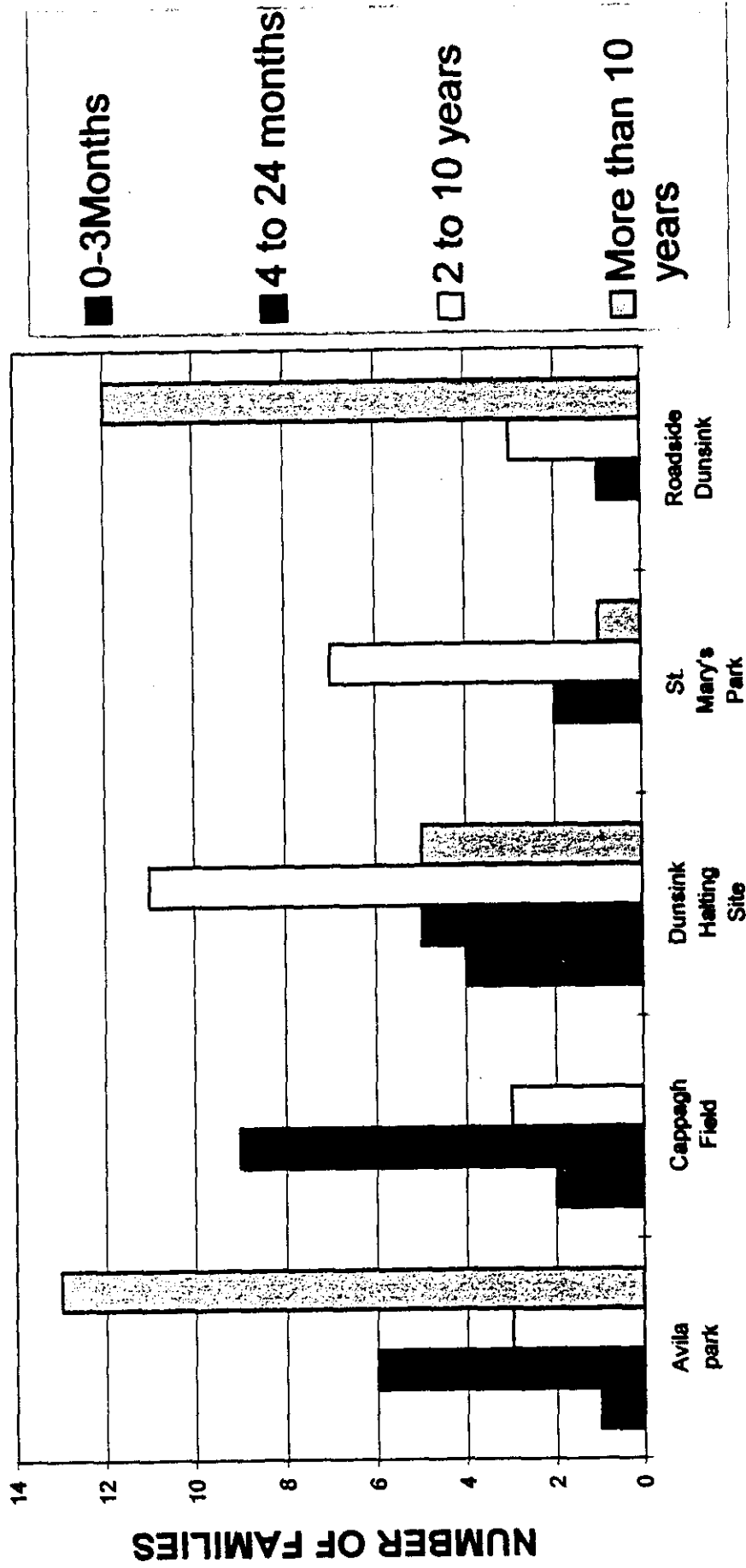


# Family Size

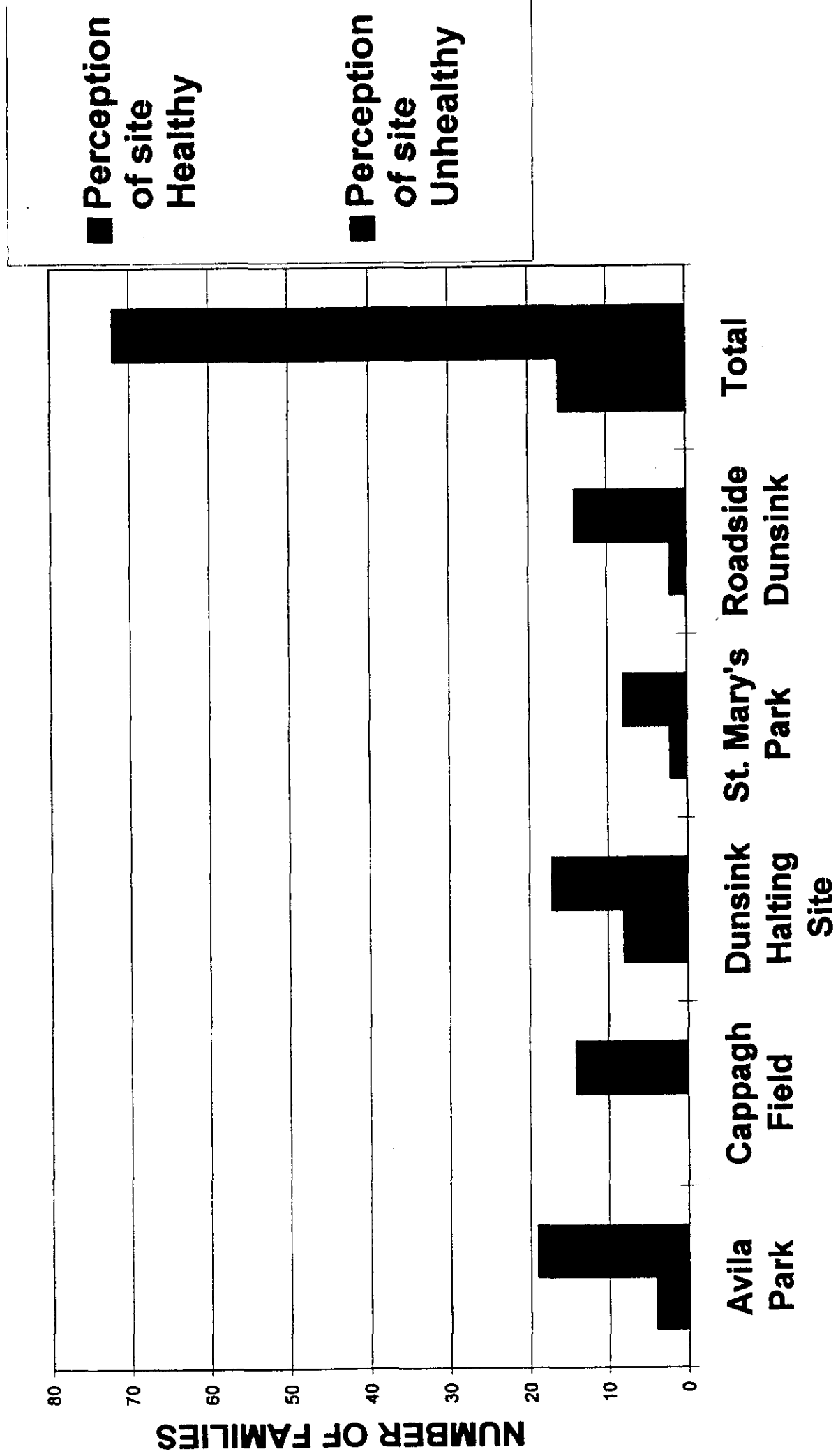


Total Number Of People in Family

# Length Of Stay At Site



# Perception of Site (Healthy/Unhealthy)

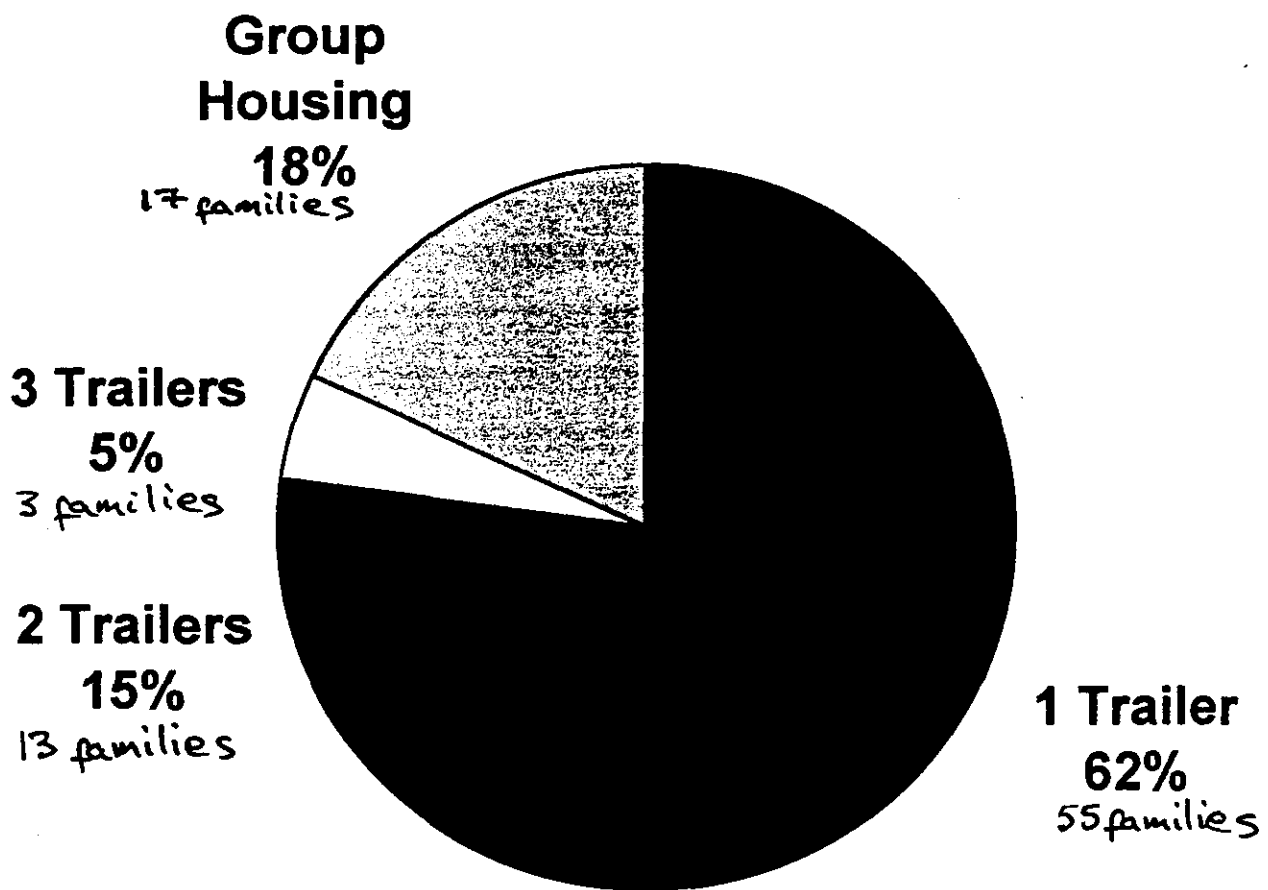




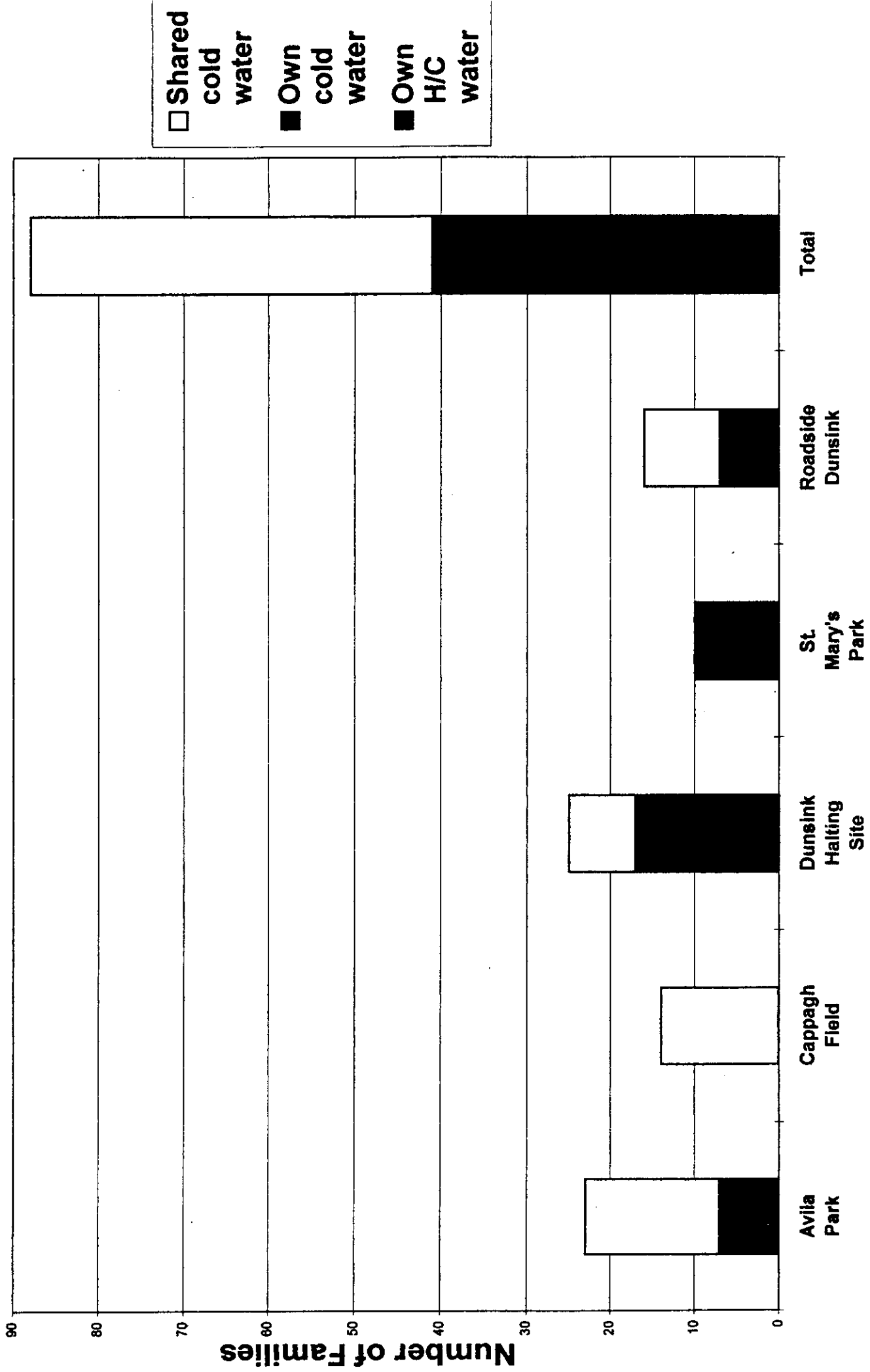
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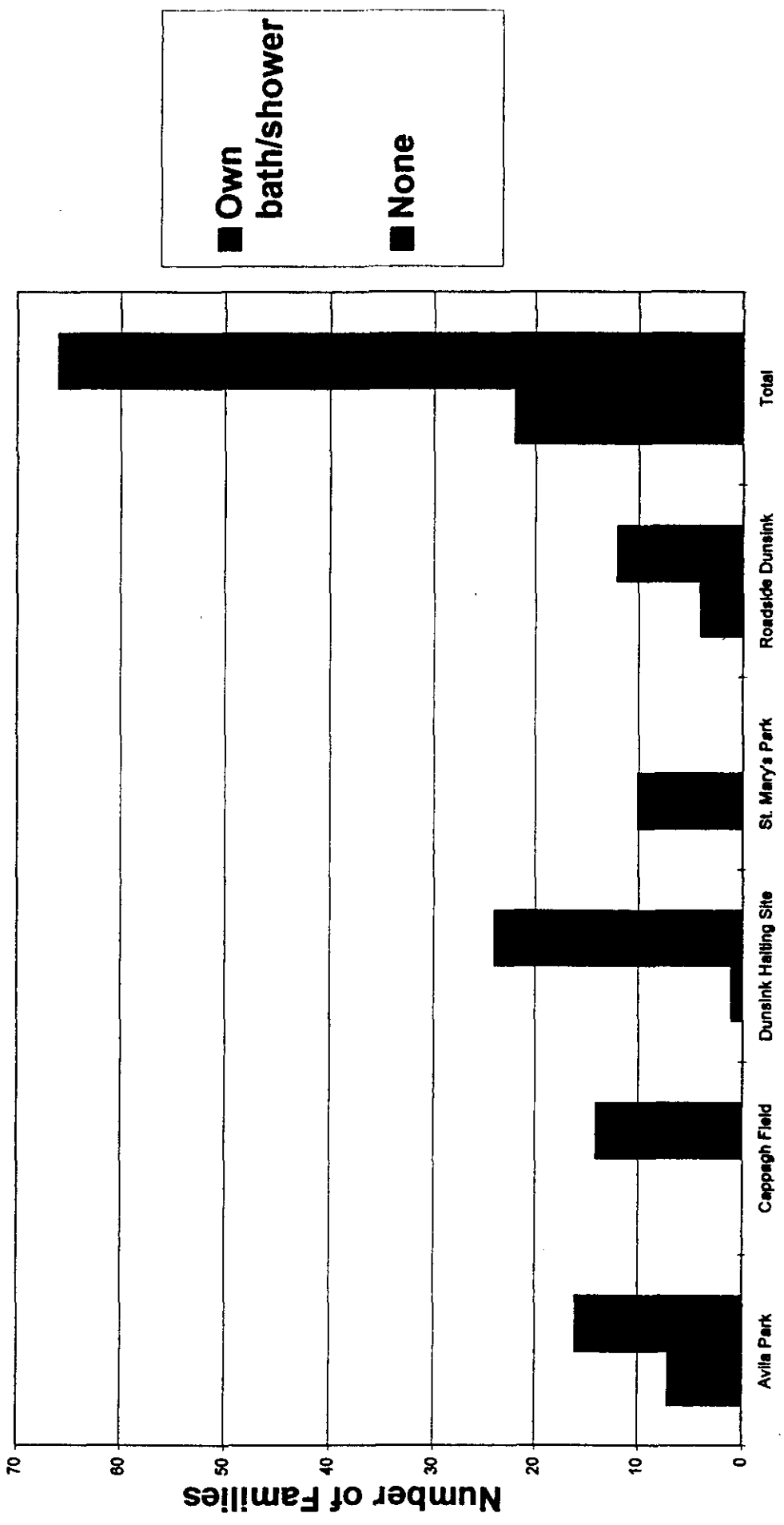
# ACCOMMODATION



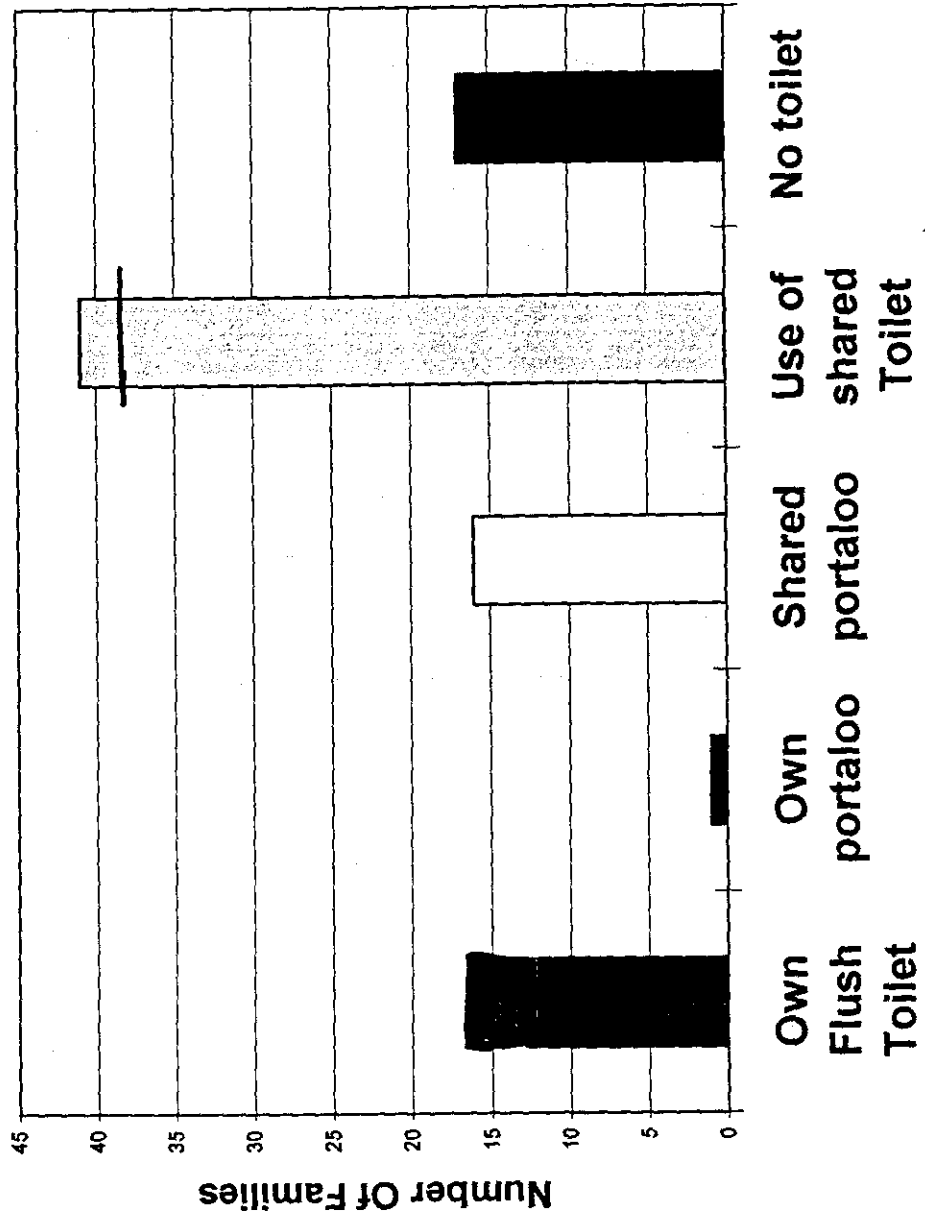
# Water Supply



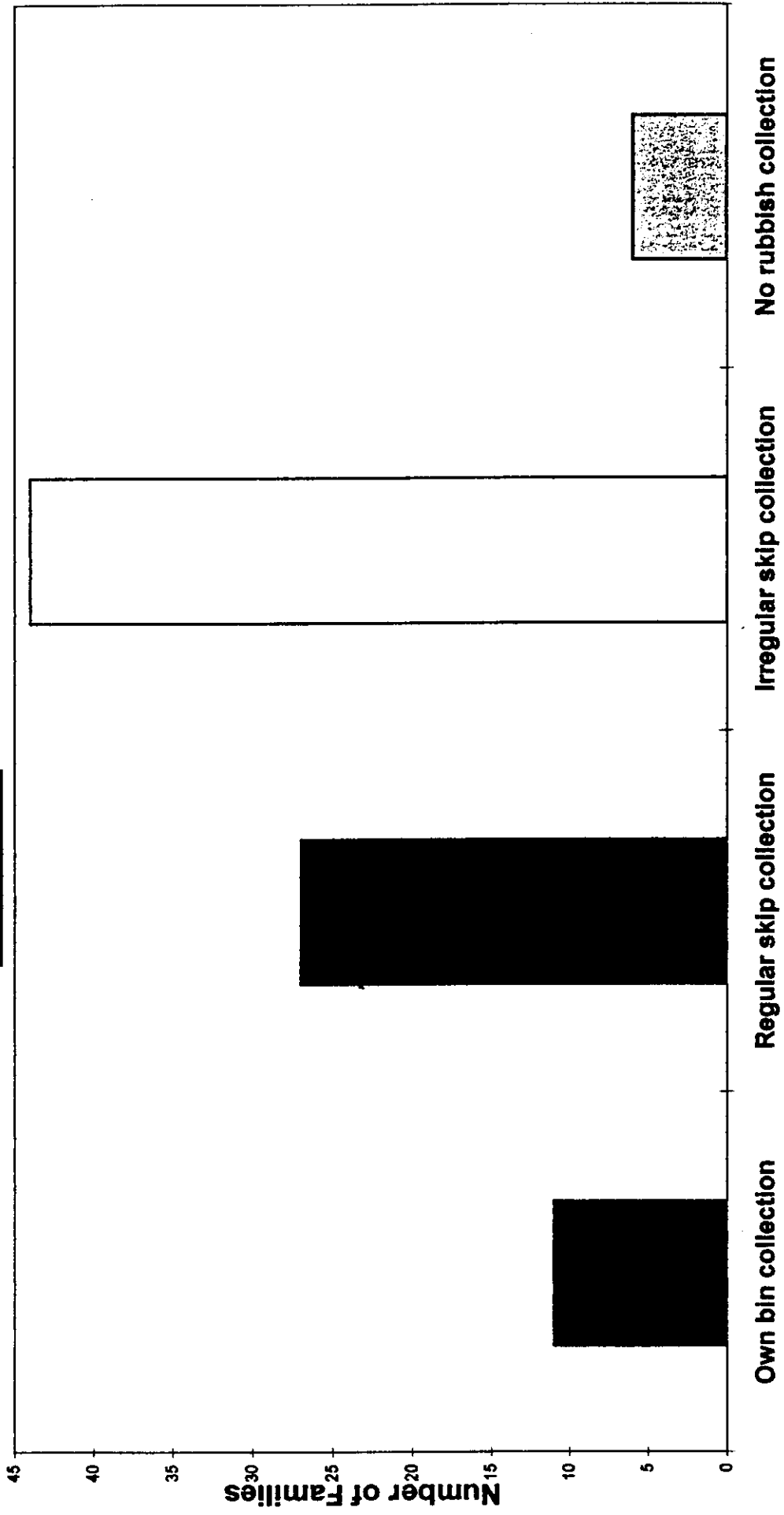
# Bath/Shower Availability



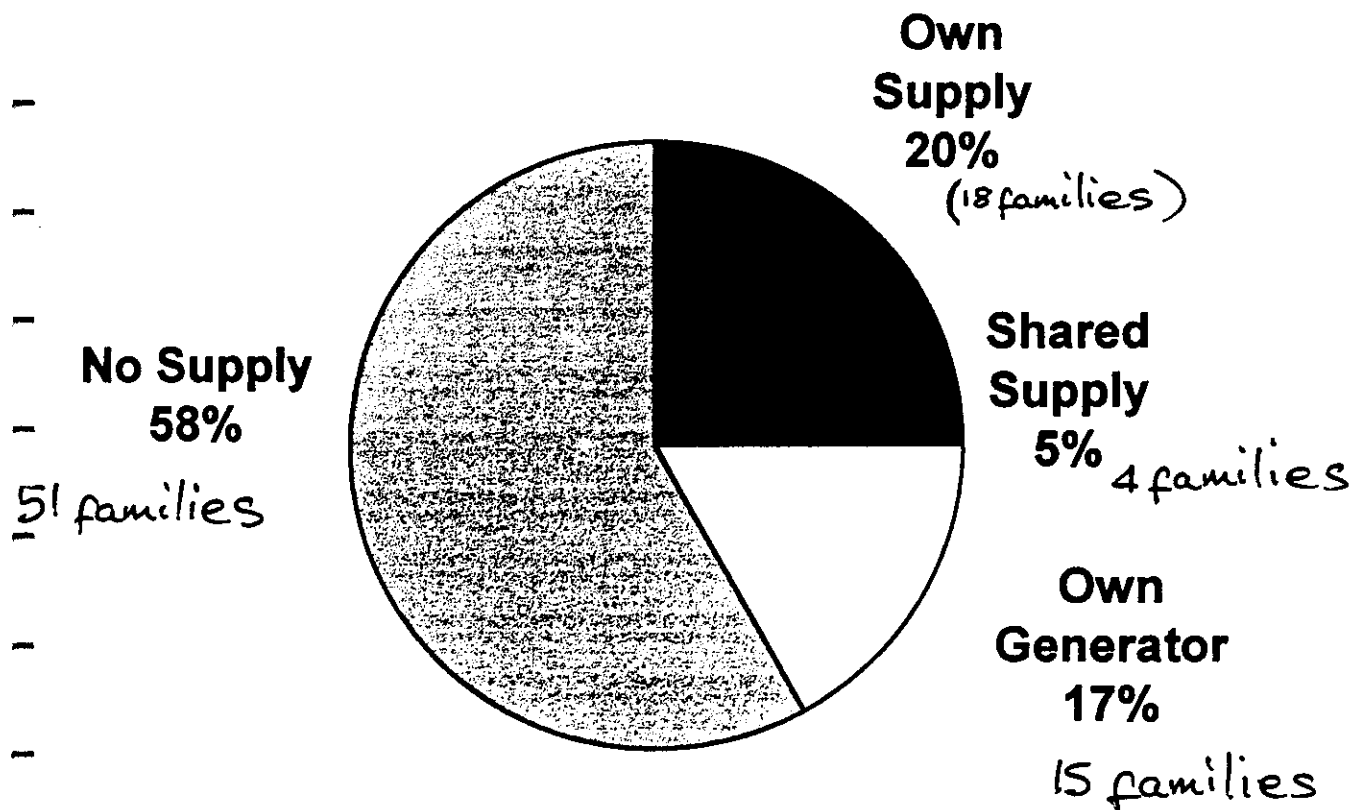
# Toilet Facilities All Sites



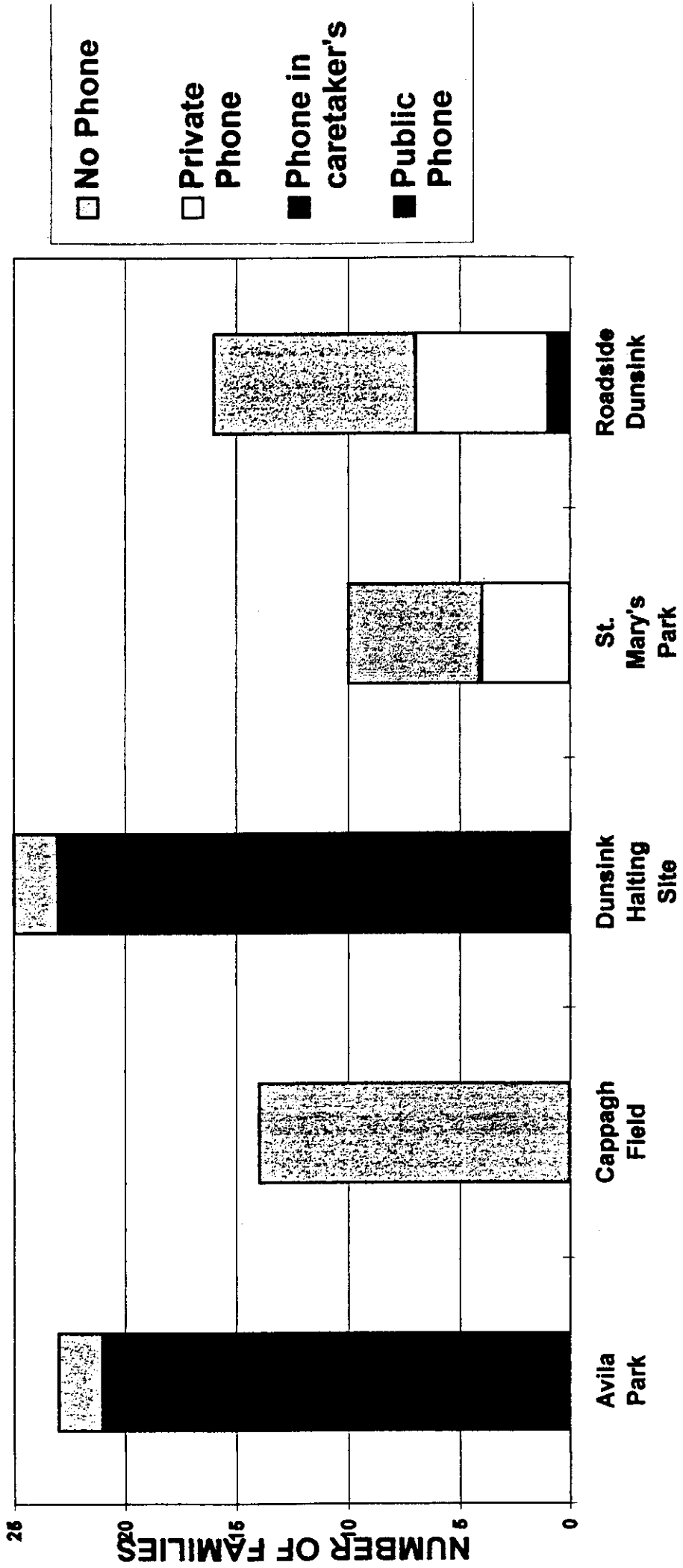
**Rubbish Collection**  
**All Sites**



# ELECTRICITY SUPPLY ON ALL SITES

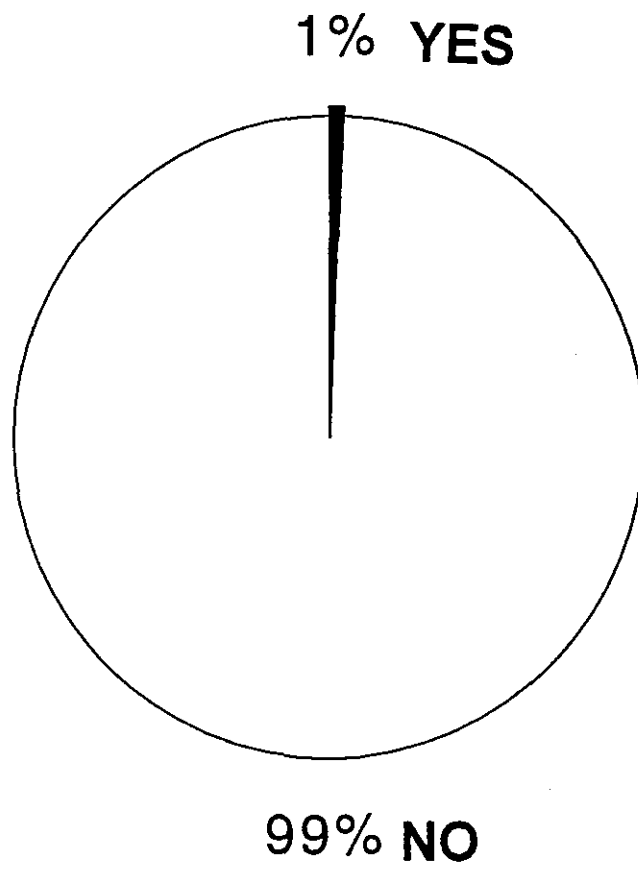


# Phone on Site





# PLAY FACILITIES



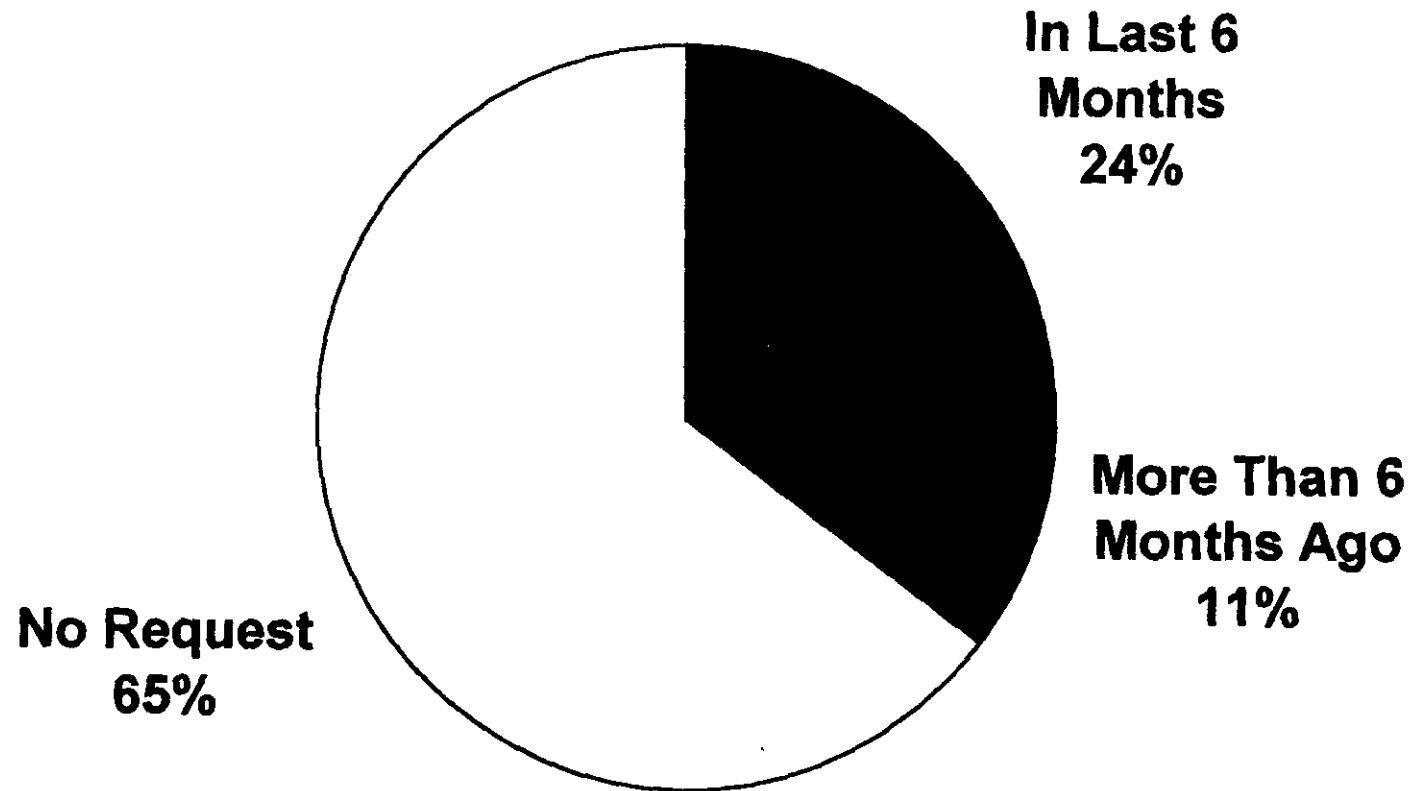
- **There are no play facilities on any of the sites surveyed**

- **Fire Prevention:**

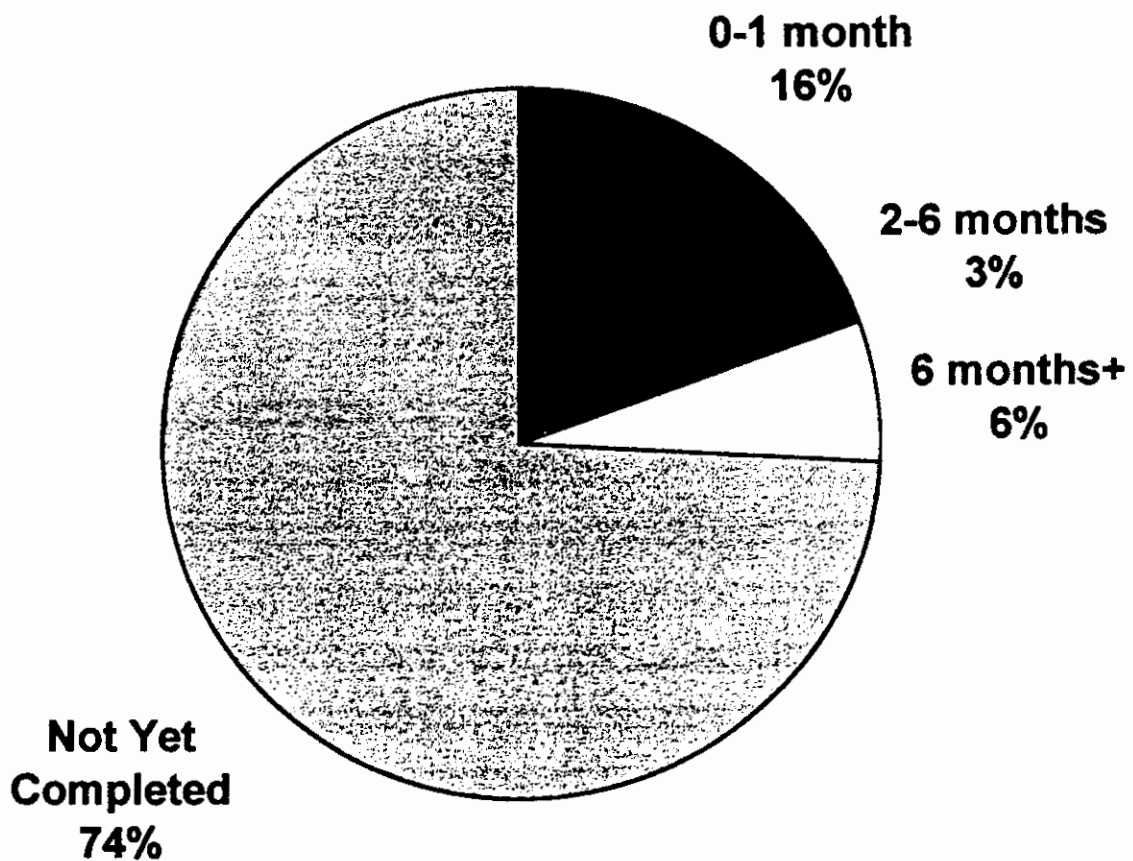
- 1. **Fire Hoses: 2**
- 2. **Fire Extinguisher: 1**
- 3. **No Fire Precautions: 85**

- **There is no public telephone on any of the sites.**

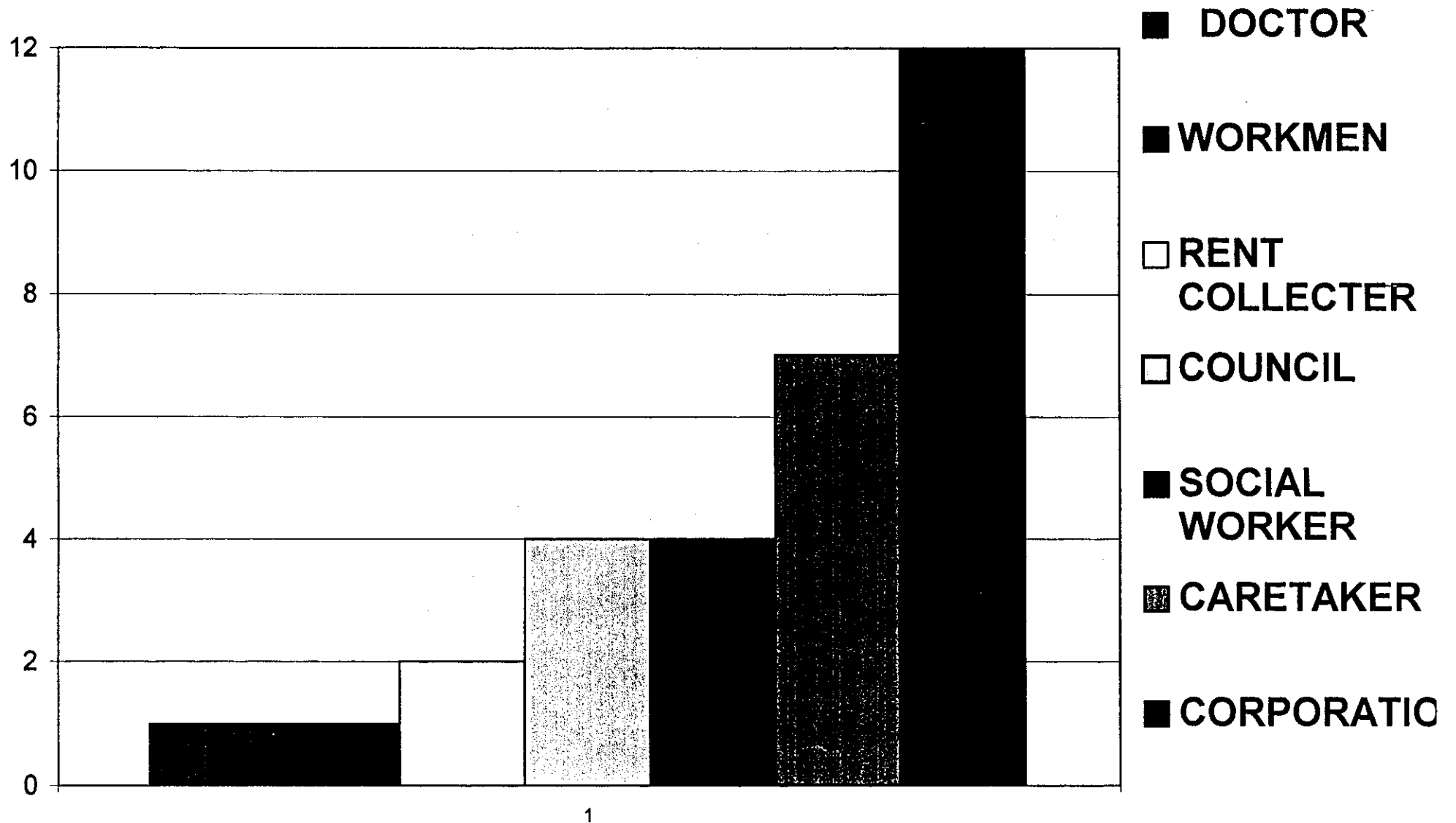
# Last Request For Repairs



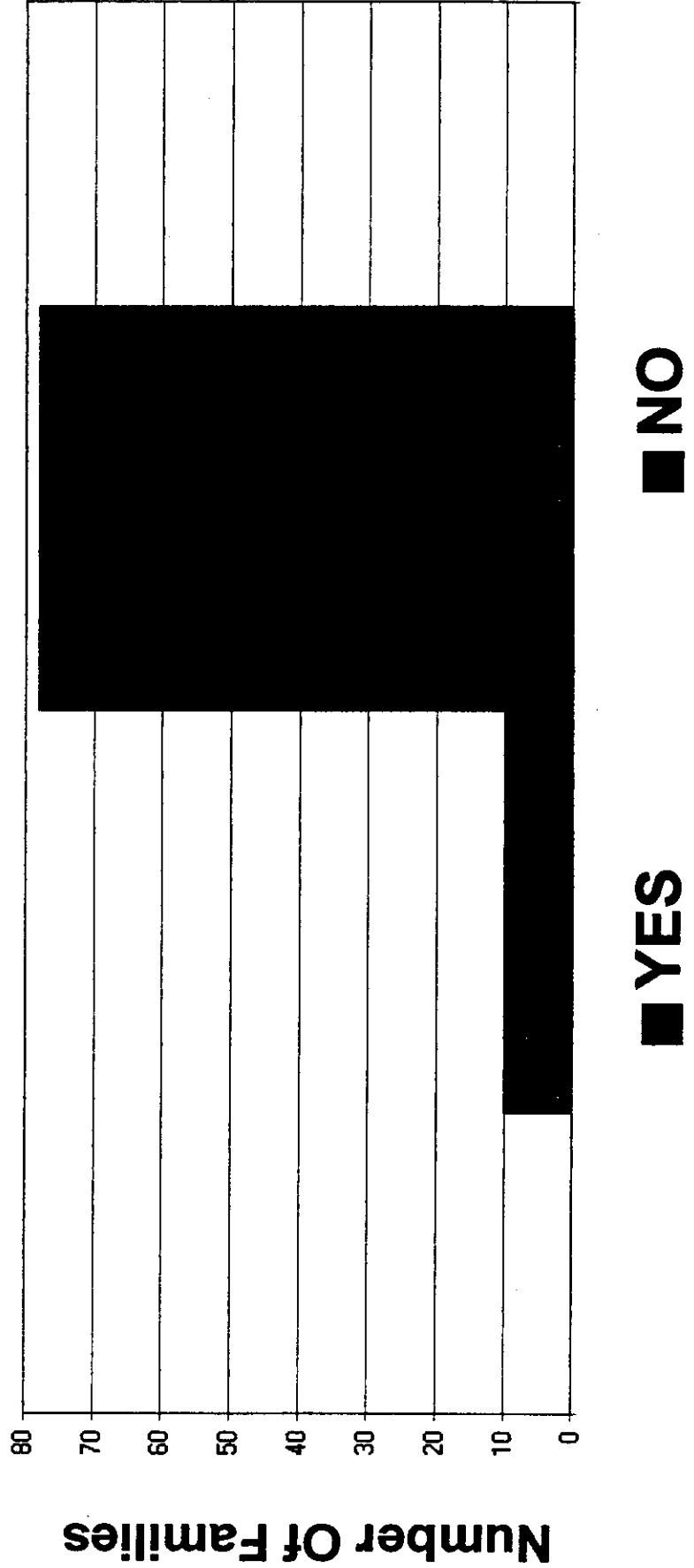
# How Long For Repairs To Be Completed?



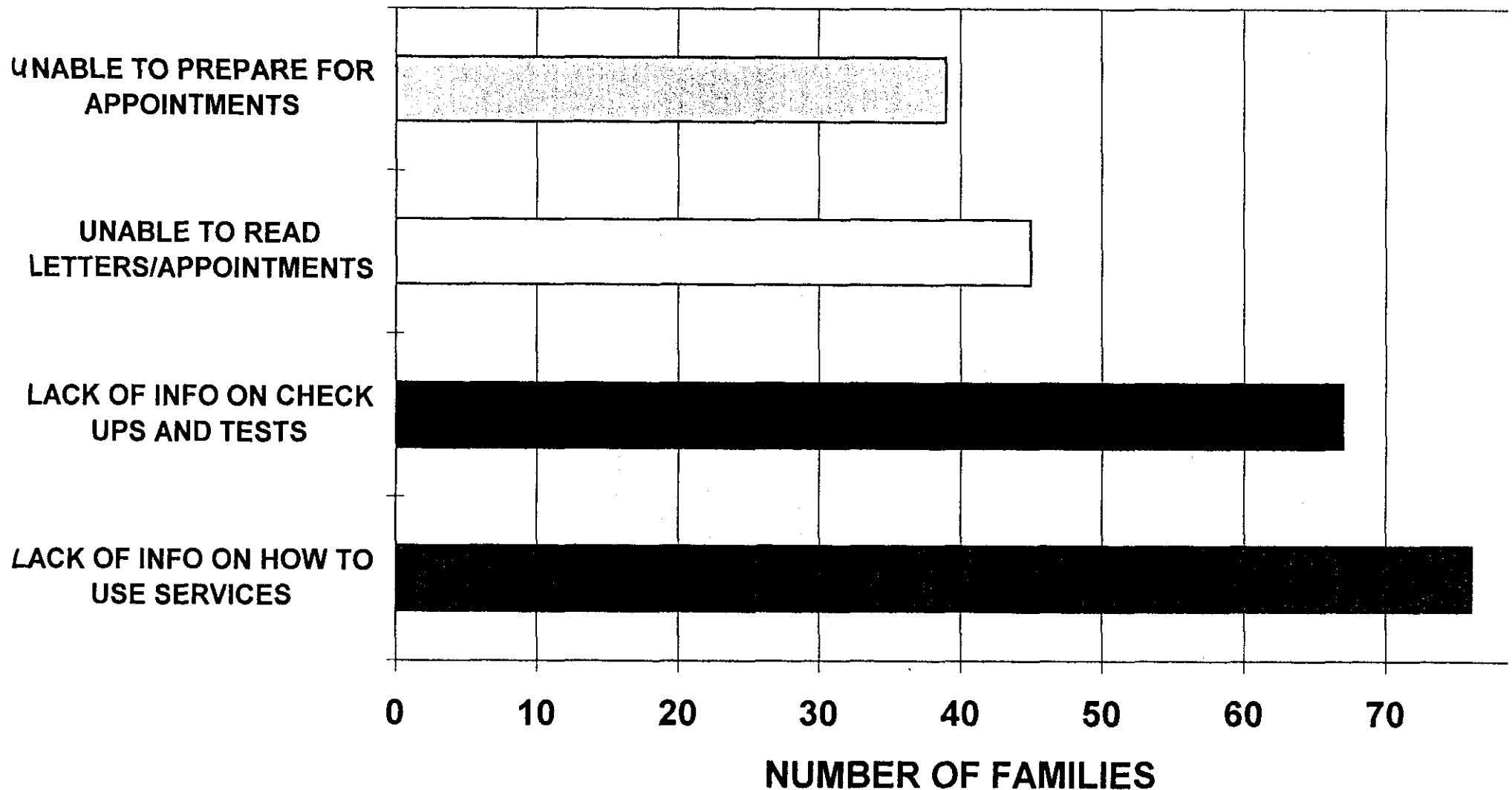
# REQUEST FOR REPAIRS--TO WHOM?



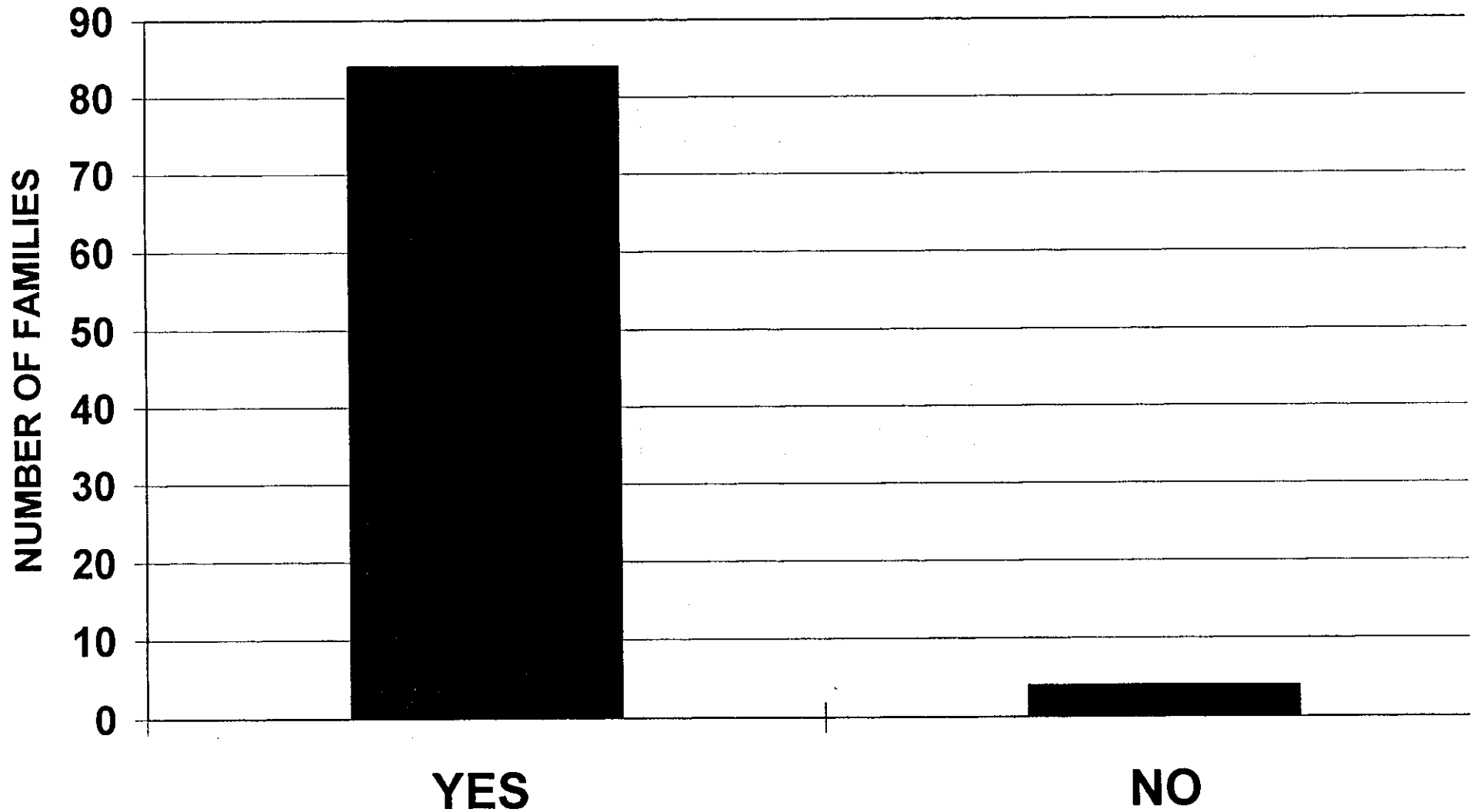
# Understanding Of Entitlements In The Health Services



# REASONS FOR LACK OF UNDERSTANDING OF HEALTH SERVICES

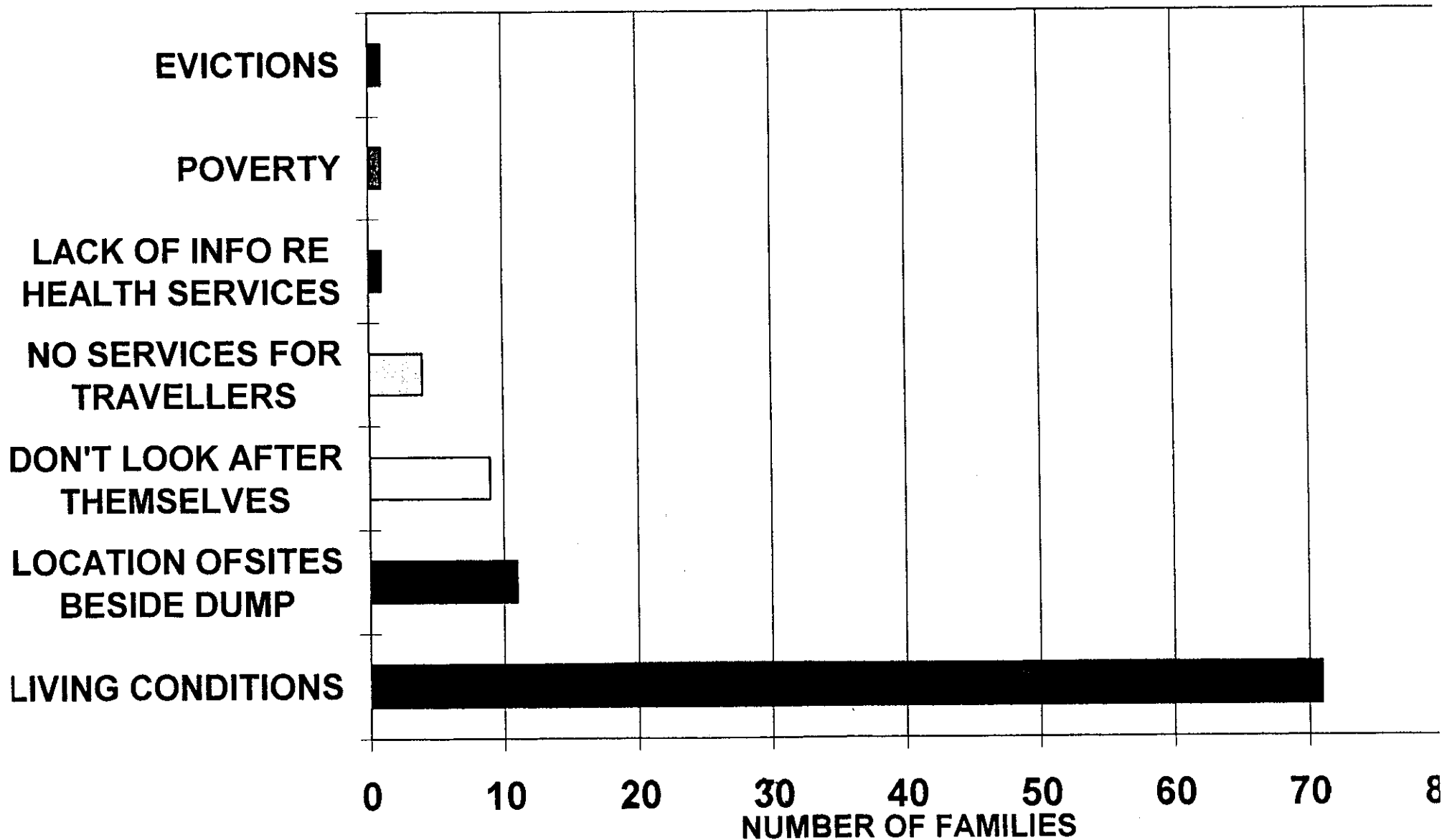


# TRAVELLERS MORE ILLNESS THAN OTHERS?

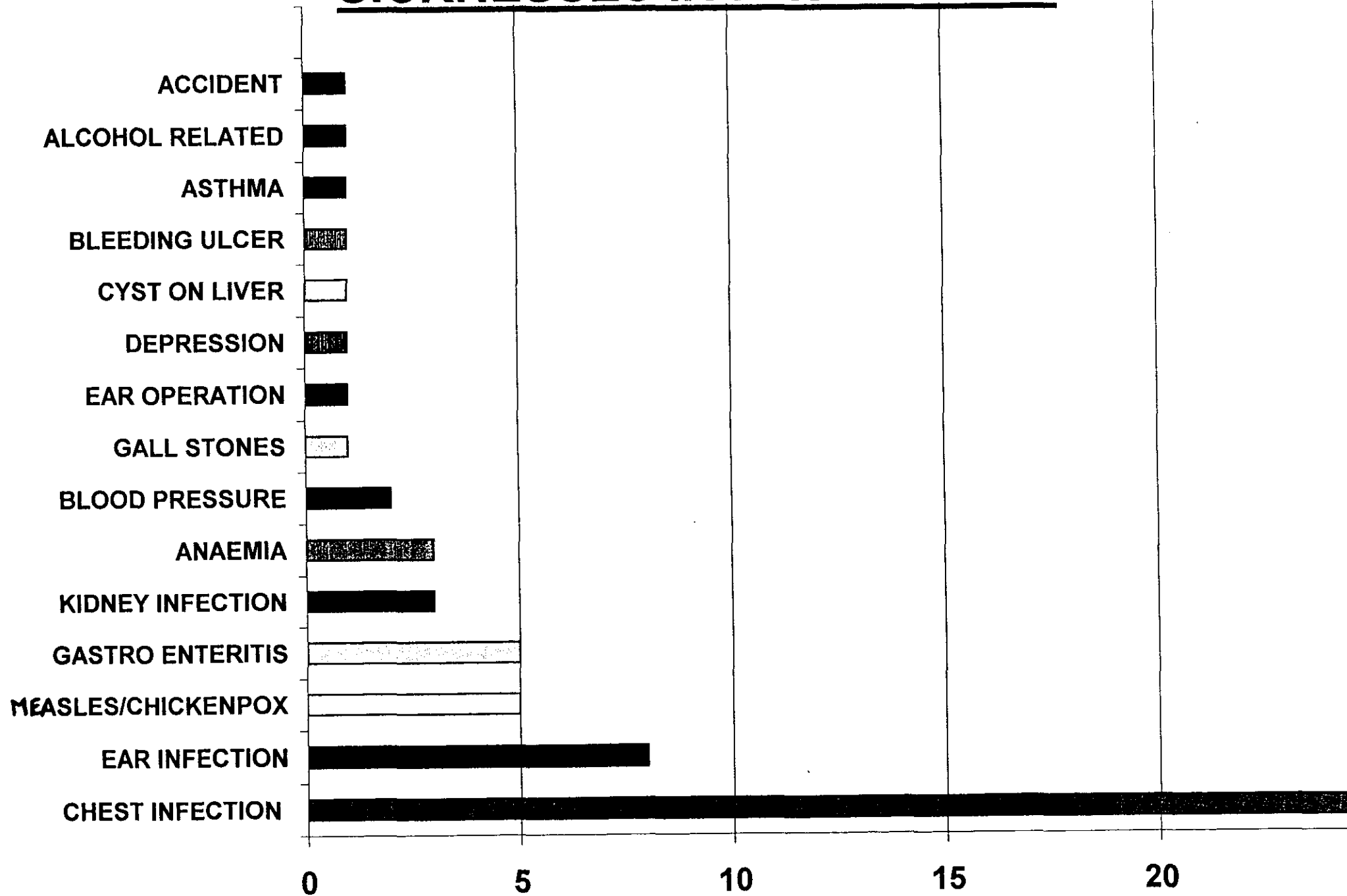




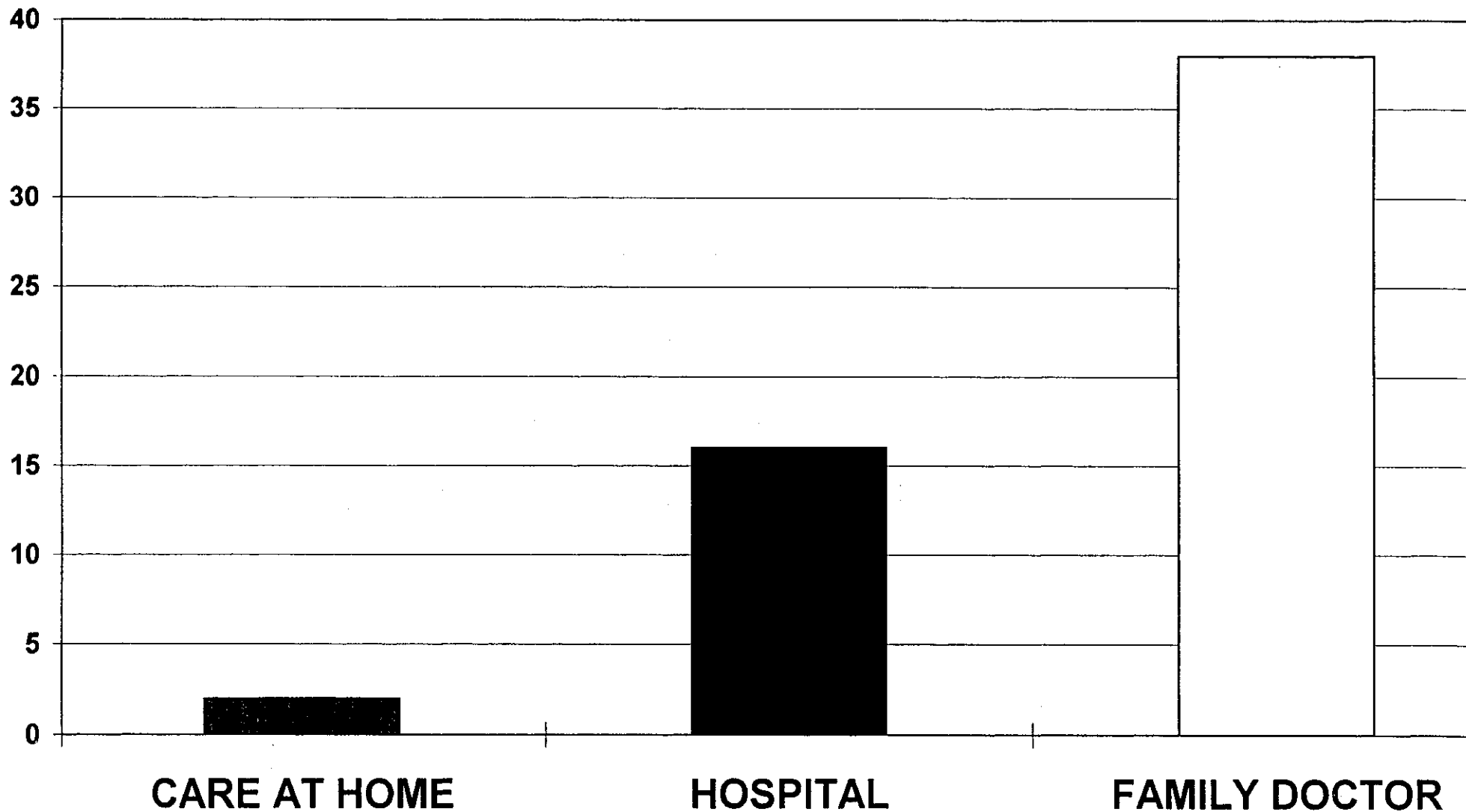
# WHY TRAVELLERS HAVE MORE ILLNESS THAN OTHERS?



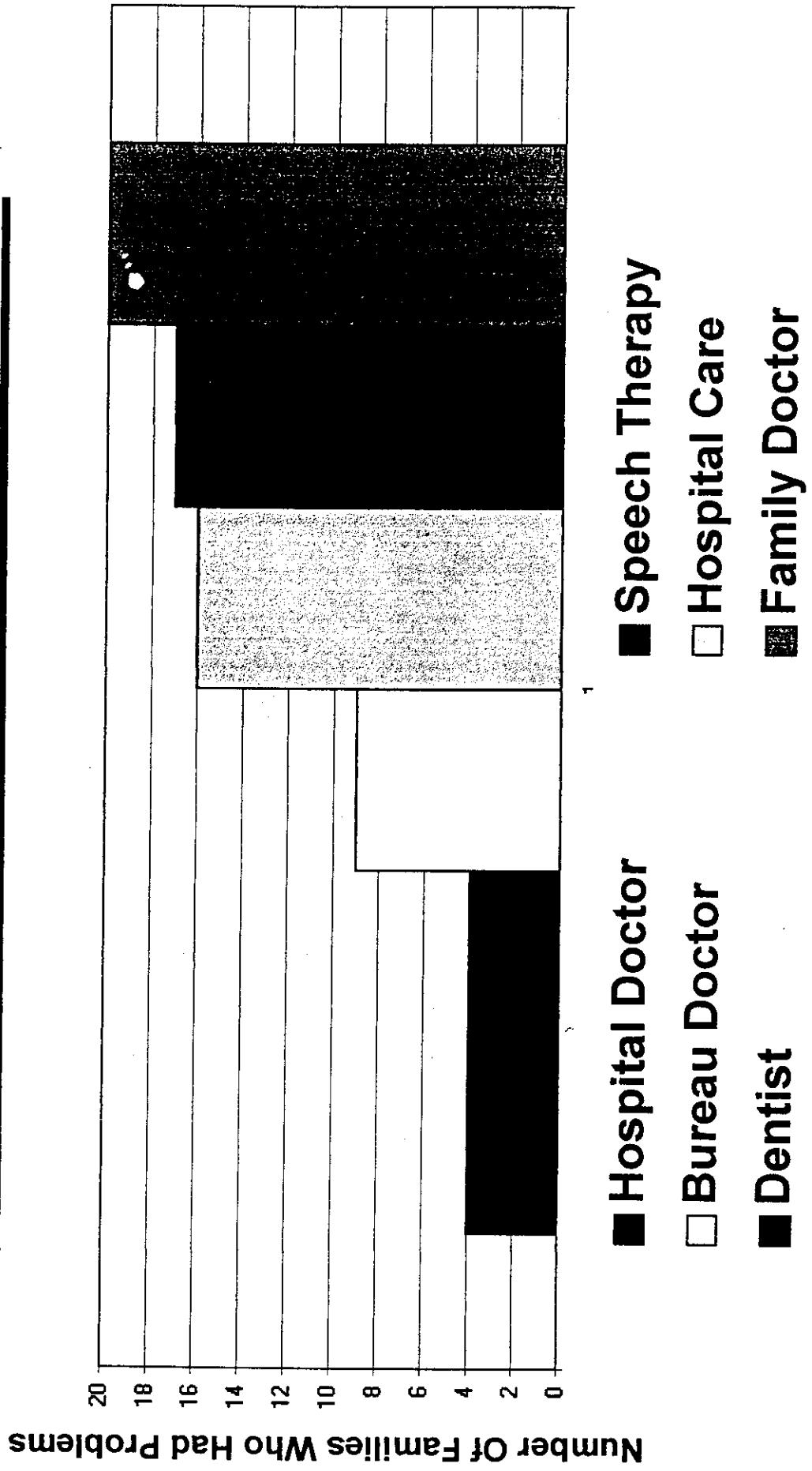
# SICKNESSES IN PAST MONTH



# SERVICES USED FOR SICKNESSES IN PAST MONTH



# Problems With Health Services



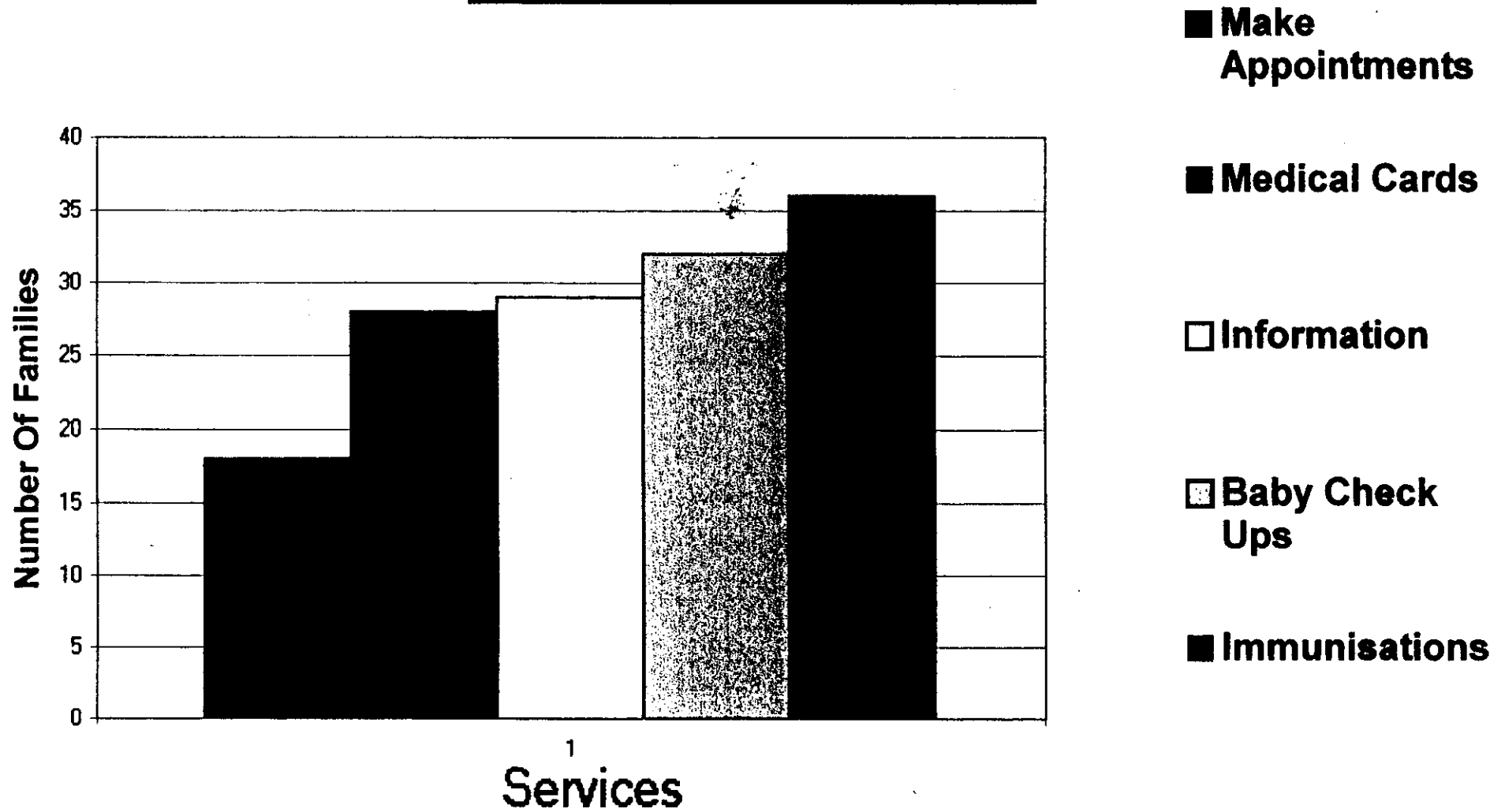
## MOBILE CLINIC

**46 of the 88 families surveyed use the mobile clinic**

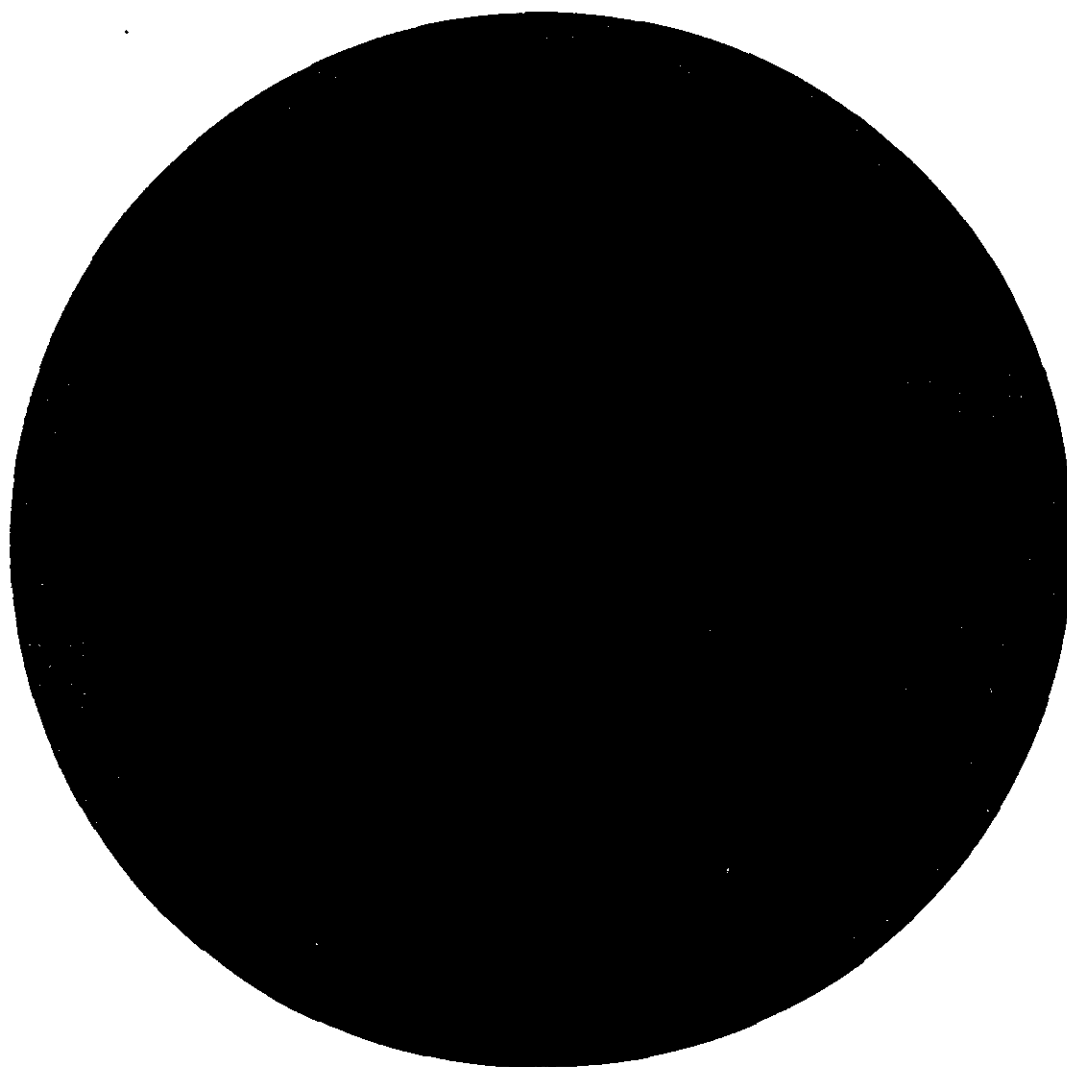
**29 of these families stated they can avail of it every second month**

**13 said they use it monthly**

# Use Of Mobile Clinic

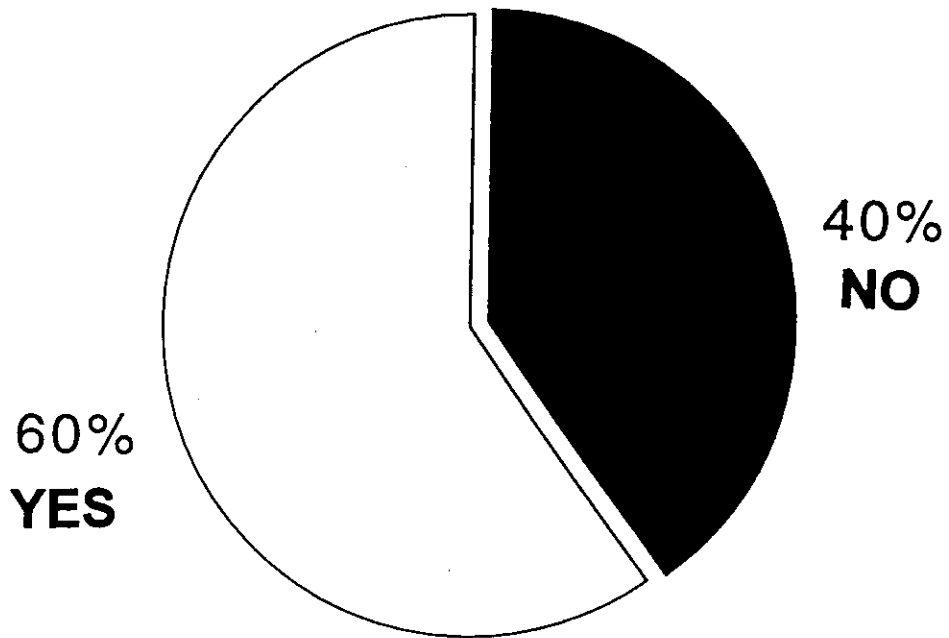


**Are Visits from**  
**Traveller Community**  
**Workers A Good**  
**Idea?**



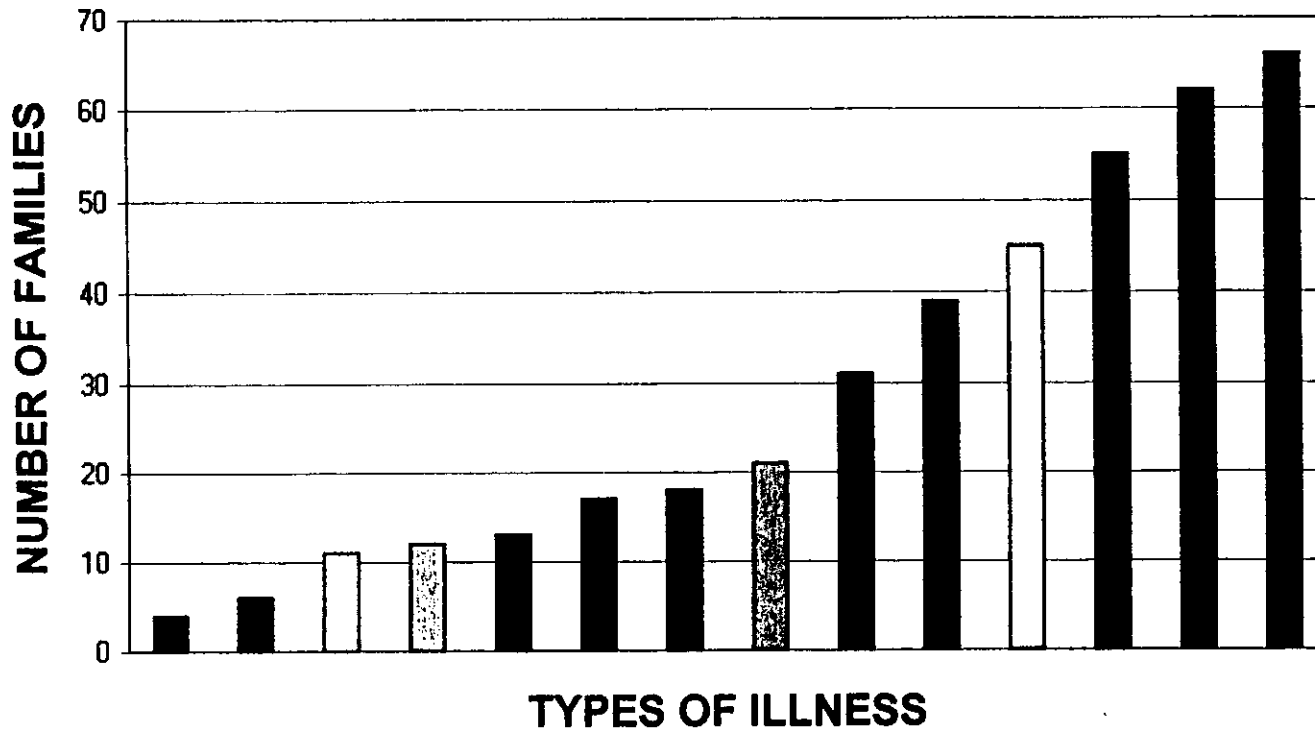
**GOOD  
IDEA !  
100%**

# Family Member With Ongoing Health Problem



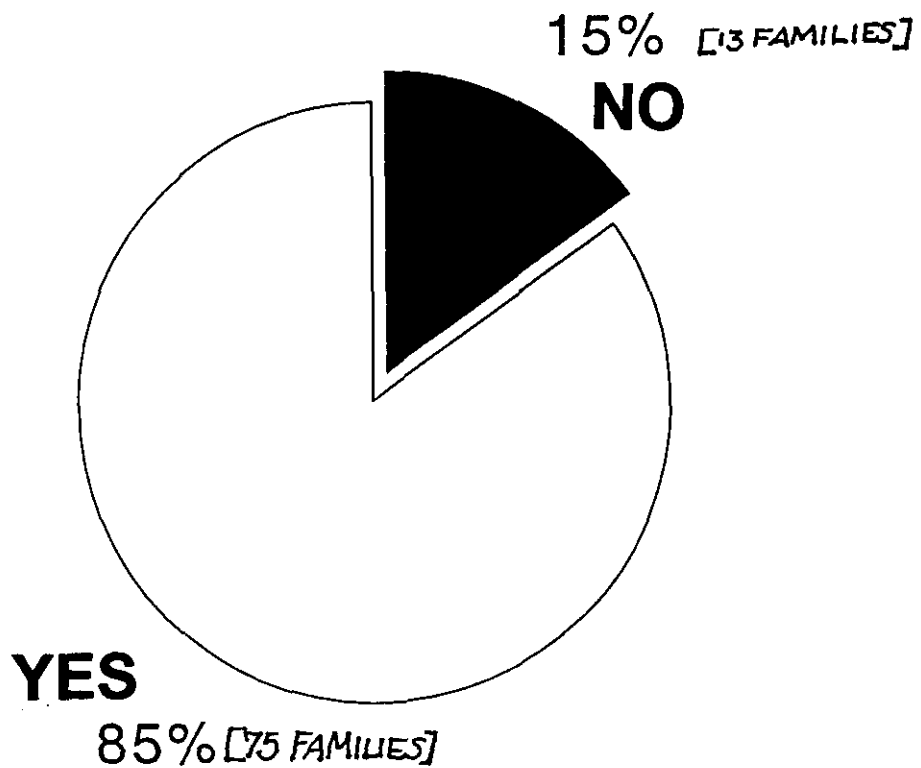


# Main Health Problems

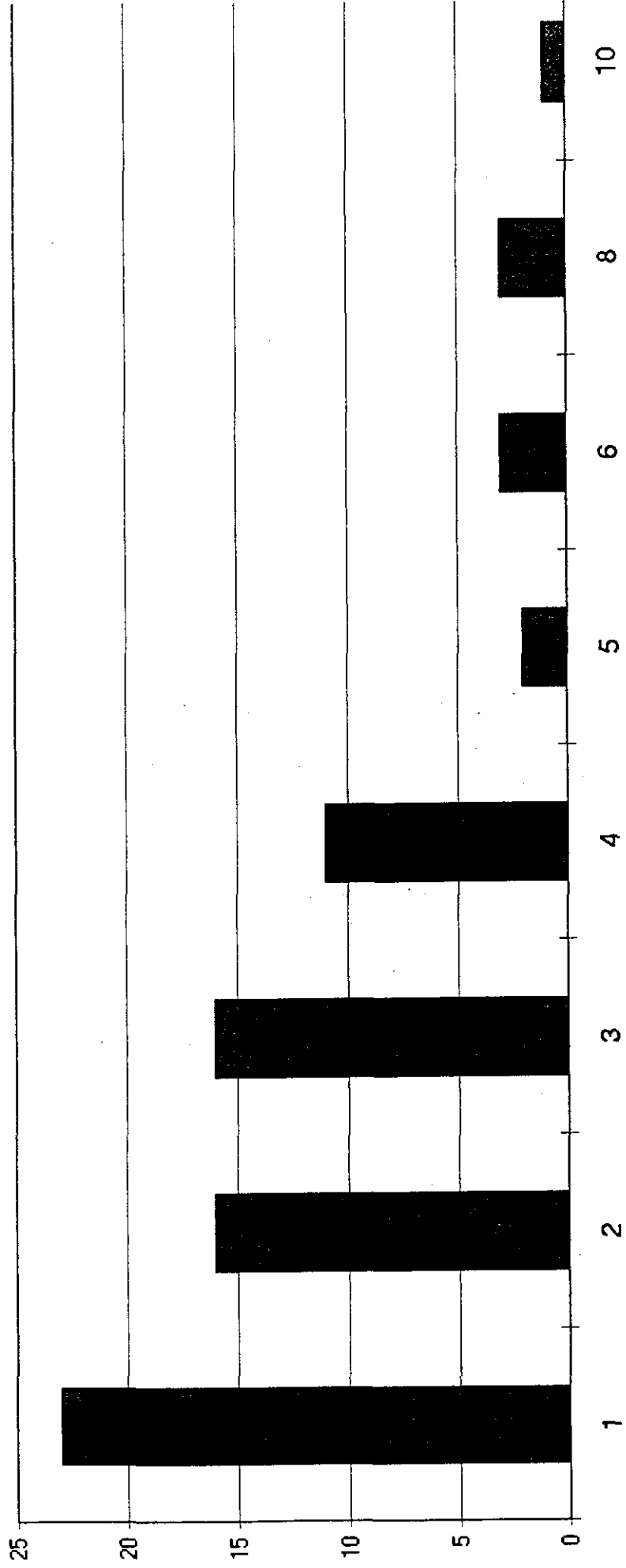


- Problem with Alcohol/Tablets
- Epilepsy
- Bed wetting
- Speech
- Hearing Problems
- Ulcers
- Arthritis
- ▣ Depression
- Gastro-enteritis
- Kidney infection
- Ear Infections
- Chest Infections
- Throat Infections
- Runny Nose

# Number Who Attended Family Doctor In Past Month



# Number Of Visits To Family Doctor In Past Month



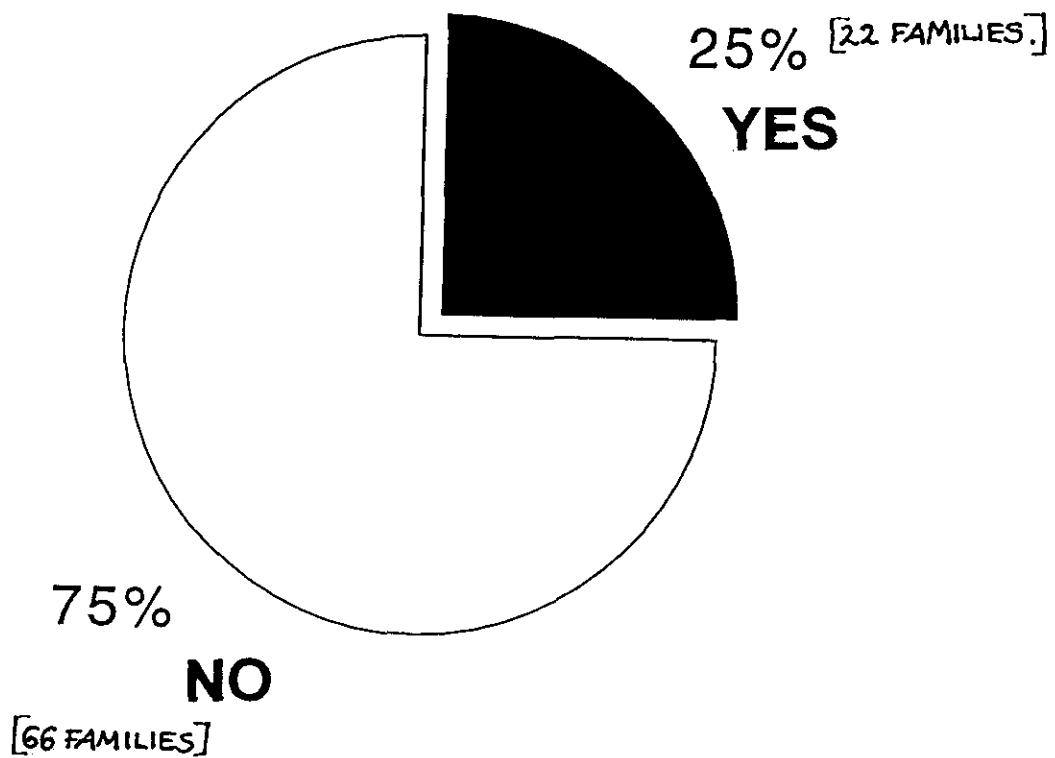
Number Of Visits To The Doctor

**Do you go to your local clinic to see the nurse or doctor ?**

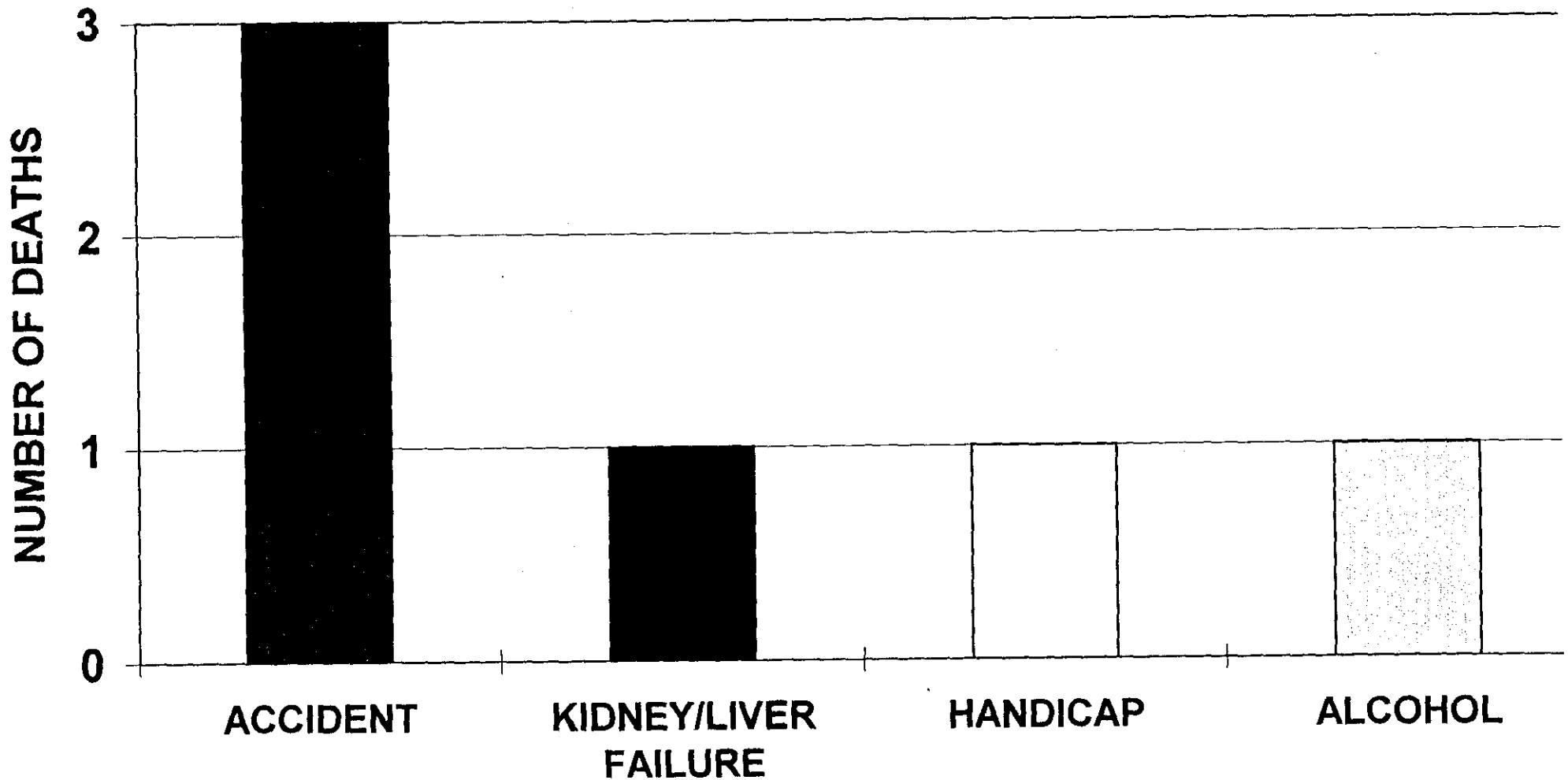
**Yes:            27 families**

**No:             61 families**

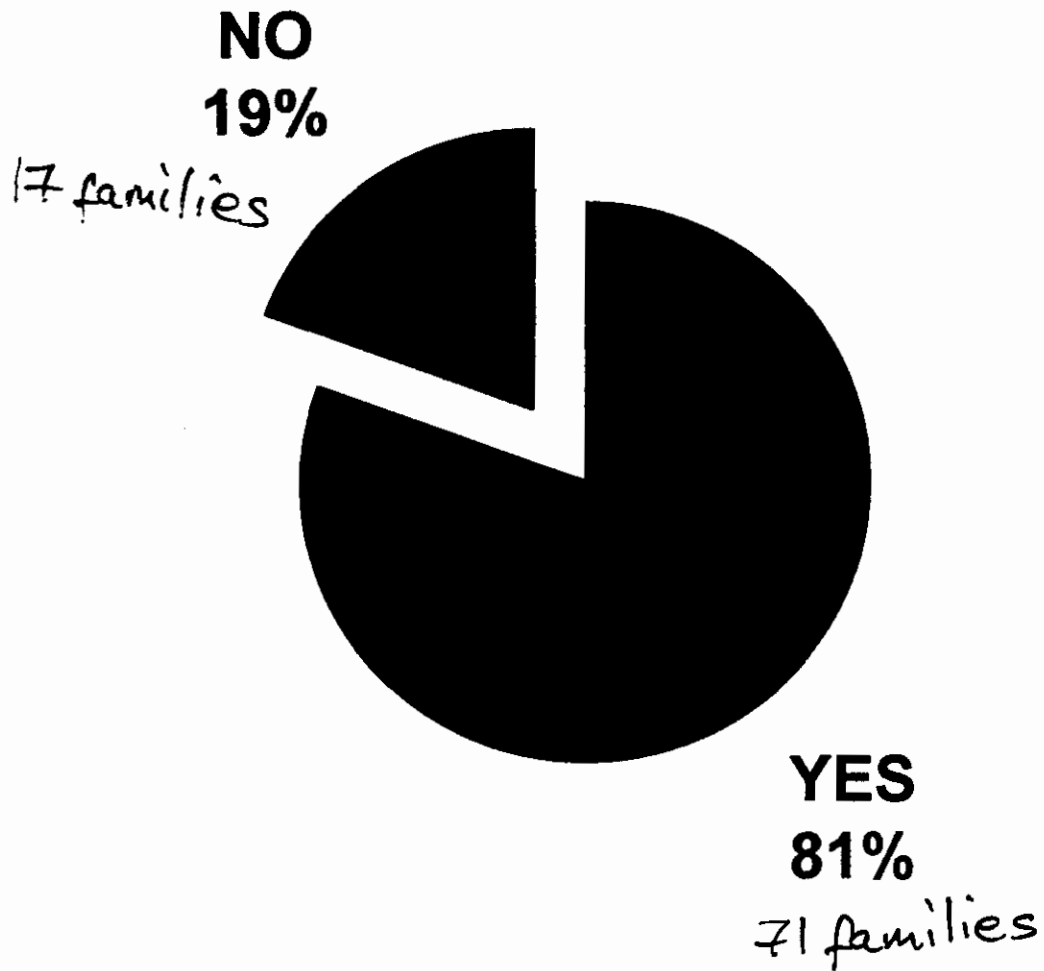
**Number Of Families**  
**Who Attended**  
**CASUALTY In Past**  
**Month**



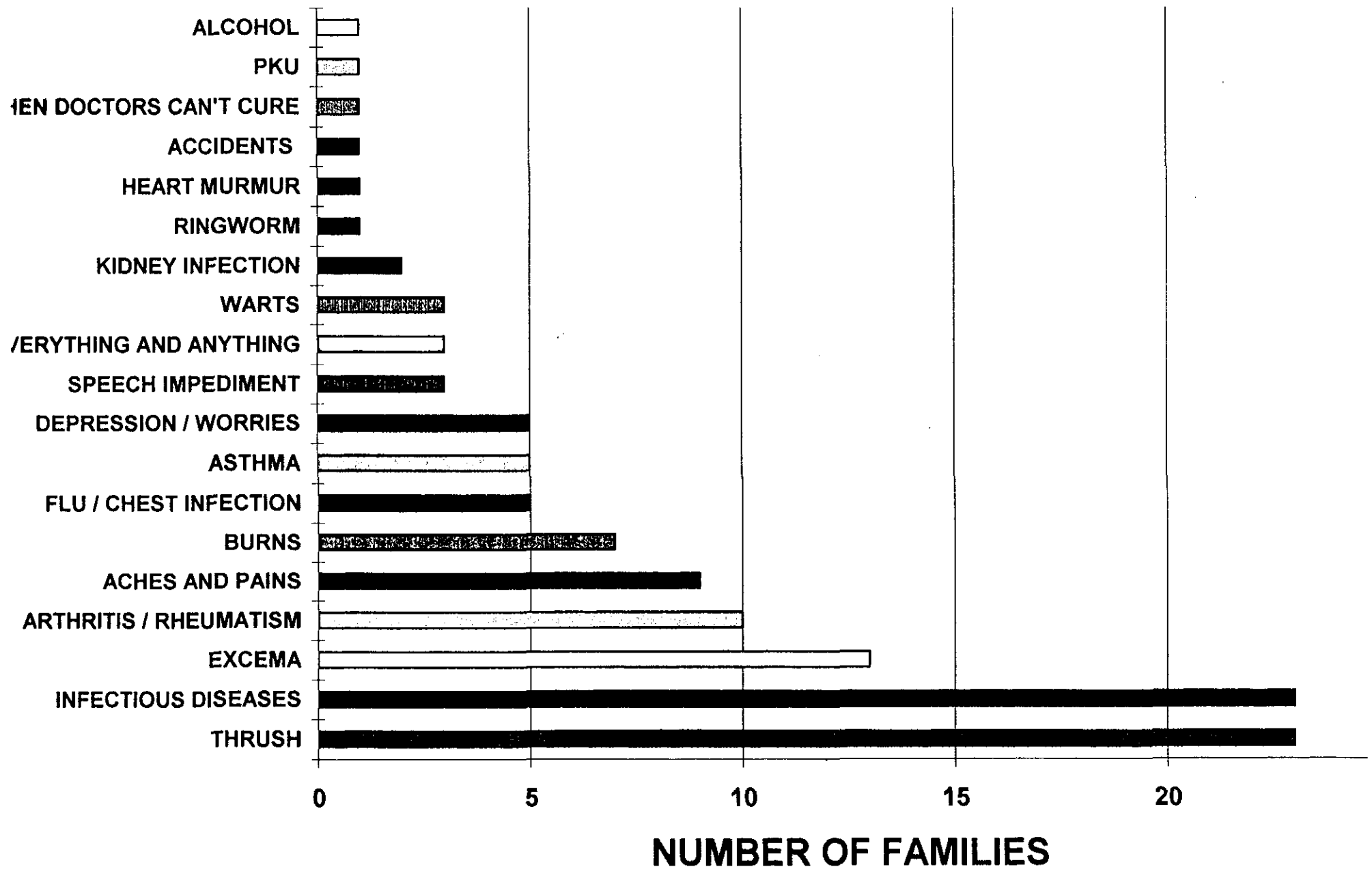
# CAUSES OF DEATHS IN FAMILIES IN PAST YEAR



# Number Who Attend Healer When Sick

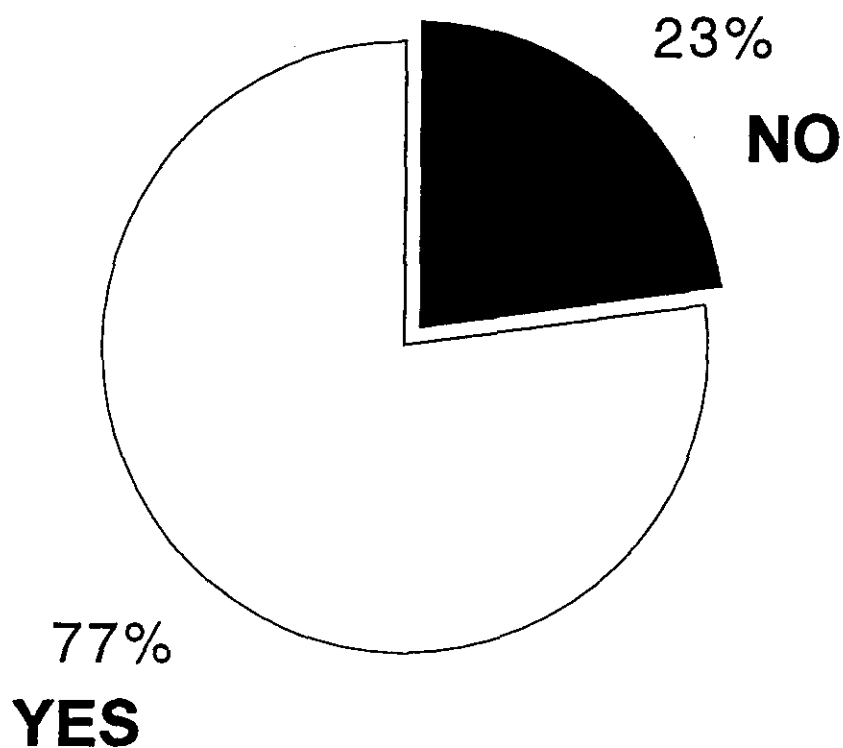


# ILLNESSES THAT CURES ARE SOUGHT FOR

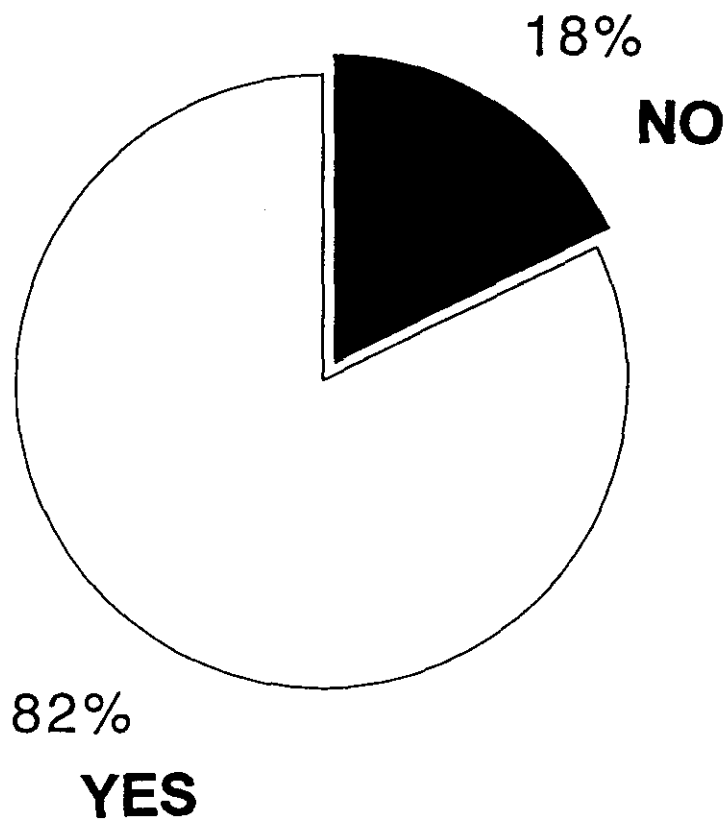




# Attendance At Antenatal Pregnancy Visits



# Up To Date Medical Card

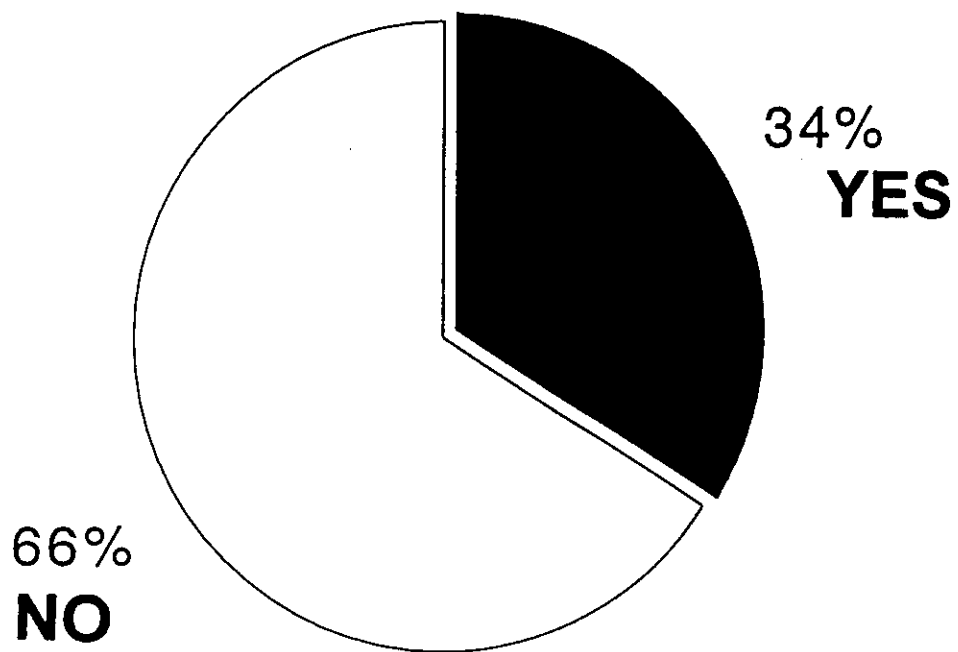


**Ante-natal Visits**

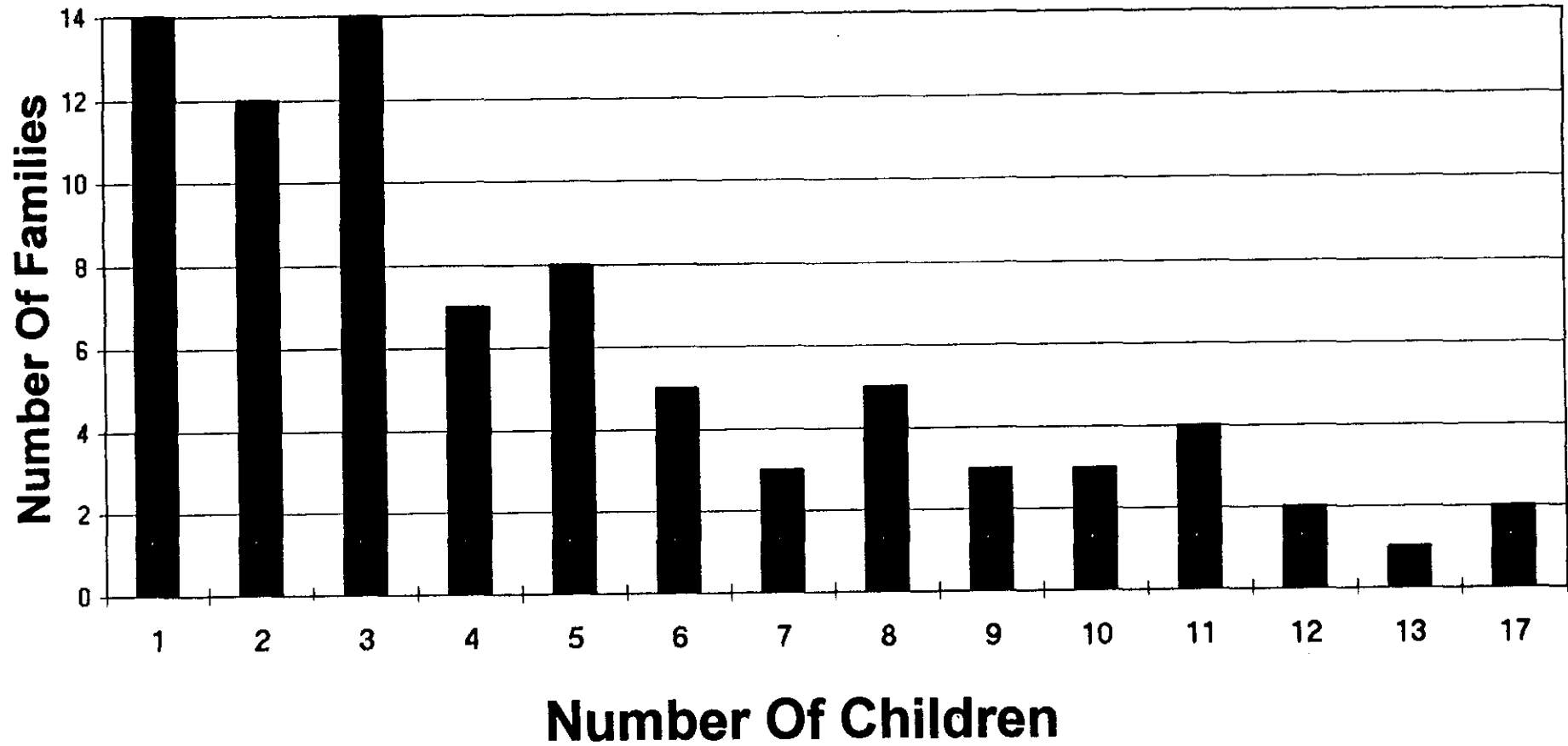
**Months Pregnant at first Visit**

<b>0 - 3 Months</b>	-	<b>26</b>
<b>4 - 6 Months</b>	-	<b>32</b>
<b>7 - 9 Months</b>	-	<b><u>6</u></b>
	<b>Total:</b>	<b>64</b>

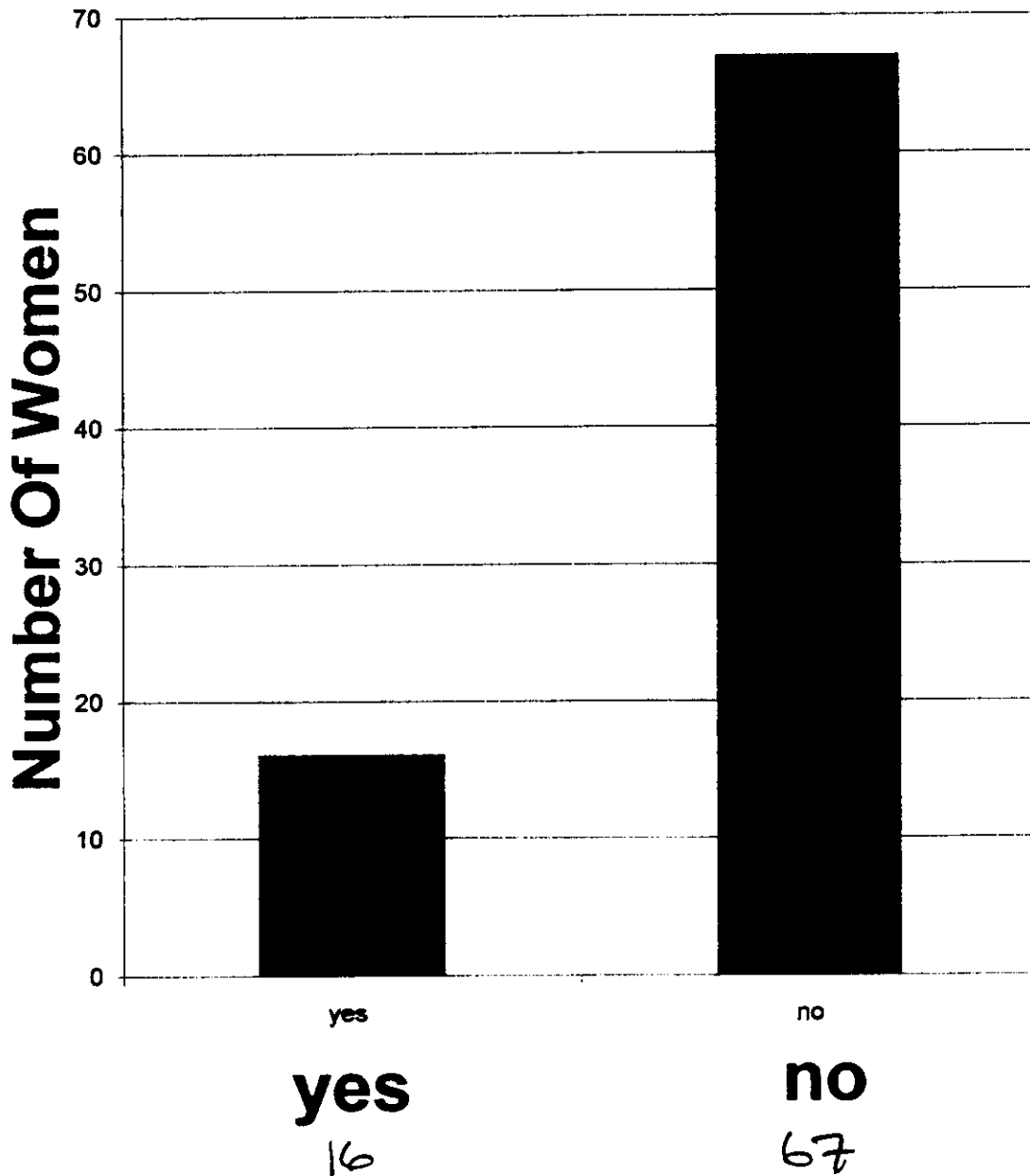
# Attendance At Postnatal Pregnancy Visits



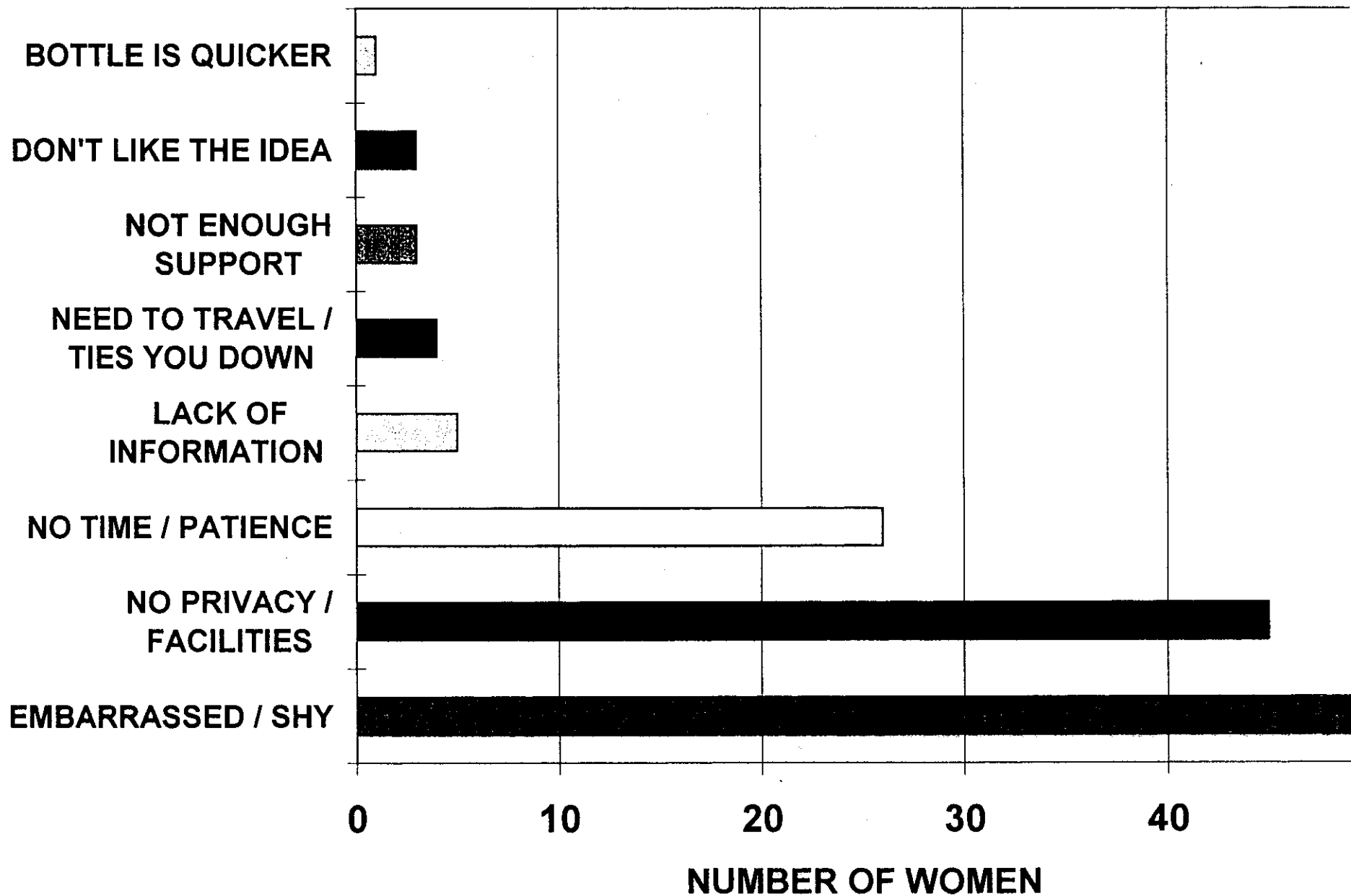
# Numbers Of Children in The Families



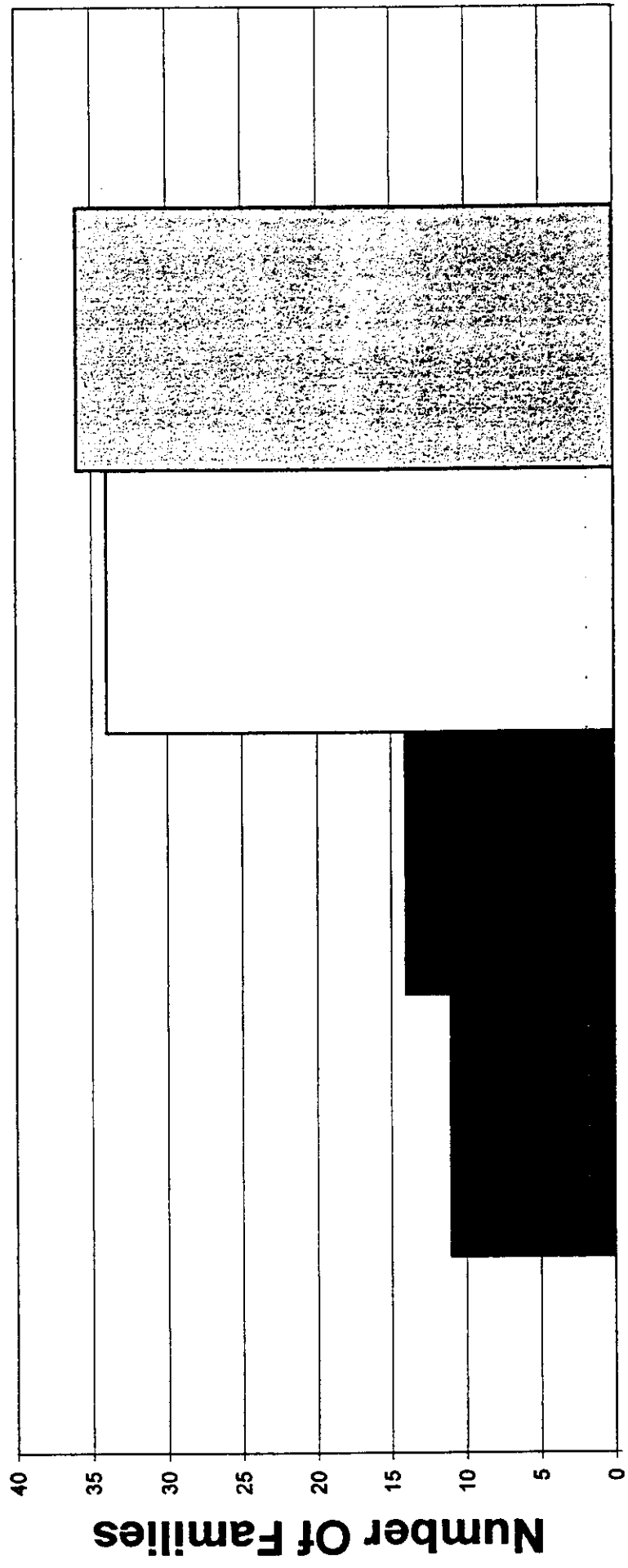
# Numbers of Women Who Breastfed Their Children



# WHY TRAVELLER WOMEN DON'T BREASTFEED



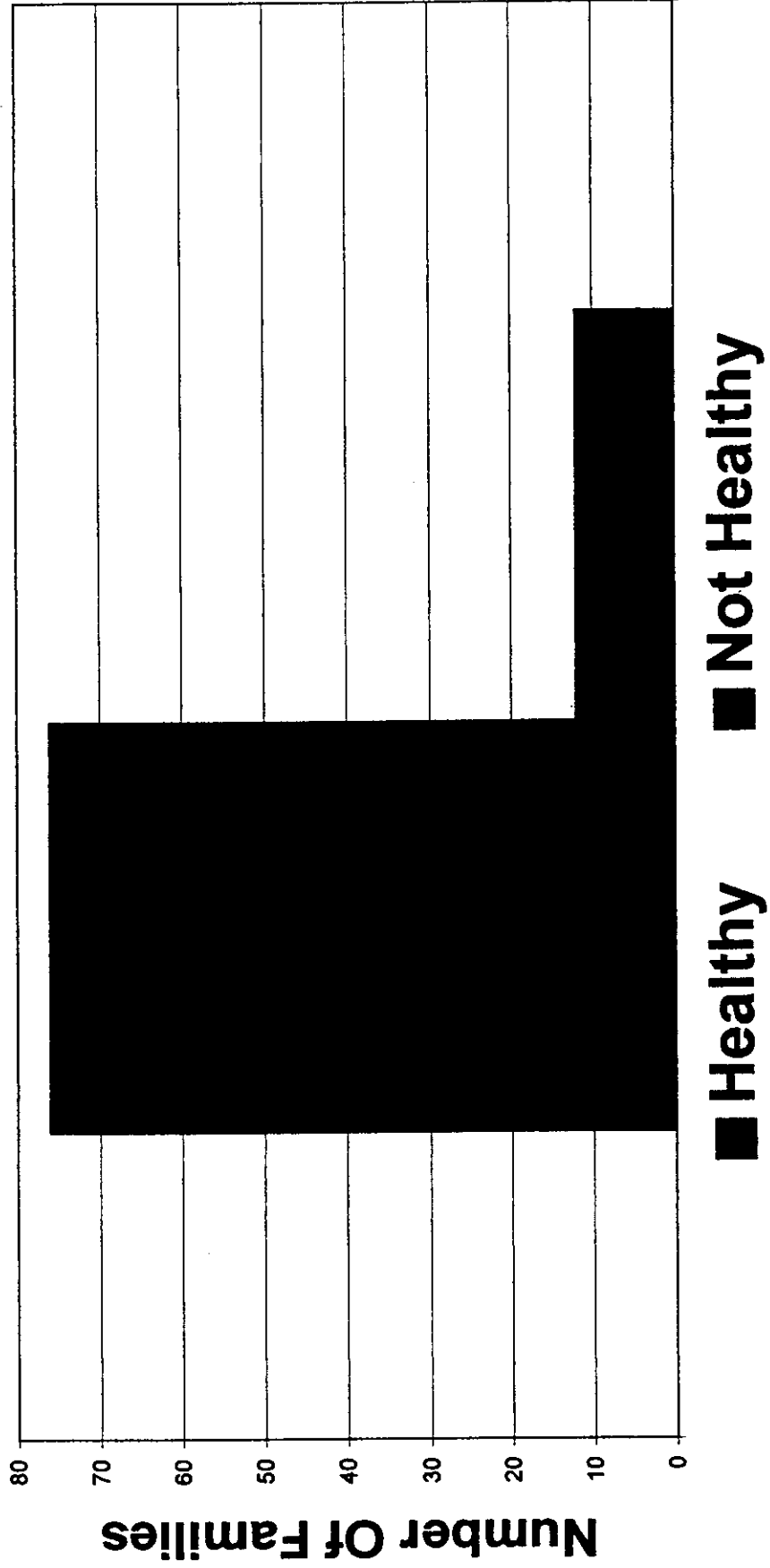
# Healthy Activities



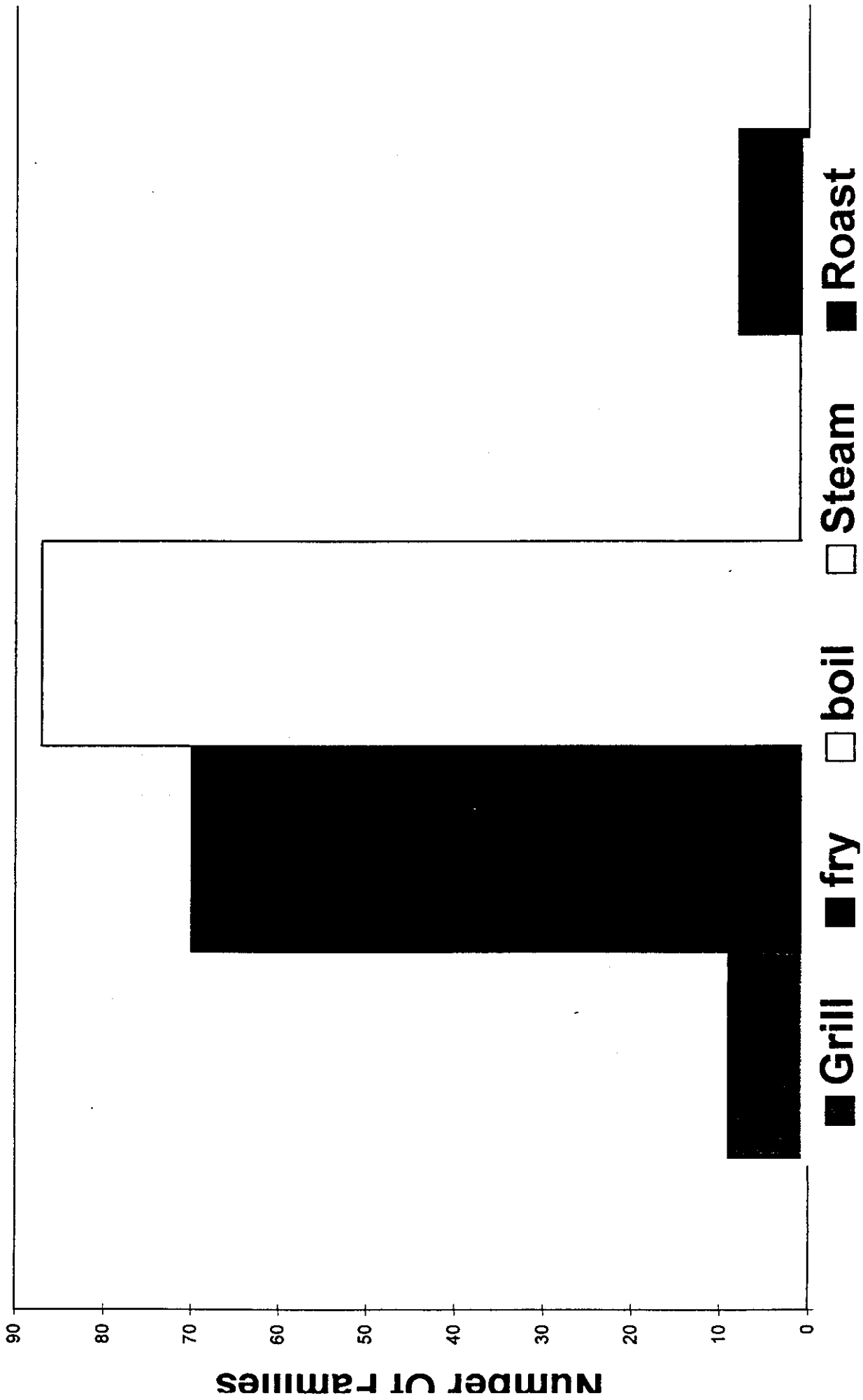
■ Play A Sport ■ Watch Your Diet □ Relaxation □ Brisk Walk



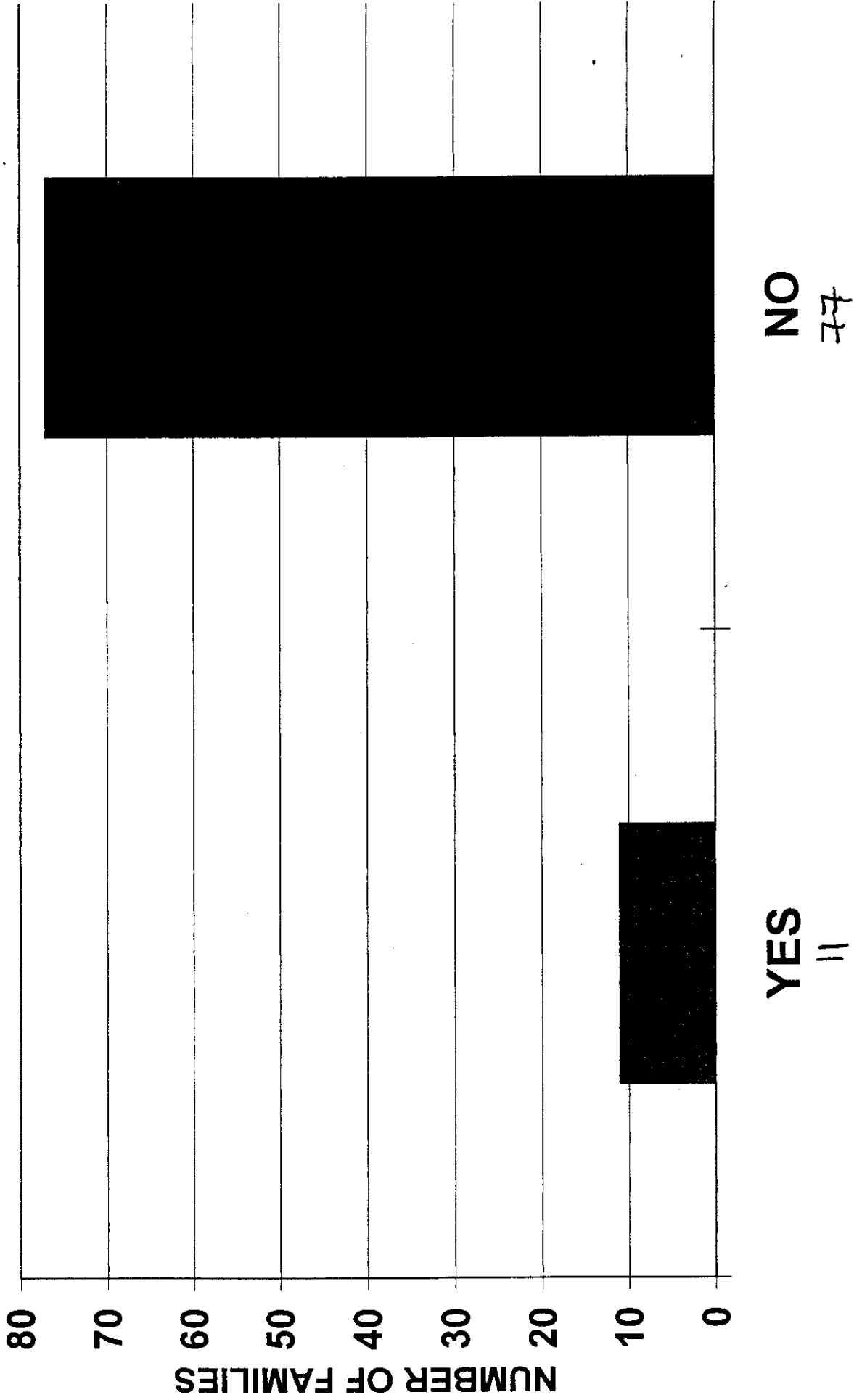
# Do Your Family Eat Healthy Meals?



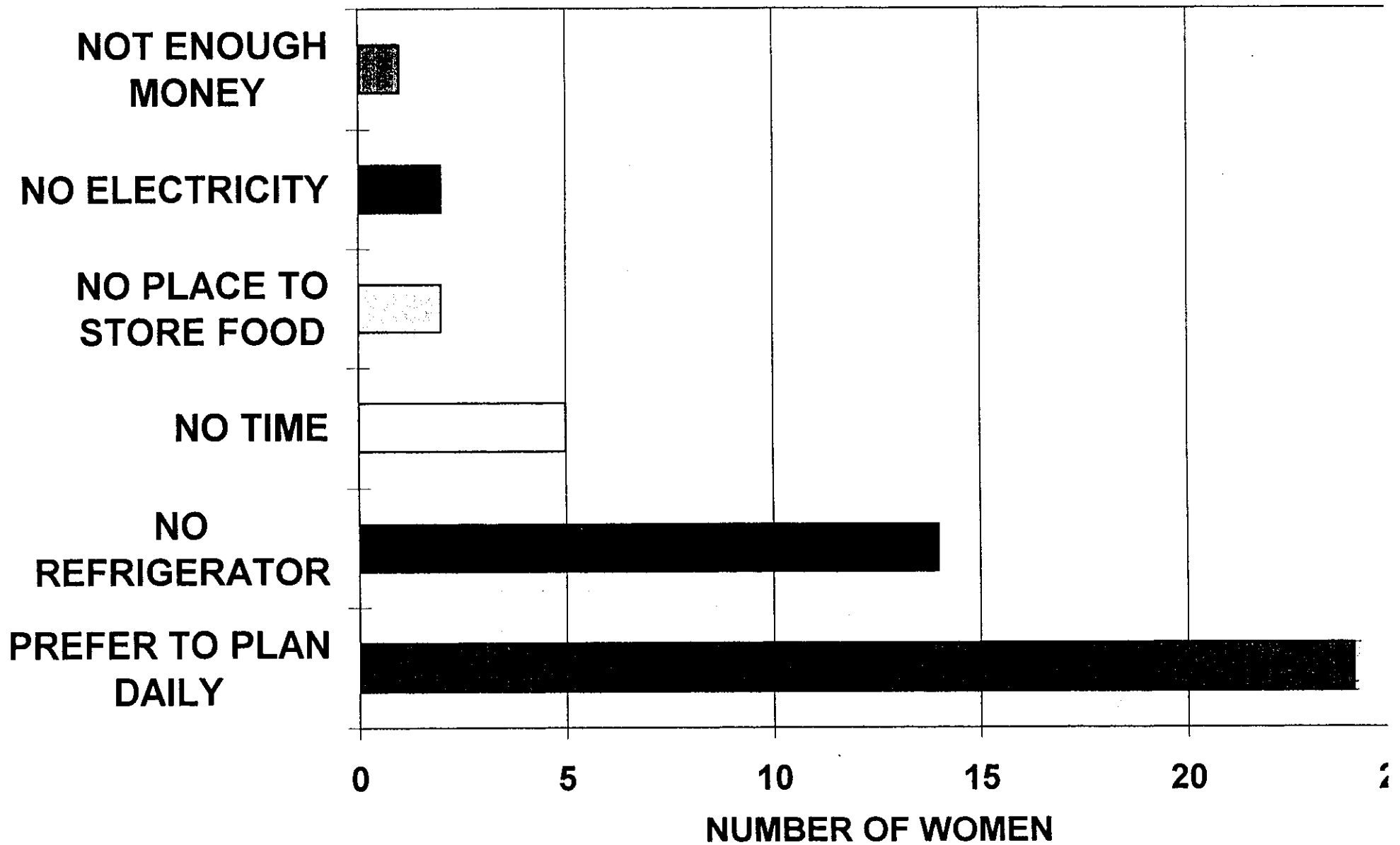
# Usual Ways Of Cooking Food



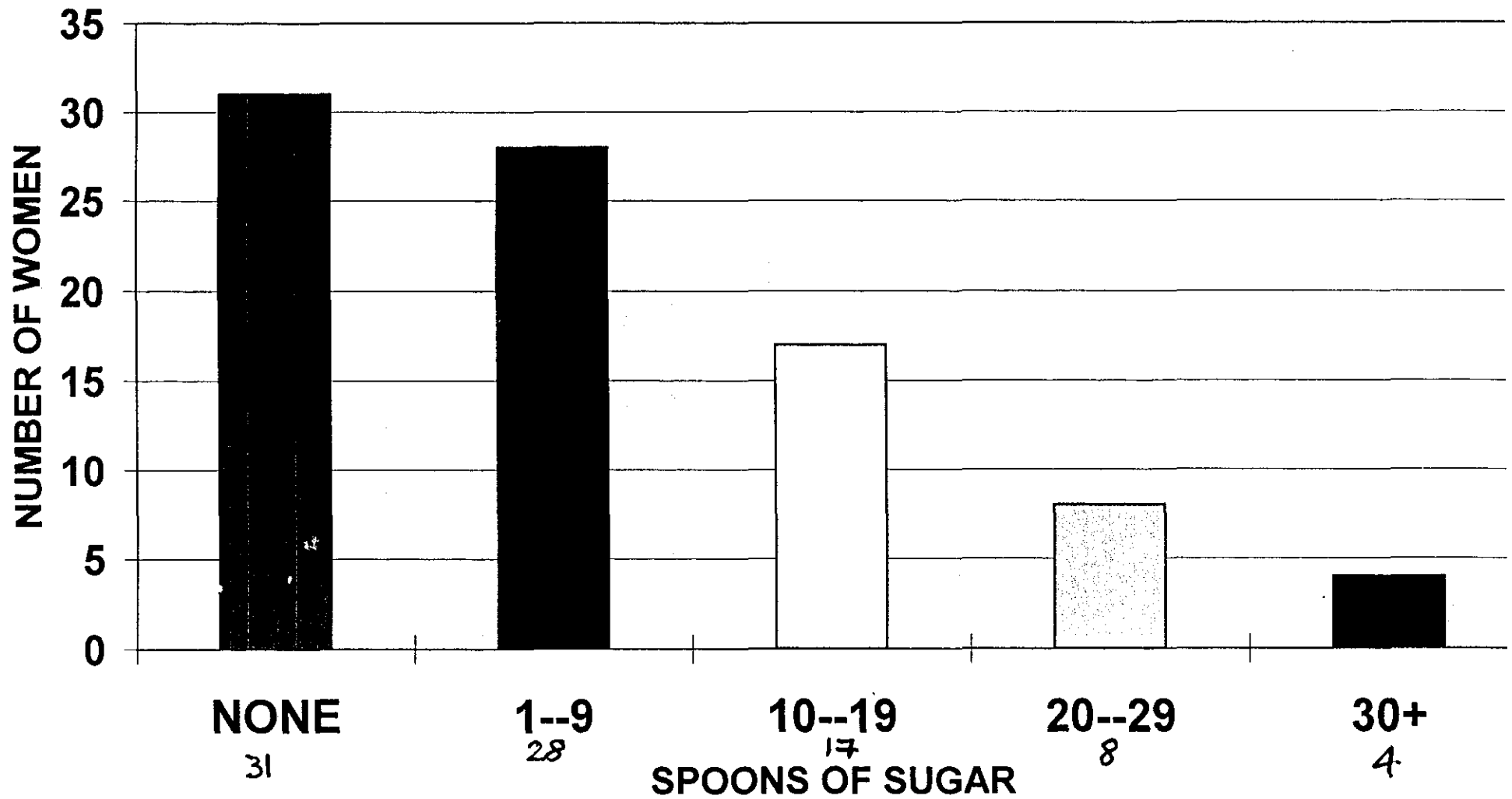
# PLAN MEALS WEEKLY?



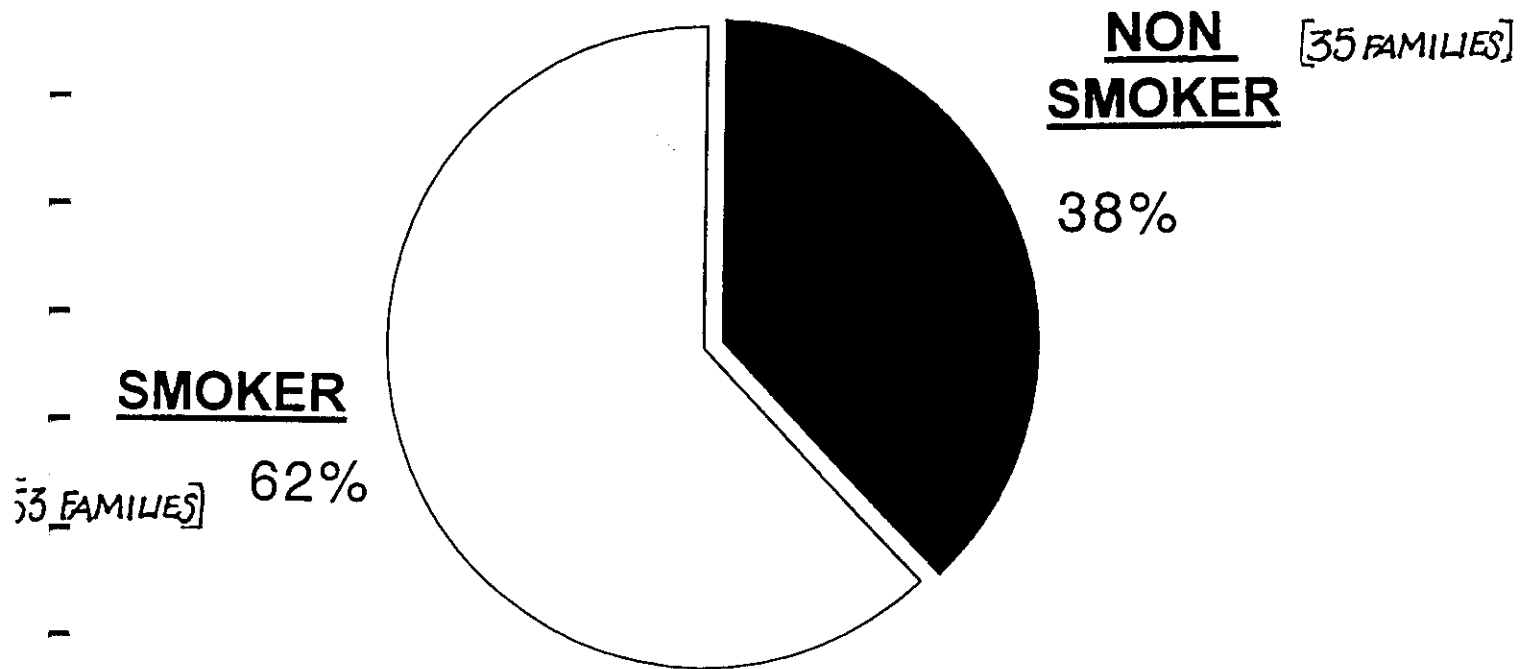
# WHY NOT PLAN MEALS WEEKLY?



# SPOONS OF SUGAR ADDED TO DRINKS / CEREAL PER DAY



# INCIDENCE OF SMOKER IN FAMILY



**Number of Smokers**

**1 Smoker**

**27 Families**

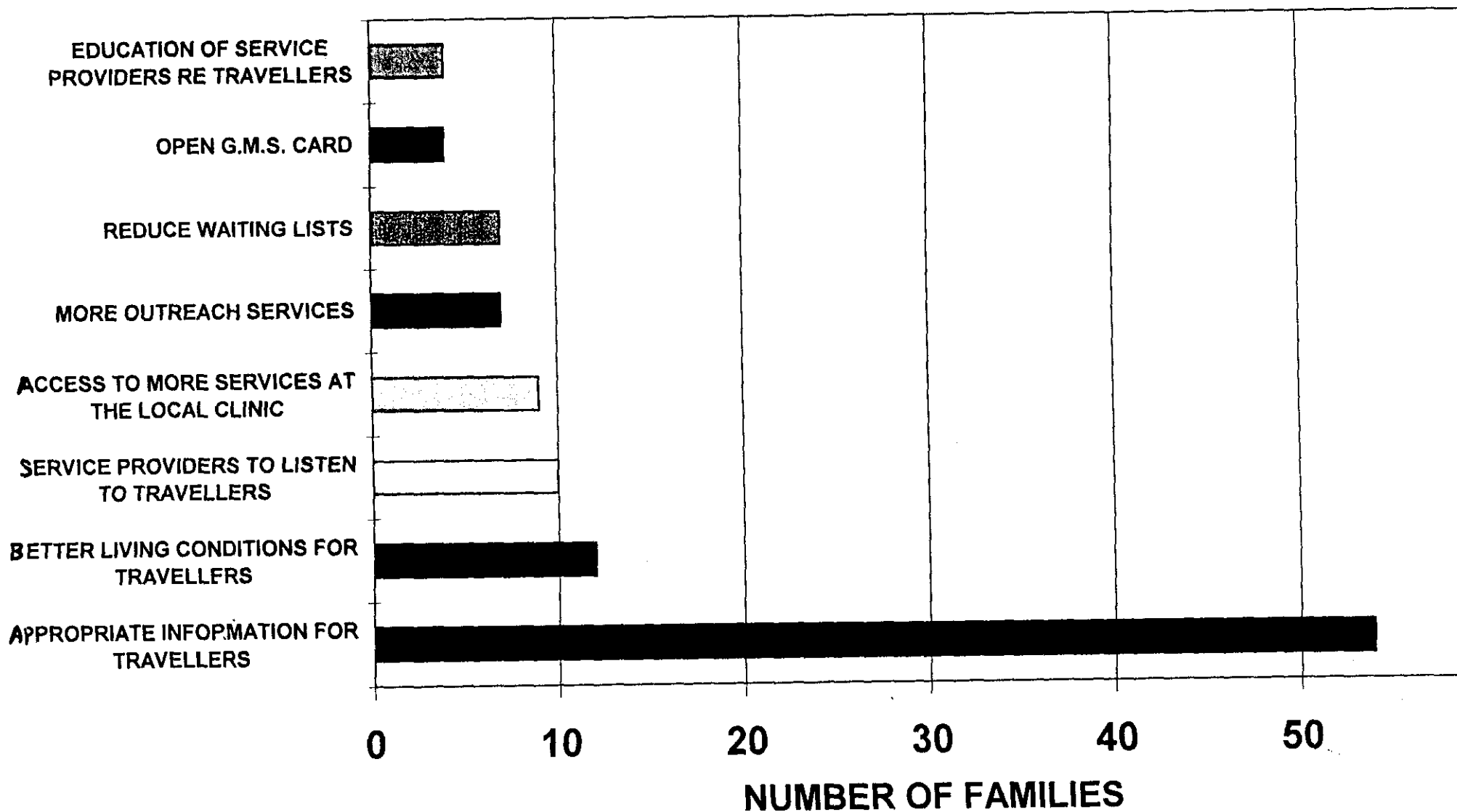
**2 Smokers**

**23 Families**

**3 Smokers**

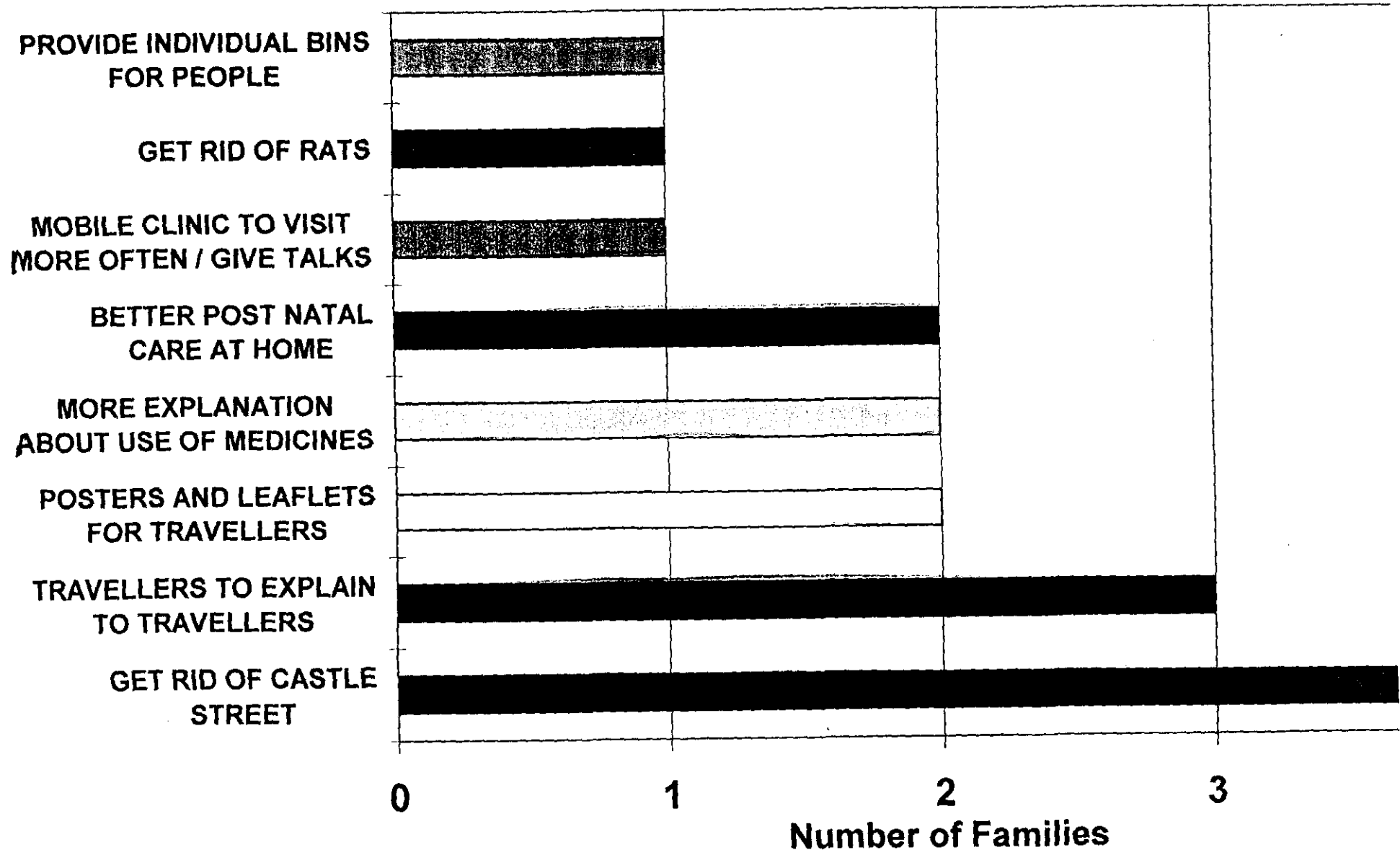
**3 Families**

# USEFUL CHANGES TO HEALTH SERVICES-2





# USEFUL CHANGES TO THE HEALTH SERVICES-1



**PRIMARY HEALTH CARE FOR TRAVELLERS PROJECT**

**QUESTIONNAIRE**

## Primary Health Care For Travellers Project

### Questionnaire Objectives

- Provide a baseline of information about Travellers (i.e. to give a baseline of disease pattern and utilisation of service at present time before starting the programme).
- Inform policy making at all levels of the Eastern Health Board
- Ensure the development of culturally appropriate and sensitive health services for Travellers.
- Inform the Travelling Community of the findings regarding their health and illness experience.
- To enable Travellers to participate in the planning process.
- Be used as the basis of any training initiatives which are developed for key staff working with Travellers.

**Any information provided will be treated in the strictest confidence and your identity will not be divulged. You are free to decline to answer any question or to refuse to participate in the questionnaire.**

# Primary Health Care For Travellers Project

## FAMILY DETAILS

1 Family Details: Are the following people part of your family.

Father (Y/N)	.....	<input type="checkbox"/>	1
Mother (Y/N)	.....	<input type="checkbox"/>	2
Grandfather (Y/N)	.....	<input type="checkbox"/>	3
Grandmother (Y/N)	.....	<input type="checkbox"/>	4
Children: Boys (Y/N)	.....	<input type="checkbox"/>	5
Girls: (Y/N)	.....	<input type="checkbox"/>	6

Specify number \_\_\_\_\_

(f) Any other relatives: Specify \_\_\_\_\_

2 Ages of Children:

(a) Boys: \_\_\_\_\_

(b) Girls: \_\_\_\_\_

3 Total number of people in the family ..... 

<input type="text"/>	<input type="text"/>
----------------------	----------------------

  
7 8

4 Accommodation Status

Does your family live in:

(a) A trailer

(b) Two trailers

(c) Three or more trailers 

<input type="text"/>
----------------------

 9

(d) Group Housing

(e) Ordinary Housing

(f) Other (specify) \_\_\_\_\_

5 Site

- (a) Avila Park
- (b) Cappagh Field
- (c) Dunsink Halting Site
- (d) St Mary's Park
- (e) Roadside Dunsink

 10

6 Do you live in:

- (a) A serviced official site
- (b) A temporary site
- (c) Field or roadside unofficial site
- (d) Other (Specify)

 11

7 Water:

- (a) Your own hot and cold water supply:
- (b) Individual cold water supply:
- (c) Shared cold water supply:
- (d) Shared hot and cold water supply:

 12

Is it in good or bad condition?(Y/N).....  13

8 Bath/Shower

- (a) Your own shower or bath:
- (b) Shared shower or bath:
- (c) No shower or bath

 14

Does it work? (Y/N).....  15

Are there problems about using it? (Y/N).....  16

9 Toilets: Have you got (Please tick):

(a) Your own flush toilet:

(b) Your own portaloo:

 17

(c) Shared portaloo:

(d) Use of shared toilets:

(e) No toilet:

Does it work? (Y/N).....  18

10 Portoloo

(a) Portaloo emptied regularly

(b) Portaloo emptied irregularly (now and then)

 19

(c) Portaloo not emptied at all

Do you use it? (Y/N).....  20

Specify \_\_\_\_\_

11 Rubbish

(a) Your own bin collection:

(b) Regular skip collection:

 21

(c) Irregular skip collection (now and then)

(d) No rubbish collection:

12 Electricity:

(a) Your own electricity supply:

(b) Shared electricity supply:

 22

(c) No electricity supply:

(d) Your own generator:

13 Telephone: Has the Site or Group Housing Scheme Got:

(a) A public phone

(b) A phone in the caretakers house

 23

(c) Private Phone

(d) No phone

Does it work? (Y/N).....  24

Do you use it? (Y/N).....  25

14 Fire Prevention

(a) Fire hoses

 26

(b) Fire extinguishers

(c) No fire precautions

Does it work? (Y/N).....  27

15 Play Facilities

(a) Play facilities (Y/N).....  28

16 Do you consider your present site to be healthy? (Y/N).....  29

17 How long have you been on this site?

(a) Less than 3 months:

(b) 4 - 6 months:

(c) 7 - 12 months:

(d) Up to 2 years:

30

(e) 2 - 5 years:

(f) 5 - 10 years:

(g) 10 years + (Specify) \_\_\_\_\_

**REPAIRS**

18 When did you last make a request for repairs?

(a) 0 - 1 month

(b) 2 - 3 months

(c) 4 - 6 months

31

(d) 6 months +

(e) No request

19 How did you make the request?

\_\_\_\_\_

20 Who did you talk to? \_\_\_\_\_

21 How did they respond? \_\_\_\_\_



22 How long did it take before the repairs was completed?

- (a) 0 - 1 month
- (b) 2 - 3 months
- (c) 4 - 6 months
- (d) 6 months +
- (e) not yet completed

32

**HEALTH**

23 Have you got a current (up to date) medical card? (Y/N) .....  33

24 If your answer is No when did it run out?

- (a) 0 - 6 months
- (b) 7 months +

34

25 Is it for your own doctor (explain) (Y/N)?.....  35

26 Does any members of your family need special help? (Y/N)

27 Have a long term illness book? (Y/N).....  36

28 Require a special diet? (Y/N).....  37

Please Specify \_\_\_\_\_

29(a) Do any members of your family who live with you have any ongoing health problems? (Y/N).....  38

If Yes, how many people?.....   39 40

29(b) What are the main health problems your family have each year?

What kinds of problems?(Y/N)

Chest Infections.....		41
Bronchitis.....		42
Stomach Ulcers.....		43
Gastro-entritis (diarrhora and vomiting).....		44
Kidney Infections.....		45
Incontinence (wetting oneself).....		46
Enuresis (bedwetting).....		47
Ear Infections .....		48
Throat Infections.....		49
Runny Nose.....		50
Hearing.....		51
Spech.....		52
Epilepsy.....		53
Stroke.....		54
Arthritis.....		55
Depression.....		56
Addiction (Problem with alcohol/tablets).....		57
Other (Specify) _____		

30 Has anybody been sick in the family in the past month?(Y/N).....

If yes how many people?.....

		58
59	60	

With what condition? \_\_\_\_\_

What did you do? \_\_\_\_\_

31 What services did you get? \_\_\_\_\_

(a) Hospital

(b) GP

	61
--	----

(c) Self Care (looked after at home)

What problems did you meet with? \_\_\_\_\_

32 If the person had to go to hospital were they kept in? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how long were they in hospital? \_\_\_\_\_

Were you told about diagnosis? (Y/N)..... 62

Was it clear and useful?(Y/N)..... 63

33 Do you ever go to healers or people with cures when you are sick?(Y/N)... 64

If yes, what kinds of illness would you seek a cure for?


65 66

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What cures and advise have they offered? \_\_\_\_\_

34 Has any member of your family died over the past year?(Y/N).....  67

Age at death \_\_\_\_\_

Cause of death \_\_\_\_\_

Type of treatment \_\_\_\_\_

Care requirements \_\_\_\_\_

Provided by whom? \_\_\_\_\_

35 Does the mobile clinic visit your site?(Y/N).....  68

If yes, do you use it? (Y/N).....  69

If you use it, how often?

(a) weekly

(b) fortnightly

70

(c) monthly

(d) bimonthly

36 If yes, what services do you use if for?

Immunizations (needles) (Y/N).....  71

Babies check-ups (Y/N).....  72

Information (Y/N).....  73

Medical cards (Y/N).....  74

To make appointments (for hospital, family planning, other services) (Y/N)....  75

Other (Specify) \_\_\_\_\_

- 37 Do you know when the mobile clinic will visit your site again?(Y/N)..... 


 76
- 38 Do you go to your local clinic to see the nurse or doctor?(Y/N)..... 


 77

When did you last go to the clinic to see the nurse or doctor? \_\_\_\_\_

What for? \_\_\_\_\_

- 39 Did your family use any of the following services in the past month?
- Doctor (GP) service (Y/N)..... 


 78
- How many times?..... 

--	--

 79 80
- Child health services (e.g. public health nurse) (Y/N)..... 


 81
- How many times?..... 

--	--

 82 83
- Speech Therapy Service (Y/N)..... 


 84
- How many times?..... 

--	--

 85 86
- Dental Service(Y/N)..... 


 87
- How many times?..... 

--	--

 88 89
- Maternity Service (ante-natal classes) (Y/N)..... 


 90
- How many times?..... 

--	--

 91 92
- Accident and emergency (casualty) (Y/N)..... 


 93
- How many times?..... 

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 94 95

Family Planning Clinic(Y/N).....  96  
How many times?.....    
97 98

40 Have you been referred by the G.P. to any of the following services in the past year?

Ophthalmic Service (eye test) (Y/N).....  99  
How many times?.....    
100 101

Cervical Screening (smear tests) (Y/N).....  102  
How many times?.....    
103 104

Breast examination? (Y/N).....  105  
How many times?.....    
106 107

Menopausal Clinic? (Y/N).....  108  
How many times?.....    
109 110

Incontinence Clinic (wetting oneself)?.....  111  
How many times?.....    
112 113

41 Please say if you have problems with

Doctor (G.P.) service (Y/N).....  114

Specify \_\_\_\_\_

Bureau doctor (Y/N).....  115

Specify \_\_\_\_\_

Hospital doctor (Y/N).....  116

Specify \_\_\_\_\_

Hospital Care (Y/N).....  117

Specify \_\_\_\_\_

Dentist (Y/N).....  118

Specify \_\_\_\_\_

Speech Therapy Service (Y/N).....  119

Specify \_\_\_\_\_

42 Do you understand what you are entitled to the health service?(Y/N).....  120

If No, is it to do with

(a) lack of information how to use the services? (Y/N).....  121

(b) lack of information about the need to have check-ups and certain tests?(Y/N).....  122

(c) unable to read letter or appointment?(Y/N).....  123

(d) unable to prepare adequately (wash oneself) to go for an appointment?(Y/N).....  124

WOMENS HEALTH

43 Do you attend for ante-natal pregnancy check ups?(Y/N).....  125

If No, Why not? \_\_\_\_\_

44 If Yes, which of the following do you attend for your ante-natal care?

(a) doctor (G.P.)

(b) Maternity Hospital  126

(c) Both

45 On your last pregnancy, how many months pregnant were you at your first visit?

(a) 0 - 3 months

(b) 4 - 6 months

(c) 7 - 9 months  127

(d) no ante-natal care

46 Did you go for a post-natal check-up?(Y/N).....  128

47 What age were you when your first child was born? \_\_\_\_\_

48 What space is there between your last two children? \_\_\_\_\_

49 What age were you when your last child was born? \_\_\_\_\_

50 Total number of children in your family.....    
129 130

51 What age were you when you started school?.....    
131 132

52 How long did you attend school for?.....    
133 134

Specify \_\_\_\_\_



53 What age were you when you left school?.....

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135 136

54 Where would you go for the following health services?

Family Planning \_\_\_\_\_

Smear Tests \_\_\_\_\_

Screening for Breast Cancer \_\_\_\_\_

Dental service (while pregnant) \_\_\_\_\_

Any other womens health needs (specify) \_\_\_\_\_

55 What changes would you most like to see put into the health service to make it more useful to you?

\_\_\_\_\_  
\_\_\_\_\_

56 Do you think Travellers have more illnesses than others?(Y/N).....

--

 137

If yes, say why \_\_\_\_\_

\_\_\_\_\_

57 Do you think visits from Traveller Community Health Workers  
are a good idea? (Y/N).....

--

 138

58 What do you think Travellers themselves could do to improve their health?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NUTRITION

59 Do you do any of the following to improve your health?

Watch your diet (Y/N).....	<input type="checkbox"/>	139
Play a sport (Y/N).....	<input type="checkbox"/>	140
Brisk walking (Y/N) .....	<input type="checkbox"/>	141
Take time just to relax (Y/N).....	<input type="checkbox"/>	142

Other activities (Specify) \_\_\_\_\_

60 Does any member of your family smoke? (Y/N).....  143

If yes, how many people?.....

144 145

61 Did you breast feed any of your children? (Y/N).....  146

62 If Yes, how many did you breast feed for three months or more?.....

147 148

63 If Yes, when did you start to breast feed your last baby? \_\_\_\_\_

64 Did you give any other feeds? (Y/N).....  149

65 If Yes, when did you start extra feeds and what were they?

\_\_\_\_\_

66 How long did you give extra feeds for? \_\_\_\_\_

67 Do you put cereal in the bottle? (Y/N).....  150

68 When did you start to spoon feed your last baby? \_\_\_\_\_

Specify \_\_\_\_\_

69 When did you stop breast feeding your last baby? \_\_\_\_\_

Specify \_\_\_\_\_

70 Why do you think that some Traveller women don't breast feed?

\_\_\_\_\_

71 Do you plan your meals weekly? (Y/N).....  151

If no, why not? \_\_\_\_\_

\_\_\_\_\_

72 Do you try to cook different meals during the week? (Y/N).....  152

73 What sort of bread do you usually eat? \_\_\_\_\_

74 Where do you usually buy your food?

(a) Supermarket

(b) Local Shop

153

(c) Local van

(d) Other \_\_\_\_\_

75 Sugar

Everyday how many of the following do you drink (fill in spoons of sugar taken)

	Number of Cups A Day	Spoons of Sugar
Tea		
Coffee		
Cereals		
Other drinks (e.g. minerals, milk, butter milk)		
Total number of spoons of sugar a day		

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154 155

76 Which brand of spread do you use on your bread?

Specify Brand \_\_\_\_\_

77 Do you think the meals your family eat are healthy?(Y/N).....  156

78 What are the two most usual ways you cook your food?

(a) Grill

(b) Fry

 157

(c) Boil

(d) Steam

 158

(e) Roast

79 What do you think Travelers could do to improve their diet?

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